Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

The Little Hospital That Does

2/26/2020

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

South Huron Hospital Association (SHHA), known as "The Little Hospital that Does", is a lean organization dedicated to improving and maintaining the health of the communities we serve. These rural communities depend upon us for 24/7 emergency care, a 19 bed in-patient unit, and diagnostic services such as lab, x-ray, ultrasound, and clinics to provide services locally.

We are active and contributing to the Huron Perth Area Ontario Health Team (OHT) (attributed population 147,000) in which there are limited transportation options, nearly 11% live under the low-income cut off and our number of senior citizens is 4% higher than the provincial average. There are a greater number of people living with and managing chronic disease and it is one of the leading causes of morbidity and mortality for our residents. More focus is being placed on palliative care, mental health and mental illness and addictions.

Our QIP is best contextualized within our climate of integration along with a desire to achieve high quality standards in patient and staff satisfaction, and the need to make the best use of our limited financial resources. We can see how the different parts of our QIP connect. Our work is deliberate with intentional collaborations to achieve efficient transitions, excellent patient experience, and safe, effective care.

Describe your organization's greatest QI achievement from the past year

This year we are particularly proud of the work done around Safe and Effective Care at SHHA. As healthcare providers, we know our job is to provide compassionate care to all of our patients. Our ability to provide that care is sometimes affected by our outlook toward a patient, or, indeed, by the actions a patient has taken.

Persons who may exhibit unpredictable, responsive, or even violent behaviours—including the increasing number of patients we see with mental health challenges and/or substance use issues, can introduce challenging dynamics for our staff. Although wanting to provide the best care, fear of violence and injury underlies our interactions.

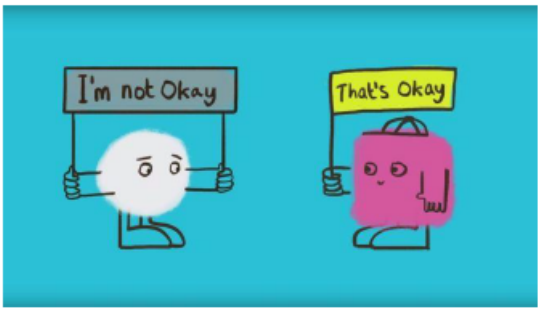
Through our work with the Huron Substance Misuse Working Group, interviews and surveys of frontline healthcare providers, police and Emergency Management Services (EMS), and patients with lived experience, we found that stigma towards those who have an addiction to substances is the largest barrier to giving and receiving medical treatment. The reflective training video which we helped produce was used for discussion among SHHA nurses, registration clerks, social worker and administration. At "lunch and learns" (with free popcorn provided!) discussion was held around treating the whole person, realizing that addiction can happen to anyone, self-reflection, education, and self-care. Feedback was sent to the Substance Misuse working group which will be used for the next stage of our work.

Knowing that healthcare workers face the greatest likelihood of experience workplace violence, a strong focus was put on workplace violence assessment, prevention and education. Full assessments were done using the Workplace Violence Risk Assessment Toolkit for Acute Care. Recommendations were made to Leadership which are being acted upon (see QIP scorecard below). Of special note is the half day mandatory Workplace Violence and Code Silver Education prepared and presented in-house. Greater than 80% of our staff and leaders have undergone the training. Recent events with our staff and patients have tested much of the above training in our facility. Staff and leadership felt stronger and better prepared and determined to improve both the care for those with mental health challenges and the safety with which we provide it.

Free Popcorn/ Video Event

"A Reflective Video with Conversation about Healthcare Stigma: A tool for the holidays and beyond!"

For All Staff and Doctors



Video Times

Tuesday December 17th, 2019 @ 1200 1500

Thursday December 19th, 2019 @ 0800 1200 1530

Location: Boardroom B110 Length: 30 minutes

NO Pre-Registration needed. Come as you are!

