fiscal 2017-2018 **Q4**

4th quarter ended March 31, 2018

KHSC this quarter

QIP **Performance** Report

Hôpital Hotel Dieu Hospital

Hôpital Général de Kingston General Hospital

Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

KHSC Quality Improvement Plan (QIP) Performance Report Fiscal 2017-18

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Strategic Direction 1

Improve the patient experience through a focus on compassion and excellence

Outcome: KHSC is a top performer on the essentials of quality, safety & service

Strategic Performance Indicators

"Would you recommend this ED to your friends and family?" (KGH QIP)	3
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KHSC Quality Improvement Plan (QIP) Performance Report Fiscal 2017-18

Strategic Direction 3

Enable clinical innovation in complex-acute and specialty care

Outcome: KHSC is positioned as a leading centre for complex-acute & specialty care

Strategic Performance Indicators

[(# of regular clinics held + # of special clinics held) / (#regular clinics assigned)] x 100 (HDH QIP)	**19**
# days from clinic appointment until dictated clinic letter has been verified [Result verification date - Clinic appointment date] (HDH QIP)	**20**

Strategic Direction 4

Create seamless transitions in care for patients across our regional health-care system

Outcome: KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions

Strategic Performance Indicators

Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort) (KGH QIP)	**21**
Patient Journey Process maps as developed by each organization (presented to HCT COPD Clinical Steering Team) Best Practice and QBP Guidelines (HDH QIP)	**22**

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Q4 FY2018 Quality Improvement Plan Report

Strategic Direction	2019 Outcome	Indicator	18-Q1	18-Q2	18-Q3	18-Q4	19-Q1
Improve the patient experience through a focus on compassion and excellence	KHSC is a top performer on the essentials of quality, safety, & service	"Would you recommend this ED to your friends and family?" (KGH QIP)	Y	Y	Y	N/A	N/A
		Percent of patients that respond "definitely yes" or "probably yes" to the question, "Would you recommend this Emergency Dept to your friends and family?" (HDH QIP)	G	G	G	N/A	N/A
		Percent of patients that rate their care during this emergency room visit as 7 or higher (on 10-point scale) (HDH QIP)	R	Y	Y	N/A	N/A
		90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (KGH QIP)	G	G	G	G	N/A
		Medication Reconciliation at Admission (KGH QIP)	Y	Y	Y	Y	N/A
		# of eligible clients receiving formal med rec upon admission to mental health clinics/by total # of eligible clients admitted for the quarter (HDH QIP)	G	G	G	G	N/A
		# of eligible clients receiving formal med rec upon admission to EPACU for total joint arthroplasty/by total # of eligible clients admitted for the quarter (HDH QIP)	Y	Y	G	Y	N/A
		# of eligible clients receiving formal med rec upon admission for bariatric surgery/by total # of eligible clients admitted for the quarter (HDH QIP)	G	G	G	G	N/A
		# of eligible patients receiving Best Possible Medication Discharge Plan (BPMDP) at disch from EPACU for total Joint Arthroplasty/by total # of eligible patients discharged for the quarter (HDH-QIP)	G	G	G	G	N/A
		Reduce percent of patients with facility acquired pressure injury (KGH QIP)	G	G	N/A	G	N/A
		Percent ALC Days (KGH QIP)(KGH SAA)	Y	R	R	Y	N/A
		Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (KGH QIP)	G	Y	G	G	N/A
		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? (KGH QIP)	Y	Y	Y	N/A	N/A

Strategic Direction	2019 Outcome	Indicator	18-Q1	18-Q2	18-Q3	18-Q4	19-Q1
Enable clinical innovation in complex-acute and specialty care	KHSC is positioned as a leading centre for complex-acute & specialty care	Percent of patients who wanted information that respond "very confident" that they have the information they need and/or know who to contact after they leave their appointment (HDH QIP)	G	G	G	N/A	N/A
		Percent of patients in adult ambulatory clinics that rate the quality of care and services received as 'excellent' or 'very good'. (HDH QIP)	G	G	G	N/A	N/A
		90% UCC Length of Stay (LOS-hrs) for complex patients (CTAS 1,2,3) (HDH QIP/SAA)	G	G	G	G	N/A
		[(# of regular clinics held + # of special clinics held) / (# regular clinics assigned)] x 100 (HDH QIP)	G	G	G	G	N/A
		# days from clinic appointment until dictated clinic letter has been verified [Result verification date - Clinic appointment date] (HDH QIP)	Y	Y	Y	Y	N/A
Create seamless transitions in care for patients across our regional health-care system	KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort) (KGH QIP)	G	G	G	G	N/A
		Patient Journey Process maps as developed by each organization (presented to HCT COPD Clinical Steering Team) Best Practice and QBP Guidelines. (HDH QIP)	G	G	G	G	N/A

	SPR					QIP					SAA				
	F18					F18					F18				
	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #
R	0%	0%	0%	0%	0	5%	5%	5%	0%	0	30%	28%	31%	41%	22
G Y	100%	100%	100%	100%	15	95%	95%	95%	100%	20	67%	70%	69%	59%	32
N/A	0%	0%	0%	0%	0	0%	0%	0%	0%	0	4%	2%	0%	0%	0
					15					20					54

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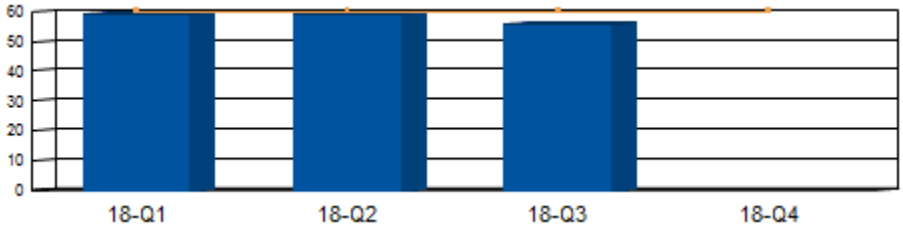
Q4 FY2018 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

KHSC is a top performer on the essentials of quality, safety, & service

Indicator: "Would you recommend this ED to your friends and family?" (KGH QIP)



	Actual	Target
18-Q1	59.2	**60**
18-Q2	59.0	**60**
18-Q3	55.6	**60**
18-Q4		**60**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Data not yet available
Staff strives to provide exemplary care we provide patient experience results and engage in patient feedback forums that allow a patients experience to be told by the patient to the staff. Patients highlight strengths and opportunities for improvement. We review the surveys to understand and rely to all what dimensions of patient experience correspond most closely with high levels of patient satisfaction and try to work on tactics to improve those. Results are delayed but results from last surveys indicated we can improve communication on what to expect while in the emergency room. We have been working with patient experience advisors to developed a "what to expect in the emergency department" brochure.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Patient experience survey results from the Emergency Department Patient Experience of Care (EDPEC) survey are always somewhat delayed; thus, the Q4 results will be reported in Q1.We knowing from previous surveys a major patient satisfier in the ED is reduced wait times we continue to work on these and look for any trends in surveys to gear new efforts to.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We will continue to look for opportunities identified by our patient from there feedback to improve the experience in the emergency department. This new survey is one source of information regarding patient experience at KGH. The challenge is how we move people from 'probably' to 'definitely'. The perception may be that 'definitely' does not allow room for improvement. We continue to work on improving access and flow through the emergency department.

