Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	6.51	6.51	Maintain current performance (CLHIN Target = 12.7%)	

Change Ideas

Change Idea #1 Continue to build capacity by using iPlan and the CLHIN's discharge planning pathway as tools for ALC management.

Methods	Process measures	Target for process measure	Comments
Implement initiatives to address Discharge Planning Pathway process measures opportunities. Investigate enhancements in iPlan to support continued/optimal use of the Discharge Planning Pathway.	Timelines identified for Discharge Planning Pathway for key steps.	Improved compliance with key timelines in the pathway.	

Measure **Dimension:** Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Unconventional spaces	P	Count / All inpatients	Daily BCS / TBD	0.00	0.00	Maintain current performance	

Change Ideas

Change Idea #1 Continue process with Corporate PFM reporting the number of admitted patients in ED waiting for an inpatient bed.

Methods	Process measures	Target for process measure	Comments
Reports to be circulated to Senior Leaders and Patient Flow Managers (PFMs) for continuous monitoring and to help with patient flow.	Consistent reporting.	100% daily reporting.	Admitted patients waiting for an inpatient bed are accepted into the ED until a bed becomes available on the unit. Besides this dedicated area in the ED, patients are only treated in appropriate care areas.

Measure **Dimension:** Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	68.60	80.00	Target established by HRH	

Change Ideas

Change Idea #1 Implement BCA tool and associated dashboards to track performance. Determine if all discharge summaries can be completed via Physician Documentation (pDoc) templates instead of traditional dictation/transcription via Nuance. This would allow for all reports to be signed via pinning, a new recommendation from the Physician Documentation Minimum Specs Working Group. Improve the quality of the discharge summaries via service specific template review performed by the Physician IT Advisory Committee.

Methods	Process measures	Target for process measure	Comments
Build Meditech BCA dashboard to report quarterly performance and/or Meditech reports to track and address non-compliance on a monthly basis.	Create Chart Completion Delinquency Report (>7 days post discharge) to determine which physicians have outstanding charts to complete.	Chart Completion Delinquency Report created and circulated monthly.	

Measure

Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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.	M	Hours / All patients	CIHI NACRS, CCO / Oct 2019– Dec 2019	5.08	5.08	Maintain current performance. (Stretch Target = 10 hours)	

Change Ideas

Change Idea #1 Revised IPOM and role shifting of RP to pull pts up. Adding additional nurse on night shift to pull pts up from ED to inpatient unit. Exploring use of RTLS to better track pts and improve the accuracy of data. ED Steering Committee to meet monthly. Led by SLT to support change.

Methods	Process measures	Target for process measure	Comments
Simulation training and co-creation of roles.	Measure time to triage to inpatient bed.	Monitor monthly at the following committees and take action as needed. - Command Centre Operations - Command Centre Executive - Director Council - ED Steering Command Centre analytic tiles and IPOMs to improve flow Working Groups- Clinical and Support Services to improve flow.	

Theme II: Service Excellence

Measure **Dimension:** Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	78.60	78.60	Maintain current performance. (57.5% noted in previous years)	

Change Ideas

Change Idea #1 Provide specific performance and patient feedback to respective departments

Methods	Process measures	Target for process measure	Comments
Monitor PDCC results and solicit feedback from patients and families	Communicate monthly results, patient feedback and targets to each respective department (100%)	100% process compliance (monthly reporting)	Total Surveys Initiated: 7546

Measure **Dimension:** Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	97.80	100.00	2% increase – High Reliability Target established by HRH	

Change Ideas

Change Idea #1 Continue to enhance internal database to improve compliance with 5-business day target

Methods	Process measures	Target for process measure	Comments
Weekly internal audit (PDSA)	52 weekly audits, 100% check of all hospital contacts	100% compliance of weekly audits	

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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)	69.00	81.00	Target established by Health Quality Ontario	

Change Ideas

Change Idea #1 Continue with Education and training for MDs with refreshers for targeted areas with low rates.

Methods	Process measures	Target for process measure	Comments
Bullet rounds to help focus and organize estimated discharge date and coordinate BPMHDP (i.e. Home Medications List) being completed as much in advance as possible.	Percent of Patients Reconciled at Discharge	81% of patients to be reconciled at time of discharge	Target specific specialties such General Surgery, Orthopaedics, Gynecology and Urology

Change Idea #2 Meds to Beds (MTBs) Program to help as driver to organize discharge and facilitate process for BPMHDP and discharge prescription(s) as much in advance as possible.

Methods	Process measures	Target for process measure	Comments
MTBs to help focus and organize estimated discharge date and coordinate BPMHDP (i.e. Home Medications List) being completed as much in advance as possible.	Percent of Patients Reconciled at Discharge	81% of patients to be reconciled at time of discharge	Meds to Beds (MTBs) Program (in selected care areas)

Measure

Dimension: Effective

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	1.00	1.00	High Reliability Target established by HRH	

Change Ideas

Change Idea #1 Re-examine palliative care assessment screens within Meditech and ALR reports

Methods	Process measures	Target for process measure	Comments
PDSA Cycles to redesign screens	Minimum of 2 development PDSA cycle, 2 test PDSA cycles completed prior to fiscal year end	100% completion of 4 PDSA cycles, validation against best available evidence/research 100% compliance with chart audits	

Measure

Dimension: Effective

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	% / ED patients	CIHI NACRS / April - June 2019	17.26	17.26	Maintain current performance. (Provincial Target = 20%)	

Change Ideas

Change Idea #1 Continue to refer discharged ED/EPU patients to the ARCS service. Continue to work with ED to develop and implement care plans for high repeat users.

Methods	Process measures	Target for process measure	Comments
Monthly collection of stats and data review with Cota regarding the ARCS service outcomes	Number of patients referred to ARCS. Percentage of patients referred to and accepted by ARCS. Of the patients who receive short term case management service from ARCS, what percentage return to ED.	Maintain above 60% of patients referred by ARCS to receive services, and to maintain a target of less than 2% of patients who received services from ARCS to return to the emergency department.	Data extracted from previous year estimated: #of patients referred to ARCS – 593, % of patients referred to ARCS who are serviced by ARCS – although 100% of referrals are accepted by ARCS, 36% either decline service or were are unable to be contacted once they leave ED. Estimate 64% of patients actually received service from ARCS. Target: Of 60% of the patients who received short term case management service from ARCS, 2% or less return to ED within 30 days of the referral.

Measure

Dimension: Safe

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	M	Count / Worker	Local data collection / Jan - Dec 2019	121.00	120.00	Target established by HRH	

Change Ideas

Change Idea #1 Continue to implement special indicator in outpatient areas for workplace violence. Continue to conduct root cause analysis for workplace violence incidents.

Methods	Process measures	Target for process measure	Comments
Post number of workplace violence incidents on unit level dashboards.	Root cause analysis for workplace violence incidents	Root cause analysis for 100% of reported incidents	FTE=3155