More information please contact Heather Klopp ext 5110

Collaboration and integration

Proposed Huron Perth & Area Ontario Health Team component to include in 2020/21 Quality Improvement Plans Narrative

The Huron Perth & Area Ontario Health Team (HPA-OHT) is comprised of 60+ organizations who have made a commitment to continue our long standing formal and informal partnerships to advance an integrated healthcare system, improve community health outcomes and patient experience. Year 1 priorities are improving care coordination, navigation and communication with identified target populations of complex health, palliative care, and mental health and addictions. The Ministry of Health's data demonstrates that there are opportunities to improve the following system performance indicators in the HPA-OHT:

- Avoidable emergency department (ED) visits,
- Alternate level of care (ALC),
- 30-day readmission rate for selected conditions,
- Repeat ED visits within 30 days for mental health and substance abuse, and
- Hospitalizations for ambulatory care sensitive conditions

These all have the potential for improved performance with successful care coordination.

The 2020/21 QIP Priorities, sector-specific indicators and the two mandatory Hospital sector indicators resonate with the Huron Perth & Area OHT's commitment for quality improvement across all sectors of the health system. In their respective QIP submissions, partners will address collaboration and integration, alternate level of care and virtual care. The HPA-OHT will advance a historically strong performance in these areas as demonstrated through such initiatives as Health Links (since 2014),the "purchase" of non-funded long term care beds for ALC-LTC patients and a 13 member Community Support Services Network through which clients and caregivers benefit from a centralized intake, shared record and shared coordination of care.

In 2019/2020, seven organizations of the Huron Perth & Area OHT partnered for Ontario's first Sub-Region Accreditation. Through this initiative the partners created a Collaborative QIP Change Plan and implemented a harmonized multi-sector Workplace Violence policy, one of several harmonized policies that have the opportunity to spread to the partners of the OHT. These seven organizations have partnered in a 2020/21 Collaborative QIP Change Plan advancing workplace violence prevention through shared education regarding responsive behaviours to front line staff and physicians.

Patient/client/resident partnering and relations

Although SHHA serves only a small Francophone population, the population has advocated strongly to receive some level of care in French. Through our Patient Relations process, they expressed that, although they understand English, in times of stress and illness, they feel comforted in their caregiver trying to help them in French - even if not fluent. They express that they want the understanding of their cultural needs taken into consideration. This has been communicated to the doctors and nurses who care for them much to the satisfaction of the patient.

We do our patient surveys in-house. To express their gratitude they agreed to volunteer to translate our Patient Experience surveys into French! They have been distributed to In-Patient, ER and Ambulatory Care at SHHA.

In this upcoming year, we will improve the data harvesting of our Survey Monkey Patient Experience Surveys so that we can more easily report the results for each of the three surveys. We will obtain the ability to show trends on the issues and where patient experience issues may be identified in departments.

Currently there is no electronic means for a patient to fill the survey on-line. We wish to implement that functionality in 2020/21.

Workplace Violence Prevention

In the last few years, Workplace Violence has remained a priority for SHHA.

* We report incidents of workplace violence to our Board Quality Committee
* We have made significant investments of leadership and staff time to complete a full Workplace Violence assessment in 2019 and have completed half of the assessment for 2020. Members of Departments, Leaders and JHSC jointly assess following the PSHSA tool. Low, medium and high risks have been addressed such as increased staffing at night in ER, increased number of surveillance cameras and lighting, and staff education.