Definition: DATA: Pam Pero COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

"Would you recommend this ED to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents).

Target: Target 17/18: 60% Perf. Corridor: Red <54% , Yellow 54%-59%, Green >=60%

Previous fiscal year - Target 16/17: 69.3% Perf. Corridor: > 10% quarterly teach. Target, Yellow Within 10% of quart. Teach. Target, Green At or above the teach avg. /quarter

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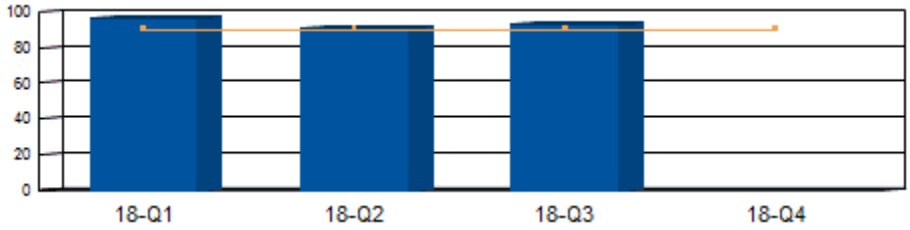
Indicator: Percent of patients that respond "definitely yes" or "probably yes" to the question, "Would you recommend this Emergency Dept to your friends and family?" (HDH QIP)



	Actual	Target
18-Q1	96	**90**
18-Q2	91	**90**
18-Q3	93	**90**
18-Q4		**90**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Data not yet available

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Patient experience survey results from the Emergency Department Patient Experience of Care (EDPEC) survey are always somewhat delayed; thus, the Q3 results are being reported in the Q4 scorecard.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Emergency Department Patient Experience of Care (EDPEC) survey are always somewhat delayed; We noticed with our patient relations department that communication can be an issue so our patient experience advisor and staff are developing a information booklet " what to expect in the emergency department ". We await the results of the next survey as well and will work to improve any areas identified.

Definition: DATA: Ontario Emergency Department Patient Experience of care Survey (OEDPEC) - Janine Schweitzer COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Patient satisfaction with UCC has been high. The goal is to maintain positive performance. Target based on Apr - Jun 2016 Performance. Target based on Apr - Jun 2016 performance. New survey and new rating scale. Target may be adjusted by UCC leaders once survey has been longer. Renovate triage area and implement new volunteer position. Performance is review quarterly.

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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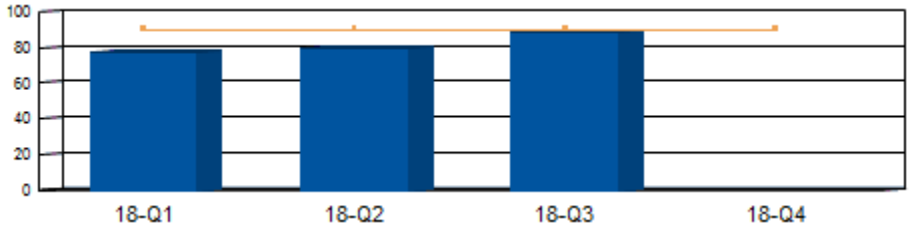
Indicator: Percent of patients that rate their care during this emergency room visit as 7 or higher (on 10-point scale) (HDH QIP)



	Actual	Target
18-Q1	77.0	**90**
18-Q2	80.0	**90**
18-Q3	88.6	**90**
18-Q4		**90**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Data not yet available

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Patient experience survey results from the Emergency Department Patient Experience of Care (EDPEC) survey are always somewhat delayed; thus, the Q3 results are being reported in the Q4 scorecard. Results will be reviewed what specific dimensions of care correlate most closely with positive care experiences. HDH recently completed a redesign of its triage area to address patient feedback that triage area was a source of confusion it was redesigned with staff and patient input. After completion patient feedback was that privacy could be improved and we have just installed retractable privacy screens that maintain the openness for mobility that was identified prior by patients.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We have identified that way finding can be an issue with both patient experience advisors and the assistance of the low vision clinics have in coming new directional signs and information that should address some issues way finding.

Definition: DATA: Ontario Emergency Department Patient Experience of care Survey (OEDPEC) - Janine Schweitzer COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Patient satisfaction with UCC has been high. The goal is to maintain positive performance. Target based on Apr - Jun 2016 Performance. Target based on Apr - Jun 2016 performance. New survey and new rating scale. Target may be adjusted by UCC leaders once survey has been longer. Renovate triage area and implement new volunteer position. Performance is review quarterly.

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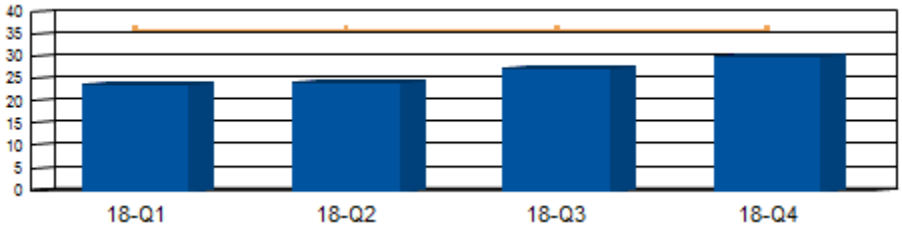
Indicator: 90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (KGH QIP)



	Actual	Target
18-Q1	24	**36**
18-Q2	24	**36**
18-Q3	27	**36**
18-Q4	30	**36**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Tactics initiated over the year that included increased bed spaces in the Medicine program, the Home First Specialist role, the Medical/Surgical Assessment and Procedure clinic and the advent of the Admission Transfer Unit ,and the start of the Patient Intake and Flow (PIF) Coordinator that has taken a lead in viewing the overall flow within the department and hospital. The formalized hospital surge protocol developed and used since the fall and the combined work of Charge Nurses , the Admitting department staff, Managers and physicians with the flow coordinator as the central role has promoted optimum bed utilization in the building has assisted efficient flow and transfer of patients from the emergency department and between units. This frees up space in the Emergency department for those in the waiting rooms. In the event that patients are required to be moved into non-traditional care spaces on inpatient wards the PIF Coordinator assessed available corporate resources (staff, beds, equipment) to determine the most appropriate location for the patient in collaboration with the unit leadership.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

We experienced an increase in the time that 9 out of 10 patients spend in the emergency department being diagnosed, received treatment and left the emergency department for an inpatient hospital bed. We experienced increased volume and high flu admission activity so experienced an increase in time from Q3 (pre flu) season. We did remain below the target and 18 hours below last year's Q4 flu / winter season time frame.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We have met the target during the Q 4 while experiencing increased patient admissions due to a prolonged flu season that saw higher number of people requiring admissions. Overall volume has increased but the initiatives put in place previous quarter have assisted. We have been experiencing a significant increase in mental health visits as well during this period, and overall volume and activity has increased.

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and waiting for admission to a hospital bed. Most patients spend less time, while 1 out of 10 patients will spend more time. The time being measured is defined as when a patient registers until the time when the patient is admitted to an inpatient hospital bed. For this indicator, 9 out of 10 patients (for all admitted patients at all levels of complexity) will spend no more than 31 hours within the ER from the time they arrive and register to the time they leave the ED.

Target: Target 17/18: 36 Perf. Corridor: Red >39 , Yellow 37 - 39 , Green <=36.

Previous fiscal year - Target 16/17: 29 Hours Perf. Corridor: Red >33 Yellow 30 - 33 Green <30

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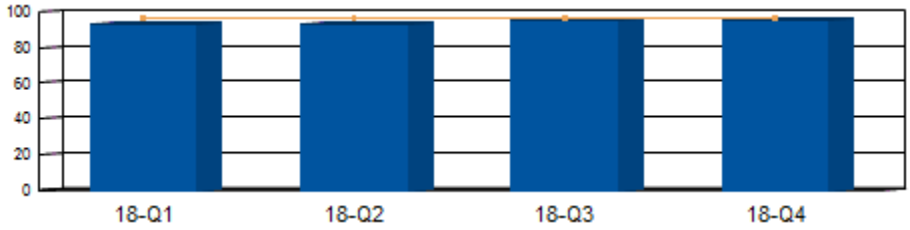
Indicator: Medication Reconciliation at Admission (KGH QIP)



	Actual	Target
18-Q1	93	**96**
18-Q2	93	**96**
18-Q3	95	**96**
18-Q4	95	**96**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Medication reconciliation reduces medication discrepancies at interface of care and prevents patient harm. Medication reconciliation on admission requires the documentation of the complete home medication list or Best Possible Medication History (BPMH) on the admission orders. Standardized admission order sets support the process by prompting the prescribers to document the BPMH on the admission orders.
Admission order sets including the medication reconciliation process are now available in an electronic format via EntryPoint for all prescribers to access online.
This quarter, the clinical pharmacists continued to promote the use of admission order sets to prescribers.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The percentage of patients who received medication reconciliation at the time of admission to the Hospital (KGH site only) remains stable this quarter with a rate of completion of 95% for all admitted patients in Fiscal 18 Q4, same as F18 Q3 compliance rate of 95%.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Target of >= 96% is a stretch target for this fiscal year.
We almost met our stretch target at 95%
The F18 Q4 intervention was successful in maintaining our 95% compliance rate.
Compliance will continue to be encouraged with the prescribers and monitored in F19

Definition: DATA: Decision Support - David Barber COMMENTS: Veronique Briggs EVP: Troy Jones REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.

Target: Target 17/18: 96% Perf. Corridor: Red < 86% , Yellow 86%-95% , Green >=96%

Previous fiscal year - Target 16/17: 96% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%

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Q4 FY2018 Quality Improvement Plan Report

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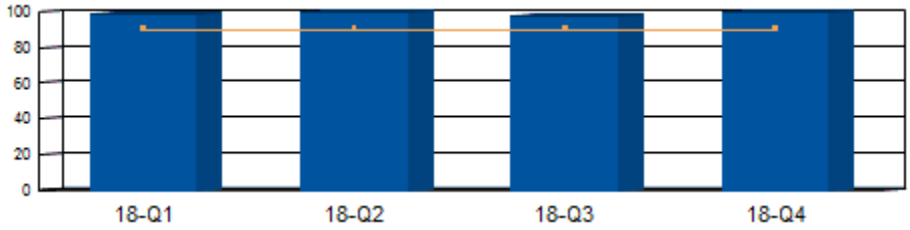
Indicator: # of eligible clients receiving formal med rec upon admission to mental health clinics/by total # of eligible clients admitted for the quarter (HDH QIP)



	Actual	Target
18-Q1	99.0	**90**
18-Q2	99.6	**90**
18-Q3	97.8	**90**
18-Q4	99.7	**90**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Medication reconciliation is fully implemented in the ambulatory mental health clinics at HDH site, with quality and compliance audits conducted regularly. The best possible medication history (BPMH) is completed by intake nurses in both adult and child mental health programs. This is part of the initial telephone intake and screening process, the med rec is completed by psychiatry or NP at the first visit.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The medication reconciliation process has been embedded into the clinical flow, with some programs using an electronic system. Prescribers find it helpful to have the most up to date complete medication history available and appreciate improved medication safety for patients, contributing to continued high rate of compliance.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We continue to perform well and achieve targets.

Definition: DATA: Nicholas Axas COMMENTS: Michelle Mathews EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The number of eligible clients receiving formal med rec upon admission to mental health clinics divided by total the number of eligible clients admitted for the quarter (HDH QIP).

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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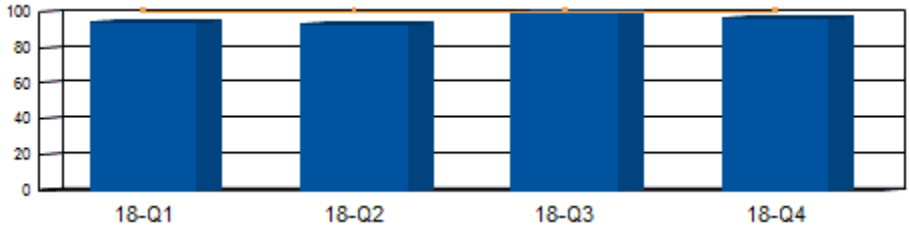
Indicator: # of eligible clients receiving formal med rec upon admission to EPACU for total joint arthroplasty/by total # of eligible clients admitted for the quarter (HDH QIP)



	Actual	Target
18-Q1	93.8	**100**
18-Q2	92.9	**100**
18-Q3	100.0	**100**
18-Q4	96.0	**100**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The pharmacy team and orthopedic team have been working collaboratively to ensure that all arthroplasty patients have medication reconciliation performed upon admission to EPACU. The Med Rec form is part of the admission order set process with the adoption of Entry Point orders at HDH site. For the past 4 months Medication Reconciliation compliance is reported to the Med Rec Steering Committee monthly and at minimum quarterly.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

This December 2017 we instituted a GIM within the pre-surgical screening clinics, as well as instituted a comparative study of medication reconciliation practices between the nursing staff and a pharmacy technician in order to determine best practices. We will review the present changes to the medication reconciliation plan and make the necessary changes to ensure that all arthroplasty patients receive complete medication reconciliation.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We will continue to work in collaboration with the Orthopedic and Pharmacy teams in order to achieve the target of 100%.

Definition: DATA: Michelle Mackay COMMENTS: Chris Gillies EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The number of eligible clients receiving formal med rec upon admission to EPACU for total joint arthroplasty divided by total the number of eligible clients admitted for the quarter (HDH QIP).

Target: Target 17/18: 100% Perf. Corridor: Red <90% , Yellow 90%-99% , Green >=100%.