Quality Improvement Plan (QIP) Scorecard 2019/20

				2019/20			
Quality Dimension	Issue	QIP Outcome Measures	Target	Quarter 1 (Apr-Jun)	Quarter 2 (Jul-Sep)	Quarter 3 (Oct-Dec)	Quarter 4 (Jan-Mar)
Safe	Safe and Effective Care	**Number of Reported Workplace Violence Incidents**	**0 incidents**	0	0	1	
		Workplace Violence-Action Plan	*Action Plan Progress*				
		Education to Leaders/Staff (& Physicians) on signs of Domestic Violence &Supports Available *	75% (& 50%) trained by end of fiscal year 2019-2020	In development	planning for "Fall 4 All" training	78% of staff/leaders In planning for physicians	
		Education to Leaders/Staff on Responding/Eliminating Harassment/Bullying *	75% trained by end of fiscal year 2019-2020	In development	planning for "Fall 4 All" training	78% of staff/leaders	
		Develop, educate, implement "Working Alone" Policy/Procedure *	75% trained by end of fiscal year 2019-2020	Policy complete; training begun	planning for "Fall 4 All" training	78% of staff/leaders	
		Develop, Educate, Implement "Storage of Valuables" Policy/Procedure *	75% trained by end of fiscal year 2019-2020	In development	In development	In development	
		Provide regular practice and drills on "Code White" Violent/Behavioral Situations; "Code Silver"; "Code Purple" *	min 4 drills by end of fiscal year 2019-2020	2 YTD	4 YTD	5 YTD	

* Awareness for Workplace Violence has been increasing. Given that this is the third year of it being highlighted in our QIP, we have spent time, energy and resources to support our assessment and mitigation of risks.

In 2020/21 we plan to:
-continue to educate our staff and leadership on the importance, prevention, and reporting of workplace violence.
-educate our volunteers on workplace violence and Violence Codes (white, purple, silver, black) and provide them with personal protection when they may be working alone - for example the Auxiliary ladies working in the tuck shop will be provided with and educated about the personal "screamer".
- provide targeted education about workplace violence at Medical Advisory Committee routinely for doctors.
-provide targeted education about all aspects of workplace violence to the Board of Directors. The Board members understand that support for this initiative comes from the top and would like to have the knowledge to provide that support.

Virtual care

Virtual care will be an important aspect to SHHA as we work with our Huron Perth Area OHT. Aspects of Virtual Care are Ontario Telemedicine Network eVisits (email, telephone, virtual visits etc), eBooking, eReferral and eConsult. It will be important that these solutions are procured centrally by Ontario Health and supported with licences, etc. However, the Ont. government functional structure is not yet up and running…so the timing of the above decision making and ability to appropriately engage is unknown.

For 2020/21 we will continue working with the HPA-OHT on the Digital Advisory Committee. Possible activities may be determining the number of doctors, nurse practitioners, midwives, physician assistants and specialists signed on to the HPA-OHT so we know what our denominator is for primary care MDs/NPs, midwives, and specialists. We can then get an idea of current workflows, what new solutions will be offered, and how we can improve our work and patient experience as a result. An excellent example is the Ocean Platform which may have capability across Primary Care and Hospitals to improve the referral process to specialists.

Executive Compensation

The Excellent Care for All Act (ECFAA) requires that the compensation of executives be linked to the achievement of performance targets in the Quality Improvement Plan. By linking achievement of targets to compensation, organizations can increase the motivation to achieve both short-term and long term goals. At SHHA we holdback 2% of our Executives' compensation (i.e. Executives are paid 98% of their yearly salary) until the QIP year is completed and results are assessed (approximately mid-Summer to early Fall).

Following significant discussion regarding the pay-at-risk indicators for the 2018/19 QIP, the Board Risk, Utilization, and Quality Committee adopted the same principles that were established for the 2018/19 QIP with the 2019/20 QIP.

These principles include:

- 2% as rate of salary that is "at risk" for the following positions:
  - President & CEO
  - Site Director/CNE
  - CFO
  - Chief of Staff
- Payout will allow for partial achievement
  - 100% payout (i.e. payout of 2% of base salary that was held back) will occur if 80-100% of targets met
  - 50% or partial payout (i.e. payout of 1% of base salary that was held back) will occur if 50-79% of targets met
- In the event that there has been significant achievement of the objectives specified but the targets set out in the QIP have not been achieved, the Board of Directors has the discretion to modify the amount of the performance-based compensation returned to the executives following assessment of the SHHA's performance related to the QIP.