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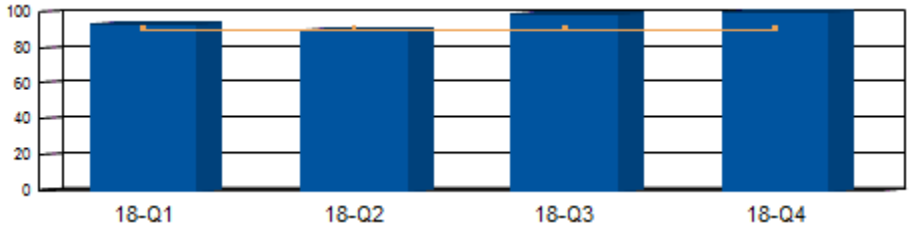
Indicator: # of eligible clients receiving formal med rec upon admission for bariatric surgery/by total # of eligible clients admitted for the quarter (HDH QIP)



	Actual	Target
18-Q1	92.6	**90**
18-Q2	90.2	**90**
18-Q3	98.7	**90**
18-Q4	100.0	**90**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The Med Rec form is part of the admission order set process with the adoption of Entry Point orders at HDH site. For the past 4 months Medication Reconciliation compliance is reported to the Med Rec Steering Committee monthly.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Very pleased to see that we are at 100% compliance of patients having complete medication reconciliation.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We will continue to sustain this excellent result. As the 2018/2019 KHSC QIP indicator for Med Rec shifts to compliance at discharge, KHSC has responded by force functioning Med Rec at discharge through re-designing the discharge process (e-discharge). The impact of this system re-design will be monitored at the Med Rec Steering Committee.

Definition: DATA: Michelle Mackay COMMENTS: Chris Gillies EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The number of eligible clients receiving formal med rec upon admission for bariatric surgery divided by total the number of eligible clients admitted for the quarter (HDH QIP).

Map current process for obtaining med history, BPMH; Assess processes and resources necessary to complete BPMH; Provide training, implement tools and support staff to achieve target. Target will be achieved by Sept. 30, 2017.

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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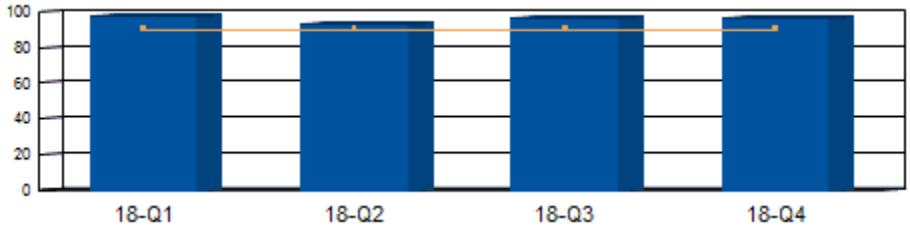
Indicator: # of eligible patients receiving Best Possible Medication Discharge Plan (BPMDP) at disch from EPACU for total Joint Arthroplasty/by total # of eligible patients discharged for the



	Actual	Target
18-Q1	98	**90**
18-Q2	93	**90**
18-Q3	96	**90**
18-Q4	96	**90**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

This result is improving and continues to be over target due to the collaborative efforts from the EPACU nursing, physician and pharmacy staff.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Best patient practices are being implemented to ensure that all patients have a comprehensive discharge plan that includes medication reconciliation. KHSC has responded by force functioning Med Rec at discharge through re-designing the discharge process (e-discharge). The impact of this system re-design will be monitored at the Med Rec Steering Committee.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We will continue to make progress and remain above target for the next quarter.

Definition: DATA: Dave Tuepah COMMENTS: Chris Gillies EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The number of eligible patients receiving Best Possible Medication Discharge Plan (BPMDP) at discharge divided by total the number of eligible patients discharged for the quarter (HDH QIP).

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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Q4 FY2018 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

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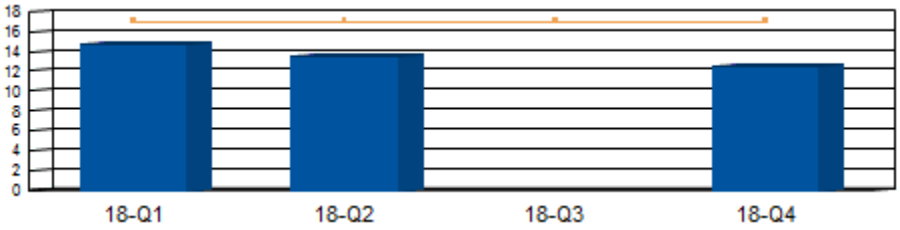
Indicator: Reduce percent of patients with facility acquired pressure injury (KGH QIP)



	Actual	Target
18-Q1	14.8	**17**
18-Q2	13.5	**17**
18-Q3		**17**
18-Q4	12.4	**17**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

This quarter we have connected Nurse Champions with Educational conference led by a Queens University Professor. We continue to support the champions with educational opportunities to enhance their knowledge. A Prevalence study was conducted across KHSC, including eligible patients across both sites. Risk of pressure ulcer is completed daily on all inpatients and audit demonstrated a greater than 90% completion rate.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

This indicator remains green and progress continues to be made from Q1 to Q4. The reduction from Q1 (14.8%) to Q4(12.4%) prevalence represents a potential reduction of 450 patients NOT developing pressure ulcers while receiving care at KHSC. As well, tactics have resulted in a greater number of front line nurses accepting the importance of pressure injury prevention as demonstrated by our need to run a second wound care conference happening in Q1 of this year.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We are on track to continue to meet target in pressure injury prevention. A continued focus of audit and feedback as well as continued educational opportunities will assist in sustaining the success we have been able to achieve,

Definition: DATA: Leanne Wakelin COMMENTS: Leanne Wakelin EVP: Silvie Crawford QUALITY IMPROVEMENT PLAN (QIP)

Mini continuous-improvement cycles focused at particular inpatient units as indicated by the compliance data collected. Other continuous improvement techniques and tools, audit and feedback will be critical. Specifically, each unit in cooperation with professional practice and nursing unit leadership will conduct a prescribed number of monthly audits with respect to incidence of pressure injuries and compliance with documentation and communication protocols.

Completion of required admission documentation (i.e. risk assessments, strategies documented on kardex). Gap analysis of how closely the planned strategies match the assessment, and how consistently they are implemented and documented.

Target: Target 17/18: 17% Perf. Corridor: Red >19%, Yellow 18%-19%, Green <=17%.

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Q4 FY2018 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

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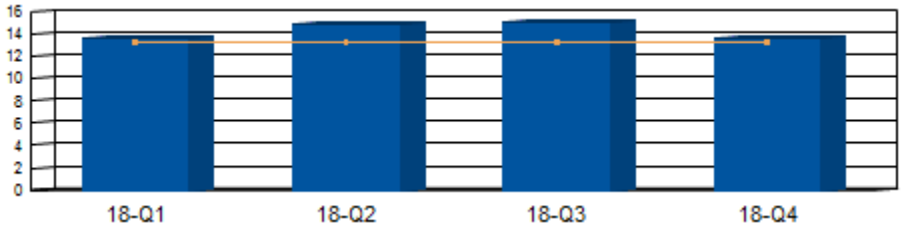
Indicator: Percent ALC Days (KGH QIP)(KGH SAA)



	Actual	Target
18-Q1	13.7	**13.2**
18-Q2	14.8	**13.2**
18-Q3	15.1	**13.2**
18-Q4	13.6	**13.2**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The percentage of ALC total patient care days has decreased over the last 3 quarters through several effective patient flow strategies. Q4 had the lowest result since Q4 last fiscal. Throughout the fiscal year there was dedicated focus on the patient flow initiatives in the Emergency Department and the inpatient units. Our work is aligned to the SE LHIN patient flow action plan to ensure consistent practices exist across the region.
All patient care programs are utilizing the Alternate Level of Care (ALC) escalation guideline (implemented in F17 Q3). This procedure requires manager, SE LHIN Home & Community Care manager and director level approval prior to designating a patient as ALC for long term care to ensure all other discharge destinations have been explored and are not viable options to discharge. The new discharge planning policy is in its final iterations and expected to be approved in Q1 of Fiscal 18/19. The policy will include routine discharge planning, designation of ALC process, and escalation process for non-compliance with discharge.
The Pay for Results refresh of the Home First philosophy to was completed in Q4, the specialist focused to work with each patient care area to ensure all opportunities for discharge home are explored rather than designating patients as ALC for long term care (LTC). This work included education regarding this philosophy delivered to incoming residents and new staff at orientation. The education session was the same one that all care providers received last fiscal year to ensure consistent messaging to our patients, their families and the primary care teams. The specialist also lead the Emergency Department team including the social worker, nurse practitioner, physiotherapist and nurses at daily morning rounds to plan complex discharges back to the community to prevent admissions for patients at risk of being admitted and designated ALC-LTC. This fiscal year 232 admissions were prevented by this team in the fiscal year.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

On average, in Q4 there were 69 patients waiting for other destinations. We saw a decrease in average ALC each month of Q4: January 77.2, February 69.9, March 59.2. Through Q4 we also saw a seasonal increase in overall patient census and hospital activity (patient census high of 520).
There has been a positive impact with our ALC strategies. We started Q4 with 79 patients designated as ALC waiting for different destinations. Thirty-one of these patients (39%) were waiting for beds at a LTC home. We ended Q4 with 60 patients designated as ALC with 31 patients (52%) waiting for LTC. During the quarter, we discharged 188 ALC patients and 18 of these patients went to LTC, 20 were discharged home with ongoing discharge planning. This clarifies the assumption that it is the same ALC patients waiting at KHSC for beds at other facilities. The last two weeks of Q3 and through Q4 we were able to utilize the new Bayshore off-site ALC unit, during this time we were able to save 903 ALC days
In Q4, several long stay ALC patients were discharged. This caused the spike in ALC days since ALC days in this indicator are based on hospital discharge information.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Access and Flow remains a priority for KHSC and we continue to evolve strategies to positively impact and optimize timely access to care for our patients.

Definition: DATA: Decision Support - Lana Cassidy COMMENTS: Tom Hart EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP) SAA INDICATOR

When a patient occupies a hospital bed and does not require the intensity of resources/services provided in the acute care setting, the patient must be designated alternate level of care (ALC) by the physician or his/her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination, or when the patient's needs or condition changes and the designation of ALC no longer applies.

Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.

Target: Target 17/18: 13.2% Perf. Corridor: Red >14.6% Yellow 13.3%-14.6% Green <=13.2%

Previous fiscal year - Target 16/17: 13.2% Perf. Corridor: Red >13% Yellow >10%-13% Green <=10%

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Q4 FY2018 Quality Improvement Plan Report

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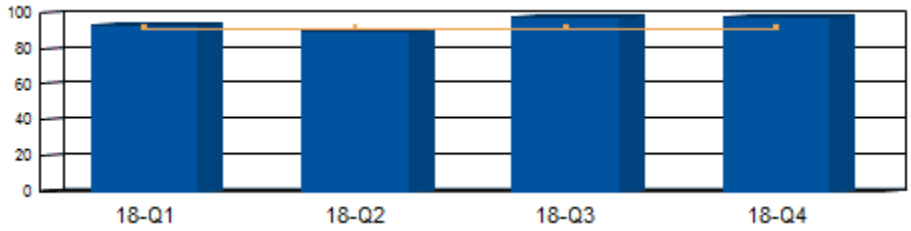
Indicator: Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (KGH QIP)



	Actual	Target
18-Q1	93.5	**91**
18-Q2	90.0	**91**
18-Q3	97.0	**91**
18-Q4	97.0	**91**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

HQO's specifications delineated for the Indicator 'Home support for discharged palliative patients' was followed by KHSC Decision Support to extract the data and generate the results (report percentage). HQO QIP Indicator Technical Specifications 2017/18, pp. 10-11

To date, most of the patients counted will have a cancer diagnosis. A very small number of patients will have other life-limiting illnesses (CHF, CKD, COPD, and Metastatic Cancer). This is largely due to the HQO formula specification that counts only specific diagnosis/service coding.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

In Q4, 97.1 % of patients with an ICD code that describes the inpatient admission as palliative care/service and were discharged from hospital to their own residential home with support.

Current performance is similar to Q3 (97.0%) and exceeds Q1 (94.0%) and Q2 (92.0%). These results have no direct impact on patients or staff. The percentages are based on a small number of separations per quarter (Q1 n=32, Q2 n=37, Q3 n=33, Q4 n=34). The n-value is based on the formula specification that counts only specific diagnosis/service coding. The impact is to KHSC, in so far as these results do not reflect a true count of the number of inpatient separations that are assessed to need a palliative care approach and/or referred for consult to the Palliative Medicine Team.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

The target set was 91.0% and we have exceeded this in Q4, and for all other FY quarters

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Brenda Carter EVP: Brenda Carter REPORT: QUALITY IMPROVEMENT PLAN (QIP)

This year, we are aiming to create a comprehensive, well-coordinated set of care pathways for patients, families and care providers. Based on consultation with stakeholders we developed a plan and performance management framework for enhancing palliative care at KGH. We are working with stakeholders in the oncology, renal, respirology and cardiology programs to map out draft palliative care pathways for their patient populations. We are developing draft pathways for the four areas. Together with clinical leaders we are reviewing the pathways to determine next steps and action items with a view to creating an implementation plan.

In addition to meeting all project milestones, a measurement plan for the performance of palliative care pathway will be developed and act as a template for measuring the performance of other pathways. The measurement plan will include the voice of the patient. Referral time to palliative care will also be measured and monitored.

Target: Target 17/18: 91 Perf. Corridor: Red <= <82% , Yellow 82%-90% , Green >=91.