- Indicators linked to at-risk pay were limited to those that:
  a) the executive leaders had the ability to control or influence positively within the QIP timeframe
  b) had a reliable and consistent means of tracking/reporting
  c) may include operational measures (i.e. 'was it done?') versus solely outcome measures (i.e. 'what was the final outcome/result relative to the target?')

It is recommended that these same principles are adopted for the 2020/21 QIP. As such, it is further recommended that the following indicators and/or associated improvement plans comprise 'pay-at-risk' measures:

- Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.

- Percentage of respondents who responded "completely" to the following question: 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?
- Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.
- Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.

Contact Information

Bruce Quigley
President and Chief Executive Officer
South Huron Hospital Association
24 Huron St W
Exeter, ON N0M 1S2
O: 519-235-5151|F: 519-235-3405

Carolynne Champagne
Executive Assistant to the President & CEO
Coordinator of Board Affairs
South Huron Hospital Association
24 Huron St W
Exeter, ON N0M 1S2
O: 519-235-5151|F: 519-235-3405
carolynne.champagne@shha.on.ca

Other

The SHHA QIP is but one component of achieving our mission and vision and ensuring quality healthcare close to home on a daily basis. Our small leadership team, along with our Quality, Utilization and Risk committee has looked at the benefits of highlighting some of our work through the chosen indicators on then QIP Workplan. Other quality improvement work will be continued or initiated throughout the year. Activities and results are reported at our Leadership Table, to our Quality and Risk Committee, to the Board of Directors, to our staff, and to our volunteers and the public.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair _____ (signature)

Board Quality Committee Chair _____ (signature)

Chief Executive Officer _____ (signature)

Other Leadership (as appropriate) _____ (signature)

Theme I: Timely and Efficient Transitions | Timely | Priority Indicator

Indicator #2

Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.

Last Year		This Year	
28	**50**	**75**	**--**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

-secure support of MAC in principle

Target for process measure

- -yes (complete)

Lessons Learned

Secured Physician approval at the Medical Advisory Committee to automatically send transcribed Discharge summaries to Primary Care Provider.

Change Idea #2

-collaborate with LHSC/Cerner to make needed technical changes (interface with Nuance) to enable auto-authentication for discharge summaries

Target for process measure

- -yes (complete)

Lessons Learned

Technical changes made and implemented to allow the auto-authentication of the discharge summaries from the Transcription service, Nuance, to the Cerner EMR.
Targeted Turn Around Time of < 24 hours for Transcription on Discharge Summaries requested and implemented.

Change Idea #3

-revise medical staff policy for dictation

Target for process measure

- -yes (complete)

Lessons Learned

Policy was not in existence to start; identified linked administrative policy and have incorporated the change

Change Idea #4

-communicate implementation of new process to primary care physicians

Target for process measure

- -yes (complete)

Lessons Learned

Hospital Memo distributed to the External Primary Care Providers.

Change Idea #5

-track a) time to physician dictation completion + b) transcription turnaround time

Target for process measure

- a) TBD (collecting baseline) b) 100%

Lessons Learned

Reports run to track Physician dictation completion and Transcription Turnaround time.

Theme II: Service Excellence | Patient-centred | Priority Indicator

Indicator #3

Percentage of respondents who responded “completely” to the following question: 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?

Last Year		This Year	
CB	CB	82.76	--
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

-revise current survey question & response options to align with technical specifications

Target for process measure

- -yes (complete)

Lessons Learned

Current survey revised to align with the technical specifications in QIP. Survey also translated to French for our Francophone patients. Survey response rates are challenged by online distribution mechanisms and physical handouts to save costs over mail outs.

Change Idea #2

-implement discharge phone calls

Target for process measure

- -work towards 80% of discharges to home or LTC by year-end beginning September 1st

Lessons Learned

Follow up Phone Calls from Resource Nurse to Inpatients Discharged Home.
Achieved 80% Discharged Rate of Inpatients discharged Home

Change Idea #3

-revise discharge teaching materials a) within Cerner; b) printed discharge sheets for select conditions

Target for process measure

- 5 by fiscal year-end

Lessons Learned

Modernized discharge teaching materials were implemented and loaded into our Cerner EMR system for automatic printing for patients

Theme III: Safe and Effective Care | Safe | Mandatory Indicator

Indicator #1

Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.