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Q4 FY2018 Quality Improvement Plan Report

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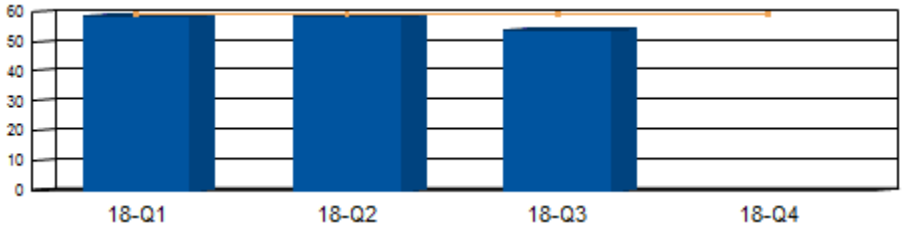
Indicator: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (KGH QIP)



	Actual	Target
18-Q1	58.4	**59**
18-Q2	58.6	**59**
18-Q3	53.8	**59**
18-Q4		**59**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

This indicator is related to one question on the patient survey asking if the patient received enough information about what to do if she or he had any concerns related to condition or treatment after leaving the hospital. The question relates to receiving the information in an easy to understand format.

A health literacy environmental scan completed last fiscal year identified areas across the organization where there are opportunities to reduce health literacy burden for patients and families. The scan led to several key recommendations to improve communication with patients and families.

One evidence based health literacy strategy is the teach back system. This year we are aiming to implement the teach back system, which provides members of the care team with the tools to reduce health literacy barriers through patient centered communication. Implementation of teach back will begin with an initial focus in several areas. Staff and physicians in the Renal Program received education related to teach back methodology to enable the use of this strategy with patients with chronic kidney disease. A teach back education plan aimed to augment our existing falls prevention program is under development.

Another component of KHSC's health literacy strategy is the patient oriented discharge summary called My Discharge Plan (MDP). The MDP is an easy to read, understandable, and usable discharge summary for patients, their families and their care providers. It focuses on using the teach back method when providing important discharge information to patients and families. KHSC was selected as one of two SE LHIN sites to implement the patient oriented discharge summary. A registered nurse is dedicated to this project and funding was provided by the Registered Nurses Association of Ontario/Associated Medical Services fellowship grant and the Adopting Research to Improve Care (ARTIC) Program.

A steering committee and working group with representation from all health disciplines as well as patient experience advisors have been working on the development of the discharge process and summary and involving Information Management for their technical expertise. The MDP will be incorporated into the discharge summary that the medical team completes and gives to the patient before discharge.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The data for Q4 is not yet available. Data is usually one quarter behind the reporting schedule. The Q3 result of 53.8% means that 53.8% or 266 patients who completed the survey said they 'completely' received enough information. Of those who responded 28.7% (n=142) answered 'quite a bit', 13% (n=64) answered 'partly' and 4.5% (n=22) answered 'not at all'.

The first patient will receive MDP in Q1 of next fiscal year. The implementation was delayed due to technical issues and competing demands with other projects. Our goal is that all internal medicine patients will be discharged with MDP. This represents an annual discharge volume of approximately 4,900 patients.

We now have a web enabled plain language dictionary that describes medical and medically related terms in everyday language. The dictionary is available on the KHSC website for easy access. This project will align with the patient oriented discharge summary project and the organization's focus on health literacy.

There is clear evidence in the literature that lack of patient involvement in care decisions and not receiving written discharge instructions are associated with unplanned readmissions. It is expected that MDP will provide patients, families and care providers with the information they need to manage their health care needs and minimize unplanned visits to the Emergency Department and admissions to the hospital.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Our goal is to successfully implement MDP in a sustainable way in the internal medicine populations of patients this fiscal year then to spread the discharge summary across the organization.

Definition: DATA: Astrid Strong(Q1), Pam Pero COMMENTS: Cynthia Phillips EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

This year we are aiming to implement the 'teach-back' system, which provides members of the care team with the tools to improve health literacy through patient-centered communication. We will introduce the topic of health literacy in the CKD program and discuss how to introduce the concept in the pre-dialysis clinic. In addition, KGH has been accepted as a partner site with University Health Network to implement an ARTIC-funded Patient-Oriented Discharge Summary (PODS) starting with the medicine program. This is a innovative discharge communication tool that meets the health literacy needs of patients and their families and includes our teach-back method as a component.

As per ARTIC project plan deliverables. The ARTIC project will start April 1st 2017. KGH is just receiving materials for the Project Coordinators and are in the pre-planning phase of this work.

Target: Target 17/18: 59% Perf. Corridor: Red <53% , Yellow 53%-58% , Green >=59.

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Q4 FY2018 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

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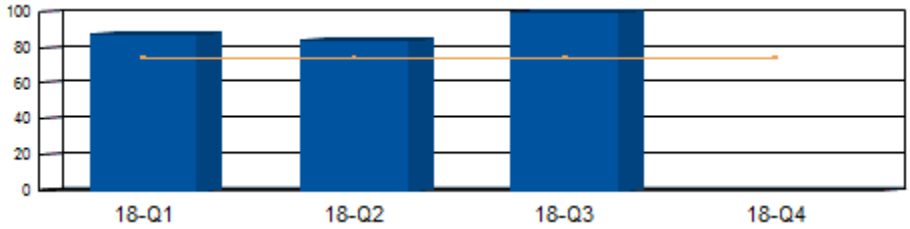
Indicator: Percent of patients who wanted information that respond "very confident" that they have the information they need and/or know who to contact after they leave their appointment



	Actual	Target
18-Q1	87	74
18-Q2	84	74
18-Q3	100	74
18-Q4		74

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Data not yet available
Hotel Dieu Hospital (HDH) site administers at least one ambulatory care point of care patient experience survey; surveys are rotated between different clinics. Survey results are reviewed and shared with staff to identify unit- specific initiatives that may be undertaken to improve patient experience.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Last reports indicated that performance was below target. We understand the importance from the perspective of patient safety and satisfaction that patients and families know what to do after they leave their clinic appointments and who to contact if questions arise after they leave the clinic. 67% of respondents asked "How confident are you that you or your family member has the information you
Need and/or know who to contact if you have questions when you leave your appointment? Of those that responded “Very Confident “.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We were below the target and have taken this feedback to the team and are looking to review and improve with patient involvement to see what were the specific information we could provide to improve the visit.

Definition: DATA: Jennifer Sawyer COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Performance reviewed by mangers, physicians, and leaders quarterly to identify strengths and improvement opportunities. Patients' response to this question has traditionally been positive; goal is to maintain positive performance, understand improvement opportunities.

Target: Target 17/18: 74% Perf. Corridor: Red <64% , Yellow 64%-73% , Green >=74%.

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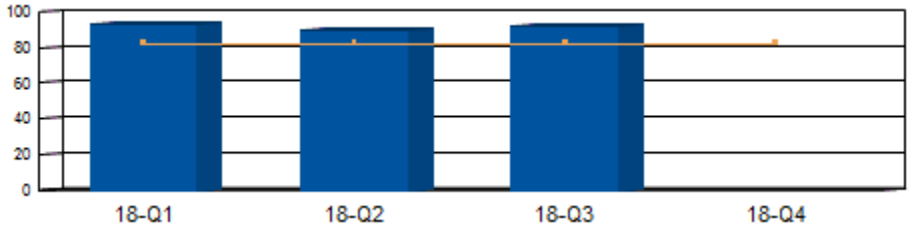
Indicator: Percent of patients in adult ambulatory clinics that rate the quality of care and services received as 'excellent' or 'very good'. (HDH QIP)



	Actual	Target
18-Q1	93	**82**
18-Q2	90	**82**
18-Q3	92	**82**
18-Q4		**82**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Data not yet available
A point of care survey was completed by patients in the Ear, Nose and Throat ambulatory clinic in March 2018. Two questions were related directly to the legacy HDH values, 'rate the quality of care you received' and 'were you treated with dignity and respect'. 88% rated the quality of care received at HDH that day as very good or excellent. 90% of respondents felt that clinic staff treated them with respect and dignity.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The Hotel Dieu Hospital (HDH) site administers at least one ambulatory care point of care patient experience survey; surveys are rotated between different clinics. Survey results are reviewed and shared with staff to identify unit specific initiatives that may be undertaken to improve patient experience. Treatment Clinic. Results were positive. No specific improvement opportunities were identified.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes we are on target but look for ways to improve after each survey.

Definition: DATA: Jennifer Sawyer COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Maintain aggregate ratings of 'excellent' and ' very good' on point-of-care survey in adult clinics. Performance is reviewed quarterly to identify strengths and improvement opportunities.

Target: Target 17/18: 82% Perf. Corridor: Red <72% , Yellow 72%-81% , Green >=82%.

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Improve the patient experience through a focus on compassion and excellence

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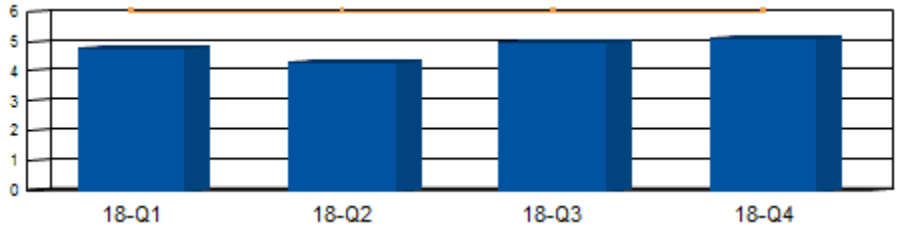
Indicator: 90% UCC Length of Stay (LOS-hrs) for complex patients (CTAS 1,2,3) (HDH QIP/SAA)



	Actual	Target
18-Q1	4.8	**6**
18-Q2	4.3	**6**
18-Q3	5.0	**6**
18-Q4	5.1	**6**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

We have been working to ensure initiatives started earlier in the year remain active such as Medical directives that allow nurses to start some very specific care within strict parameters like giving Tylenol for a patient with fever or ordering x rays on a suspected broken ankle or taking specific blood work with for certain issues before seeing the physician.
The Rapid Access clinic for patients with chronic disease prevented prolonged stays in the urgent care to watch and monitor when there were concerns related ability to see family physician in the next few days. The clinics allowed for 24 to 72 hour referral to a nurse practitioner for follow up. This means that if immediate follow up is available, earlier safe, supported discharge from the urgent care can occur. An ear, nose and throat scope was acquired to provide the ability to perform procedures that previously required a transfer to acute care by ambulance. This allows urgent care to provide the service immediately and requires transfer to acute care only when admission or consult is required. This has been used more and more over the quarter. Transfers to the emergency department have been occurring in a timelier manner related to internal flow improvement at the emergency department and therefor decreasing the urgent cares LOS for complex patients.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Performance remains good with 9 out of 10 patients with complex conditions register and leaving the Urgent Care center around 5 hours, we experienced steady number of patients presenting to the Urgent Care but an increasing number of people requiring transfer and admission to the emergency department due to the complexity of their care needs. When care is more complex the length of stay is affected.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We believe we can maintain our performance of LOS less than 6 hours. We have been experiencing an increase in the number of visits to the Urgent Care this last quarter, of note is the increase number of patients that have been seen with more complex needs this year. These patients have more complex issues and often require more investigation and treatment. We have as well noticed an increase in need to transfer to the emergency department due to this complexity and potential need for admission to hospital. We have been working closely with the Emergency department.

Definition: DATA: Decision Support - David Barber COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP) SAA INDICATOR

Maintain current performance.

Target: Target 17/18: 6 Perf. Corridor: Red <8 , Yellow >6-8 , Green <=6.

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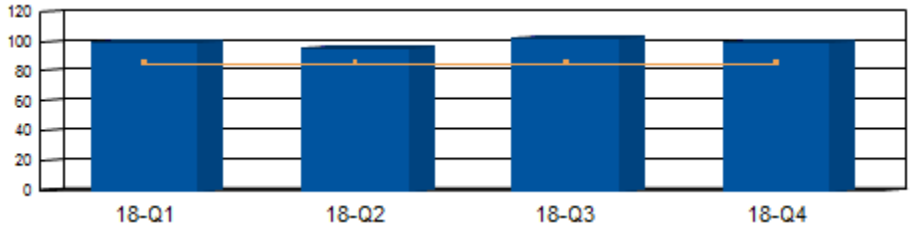
Q4 FY2018 Quality Improvement Plan Report

Enable clinical innovation in complex-acute and specialty care

KHSC is positioned as a leading centre for complex-acute & specialty care

Indicator: [(# of regular clinics held + # of special clinics held) / (# regular clinics assigned)] x 100 (HDH QIP)



	Actual	Target
18-Q1	99.8	**85**
18-Q2	94.8	**85**
18-Q3	101.6	**85**
18-Q4	99.0	**85**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Careful recycling of clinic resources within each clinical group until one month before the planned clinic date, followed by offering availability of clinic resources outside that group, has worked well to date.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

This performance is excellent, in an environment where there is significant unpredictability - for example, the need to cancel clinics because of opportunity to use additional operating room time, planned cancellations for attending on clinical teaching units and ICU, etc. The high utilization, however, points to limited capacity to expand clinic activity.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes, we are above target.

Definition: DATA: Decision Support - David Barber COMMENTS: Mike Fitzpatrick EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Maintain 2016-17 target to accommodate possible variations in physician resources. Clinic utilization is multi-faceted. Goal is to understand reasons for variation. Ensure efficient clinic utilization.

Target: Target 17/18: 85% Perf. Corridor: Red <75% , Yellow 75%-84% , Green >=85%.