Last Year		This Year	
X	0	1	--
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Educate leaders & staff on signs of domestic violence & supports available

Target for process measure

- 75% (& 50%) trained by end of fiscal year 2019-2020

Lessons Learned

Education Training Days provided by Hospital successful in allowing for >80% of the SHHA Staff and Leaders. Measures taken to educate those staff unable to attend.
Safety Presentations included Domestic Violence, Working Alone and Harassment by the Human Resource Associate.
Staff/Leaders offered positive feedback to the Corporate Educator.
Physician training in the various elements of workplace violence is underway.

Change Idea #2

Educate leaders & staff on how to respond to/eliminate harassment/bullying

Target for process measure

- 75% trained by end of fiscal year 2019-2020

Lessons Learned

Education Training Days defined Violence: a threat of violence, patient on patient, patient on staff, staff on staff, and cyber bullying.

Change Idea #3

Develop, educate, implement “Storage of Valuables to Deter Theft” policies & procedures

Target for process measure

- 75% trained by end of fiscal year 2019-2020

Lessons Learned

Protocols developed and implemented to guide working with valuables, money and narcotics.

Change Idea #4

Develop, educate, implement “Working Alone” policies & procedures

Target for process measure

- 75% trained by end of fiscal year 2019-2020

Lessons Learned

Working Alone Policy created and education provided.
The education influenced changes in practices and routines by staff for safety. There has also been an adjustment of night shift staffing so nurses are not working alone.
Safety and Security enhancements were reviewed by the Director, Facilities and Support Services.

Change Idea #5

Provide regular practice and drills each quarter on “Code White” Violent/Behavioral Situations; "Code Silver"; "Code Purple"

Target for process measure

- min 4 drills by end of fiscal year 2019-2020

Lessons Learned

Code Silver (Weapon preparedness) education provided on the Education Training Days.
Incident Reporting reviewed by Site Director/CNE.
Mock code drills performed with staff responding with a subsequent review to identify improvements to response.

2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

South Huron Hospital 24 Huron Street West, Exeter , ON, N0M1S2

AIM		Measure								Change				
Issue	**Quality dimension**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Theme I: Timely and Efficient Transitions	**Timely**	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	~~Hospital collected data / Most recent 3 month period~~	collecting baseline	65%	65% once new processes standardized; previous performance (before change) ranged 28%-47%	Grand Bend Area CHC	1. Re-establish and reinforce support and confidence of physicians for auto-authentication of discharge summaries	Adjust statement in discharge summary tagline as guided by physician input	New statement included in discharge summaries by end of Q1	yes (complete)	
										2. Report achievements/ outcomes to MAC	Quarterly report (QIP Scorecard) to MAC	Each quarterly report shared at MAC	yes (complete)	
		The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	**MANDATORY**	**Hours / All patients**	**CIHI NACRS, CCO / Oct 2019– Dec 2019**									**not applicable to SHHA as not an ERNI site for reporting (i.e. visit volumes below threshold)**
	Efficient	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data.	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / Jul 2019 - Sep 2019									-not selected for priority QIP focus for 2020-21 given current shortage of community supports for effective early discharges or to promote "home first' for facilitating long-term care access; continue inter-professional rounds and acceptance of repatriations from tertiary centres to home community that may be ALC; continue to monitor as part of HSAA and participate in OHT-related initiatives
		Unconventional spaces	P	Count / All inpatients	Daily BCS / TBD									-not applicable to SHHA as any overflow space used would not be considered 'unconventional' as the proper equipment etc. is available. Further, ER holds are rare.