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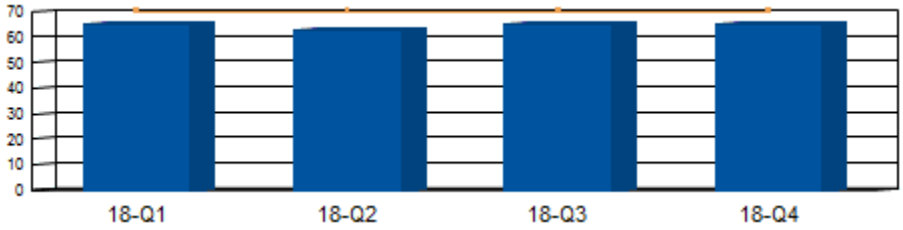
Indicator: # days from clinic appointment until dictated clinic letter has been verified [Result verification date - Clinic appointment date] (HDH QIP)



	Actual	Target
18-Q1	65	**70**
18-Q2	63	**70**
18-Q3	65	**70**
18-Q4	65	**70**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Data on this target has been discussed at the Ambulatory Care Committee and has also been communicated to department heads.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Current performance is reported as being below target. Communication with referring physicians is an important aspect of high quality ambulatory clinical care. There was an error in the previously reported metric description, in that it was believed to have encompassed all clinic visits, whereas not all clinic visits have a dictated letter, and some dictated letters are typed outside the central KHSC dictation service.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

The revised data is awaited but, in our QIP for fiscal 2019 we agreed to first carefully establish the current state for this variable and then consider opportunities for improvement, rather than establishing empiric targets without knowledge of our baseline performance.

Definition: DATA: Decision Support - David Barber COMMENTS: Mike Fitzpatrick EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Increase data quality auditing to identify long queues out outstanding clinic letters of 14 days or more; Oversight by Medical Admin; Leadership by department heads, division chairs to review and understand performance relative to target; continue to implement improvements. % of dictated clinic letters that are verified within target each quarter.

Target: Target 17/18: > 70% of dictated letters signed off by 2 wks post clinic Perf. Corridor: Red <60%, Yellow 60%-69%, Green >=70%.

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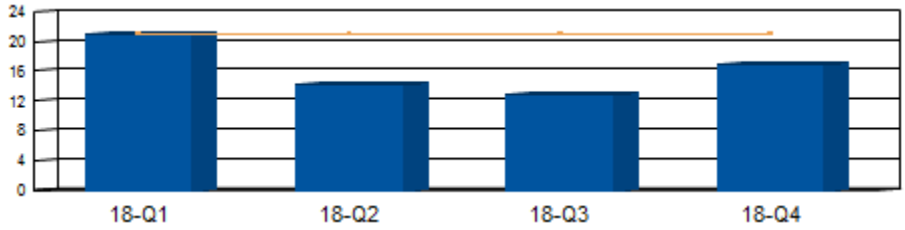
Q4 FY2018 Quality Improvement Plan Report

Create seamless transitions in care for patients across our regional health-care system

KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions

Indicator: Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort) (KGH QIP)



	Actual	Target
18-Q1	21.0	**21**
18-Q2	14.3	**21**
18-Q3	12.8	**21**
18-Q4	17.0	**21**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

This indicator is linked to focused efforts on COPD strategies from a Provincial, LHIN, Community and Hospital perspective.

The team is working on a regional map of the patient care processes related to patients presenting with chronic obstructive pulmonary disease (COPD). A plan comprised of phases of work will be implemented across the SE LHIN. An internal team is coordinating within KHSC.
In addition, KHSC has launched an Innovative Procurement process funded through OCE REACH with the goal of enabling outreach to patients with COPD across the region better manage symptoms.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The initial phase of work was to establish a working group to oversee analysis and provide advice on process. This work is complimentary to work being done on COPD order sets and the planned implementation of the INSPIRED program in the next fiscal year. Work is underway to rollout INSPIRED that equips patients to better manage their illness by providing them with action plans, phone calls after discharge, at home education & support, and advance care planning.

The COPD hospital care pathway has been mapped out at each site in the SE LHIN. We are working on bridging the links between the hospital and the community initiatives.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We continue to focus our efforts on addressing the management of COPD in order to support patients manage symptoms.

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Silvie Crawford EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

A plan comprised of phases of work will be developed and implemented across the SE LHIN. The initial phase of work will be to establish a working group to oversee analysis and provide advice on process. Subsequent phases of work will focus on building a retrospective care continuum at the patient level. This will include visits across acute care sites and other venues of care. The purpose of which is to better understand the current state of regional COPD care. The final phase of work will be to develop system level recommendations aimed at optimizing COPD care in the SE LHIN.

Note: Due to the 3 quarter delay in results we have created a non-risk-adjusted proxy readmission rate for those quarters whose results are yet to be realized.

Target: Target 17/18: 21 Perf. Corridor: Red >10% of the expected Rate Yellow Within 10% of the expected Rate Green <= Expected Rate

Previous fiscal year - Target 16/17: 17.08 Perf. Corridor: Red >10% of the expected Rate Yellow Within 10% of the expected Rate Green <= Expected Rate

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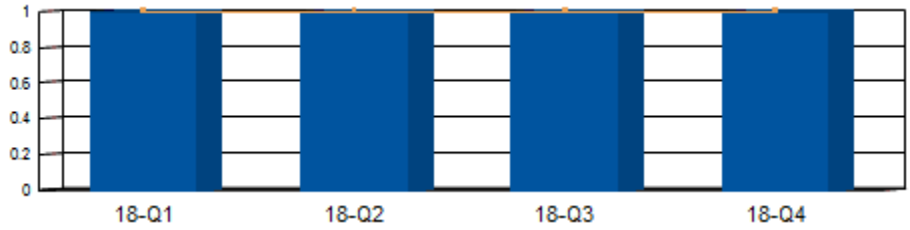
Indicator: Patient Journey Process maps as developed by each organization (presented to HCT COPD Clinical Steering Team) Best Practice and QBP Guidelines. (HDH QIP)



	Actual	Target
18-Q1	1	**1**
18-Q2	1	**1**
18-Q3	1	**1**
18-Q4	1	**1**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

A regional working group was formed and current-state analysis conducted. Work continues in 2017-18. The goal is to develop regional COPD care plan for patients in SE LHIN to improve consistency of care, reduce need for hospital admission, urgent/emergent care. The original plan developed in 2016-17 has been modified to include implementation of the INSPIRED COPD program, thus involving community care providers. The long-tem goal is to reduce readmission rates for patients with COPD in the SE LHIN (INSPIRED is a LHIN-wide evidence based care project focused on care in the community).

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The patient order set was implemented for patients admitted with COPD exacerbations in July 2017. To date the order sets have not been used consistently and a greater focus on consistent adoption of the evidence-based best practice order sets will be needed.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

KHSC has worked closely with the community to build community support for the transitions of care of patients with COPD in the SELHIN. The hospital program is poised to launch in June 2018 and we are currently liaising with the community primary care "hub" for COPD to facilitate community-based care for these patients without duplicating use of resources.

Definition: DATA: Mike Fitzpatrick COMMENTS: Mike Fitzpatrick EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Develop regional COPD care plan for patients in SE LHIN to improve consistency of care, reduce need for hospital admission, urgent/emergent care. The original plan developed in 2016-17 has been modified to include implementation of the INSPIRED COPD program, thus involving community care providers.

Target: Target 17/18: See change plan Perf. Corridor: Red No = 0, Yellow In progress = BLANK with Yellow Status, Green Yes = 1.

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Status:

N/A	Currently Not Available
	Green-Meet Acceptable Performance Target
	Red-Performance is outside acceptable target range and require
	Yellow-Monitoring Required, performance approaching