AIM		Measure								Change				
Issue	**Quality dimension**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within five business days.	P	% / All patients	Local data collection / Most recent 12 month period									-not selected for QIP priority focus in 2020-21 as 100% of complaints are acknowledged within 5 business days; will report to Board Quality Committee on # of complaints per 100 patient encounters and continue to summarize feedback for review of themes and resolution
		Percentage of respondents who responded "completely" to the following question: 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?	P	% / Survey respondents	~~CIHI CPES / Most recent 12 months~~ SHHA Patient Experience Survey	83%	85%	only 3 quarters of data collected to-date; range: 78% to 89%	Grand Bend Area Community Health Centre (GBACHC)	1. identify opportunities for improvement in discharge preparation and teaching	continue implementation of discharge phone calls	% of discharges to home receiving discharge phone call	-discharge follow-up calls completed to 80% of discharges to home	
										2. aim to more holistically address patient needs at and before discharge	collaboration with Connected Rural Communities Collaborative (CRCC) re: social isolation "Lonely No More" and other friendly visitor referrals	change discharge phone call template to include assessment for social isolation and outline referral options	yes (complete)	NOTE: less to do with receiving enough information at discharge but everything to do with ensuring a holistic perspective on meeting patient needs to ensure optimal health after discharge (i.e. addressing social determinants of health)
										3. continue to learn about best practices in preparing for discharge and adopt one new practice	review transitions between hospital and home playbook	new practice adopted to better prepare patients/families for discharge	minimum 1 adopted by fiscal year-end (as selected by staff)	

AIM		Measure								Change				
Issue	**Quality dimension**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Theme III: Safe and Effective Care	**Safe**	**Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / Jan - Dec 2019**	**1**	**0**	**theoretical best/ideal target; acutally aim to see increased reporting**		**1. physician training: workplace violence, harassment & bullying, working alone**	**develop education program**	**completed by end of Q1**	50% of physicians trained by end of Q1 yes (complete)	
										2. incorporate into new training materials on workplace violence, harassment & bullying, and working alone into new employee orientation	**develop program/video and test to be included in orientation**	**completed by end of Q1**	yes (complete)	
										3. Board education: workplace violence, harassment & bullying	**develop education program**	**completed by end of Q2**	75% of Board members trained by end of Q2 yes (complete)	
										4. conflict management training; responsibility of employees in resolving conflict	**identify program; contract educator; incorporate into Fall For All training**	**completed by end of Q3**	75% of staff/leaders trained by end of Q3 yes (complete)	
										5. reporting blitz/posters (clinical and non-clinical)	**Adopt practices of other hospitals who have successfully increased awareness of importance of reporting**	**completed by end of Q3**	yes (complete)	
		Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct 2019–Dec 2019 (Q3 2019/20)									-not selected as a priority QIP focus for 2020-21 as recent performance routinely exceeds >95%

AIM		Measure								Change				
Issue	**Quality dimension**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
	Effective	Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	% / ED patients	~~CIHI NACRS / April - June 2019~~ IDS Report (CIHI/NACRS Data) Jul 2018-Jun 2019 (4 quarters)	21%	<19%	represents 10% improvement in repeat visits	OHT partners (~60 Health Service Providers)	1. participation in OHT planning and initiatives as mental health & addictions is a focused population	ensure SHHA representation (and follow-up) at OHT planning meetings	% of OHT meetings with SHHA representation and participation	attend 80% of OHT meetings	
										2. review SHHA re-visit data; understand mode and time (day of week) of arrival/volumes/ visit patterns/ # of unique patients/ linkages to primary care etc. to identify potential opportunities or gaps in the system	summarize in report to be reviewed by Board Quality Committee and MAC	completed by end of Q4	yes (complete)	
		Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment.	P	Proportion / All patients	Local data collection / Most recent 6 month period									-not selected as 2020-21 priority QIP focus; SHHA continues to use both Edmonton Symptom Assessment System (ESAS) and the Palliative Performance Scale (PPS) for consistency in identification, assessment, and dialogue about when a palliative approach may be effective; HQO indicates this is still a developmental indicator
Equity	**Equitable**													