Theme I: Timely and Efficient Transitions

Dimension: Timely

Indicator #1

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

Last Year		This Year	
69.7%	**80%**	**71.0%**	**80%**
Performance (2021/22)	**Target (2021/22)**	**Performance (2022/23)** YTD Q1-Q3	**Target (2022/23)**

Change Idea

Focus in 2022/23 was to improve the functionality of the documentation tools available to the physician to assist in making the task of documentation easier and quicker.

Target for Process Measure

Build Meditech BCA dashboard to report quarterly performance and/or Meditech reports to track and address non-compliance on a monthly basis. Chart Completion Delinquency Report created and circulated monthly, as well as involvement from the Chiefs of Service to reach target of 80%.

Lessons Learned

Continued to promote Dragon usage so all discharge summaries can be completed via Physician Documentation (pDoc) templates in Meditech instead of traditional dictation/transcription via DeliverHealth. This could help eliminate any delays due to transcription. A working group composed of Medical Affairs, IT, Digital Learning Team, Health Information Services and Nuance have worked to update the software version of Dragon, reviewed documentation templates and started an initiative to reach out to physicians that routinely use back-end dictation. The goal is to provide a refresher of the Dragon system and illustrate new features or help optimize current documentation workflows.

The issue of chart completion was a regular standing item at MAC meetings where the monthly stats are provided. The goal is still to implement a BCA dashboard to track performance by physician. This initiative was delayed by other priorities and staffing shortages in ABI.

Change was implemented as intended, but other corporate priorities delayed the Dragon refresh/outreach to physicians till Q4. A slight improvement in the metric was seen this fiscal but should improve more next fiscal as we provide additional training and new functionality to physicians.

Dimension: Efficient

Indicator #2

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.

Last Year		This Year	
13.7%	12.7%	17.0%	12.7%
Performance (2021/22)	Target (2021/22)	Performance (2022/23) YTD Q1-Q3	Target (2022/23)

Change Idea

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

Target for Process Measure

12.7%

Lessons Learned

As part of the change idea implementation, we continue to offer individual Discharge Planning Pathway and iPlan education sessions to newly hired staff including social workers, mangers and directors being on boarded.

To optimize processes leveraging technology, a Business Intelligence (BI) screen and associated reports continues to be utilized to identify actionable delays in discharge planning, appear on an inpatient screen, and email notifications to staff, reducing avoidable delays and ALC days. Reports are reviewed with inpatient leadership on an ongoing basis, highlighting successes and opportunities for further improvement.

To achieve the target, iPlan has continued to be used to identify and support transitions to Long-Term Care Homes, and other institutional and community settings.

Discharge Planning Pathway, iPlan, and Joint Discharge Rounds continued to be leveraged to implement HEART@home program, an integrated model of care delivered by North Western Toronto OHT partners SE Health, Lumacare, and LOFT, using a bundled care approach, wrapping care around a patient on a 16-week program, followed by transition to regular Home & Community Care services or alternate destinations as appropriate.

Dimension: Efficient

Indicator #2

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.

Last Year		This Year	
13.7%	12.7%	17.0%	12.7%
Performance (2021/22)	Target (2021/22)	Performance (2022/23) YTD Q1-Q3	Target (2022/23)

Lessons Learned (continued)

Identified opportunity for ALC palliative patients and patients from CCC/Rehab facilities that have lost their beds due to prolonged acute illness. Engaged with physicians, clinical teams, and managers to proactively identify to ensure appropriate coding practices.

- Compliance with the Discharge Planning Pathway supported by Joint Discharge Rounds (JDR) and iPlan.
- Engagement with key stakeholders, including post acute and LTC partners, leveraging/designing technology, ensuring accountability through JDR and iPlan
- Orientation and training of newly recruited discharge planners and managers
- Advocacy efforts at OH Central and Toronto Central ALC tables

Dimension: Efficient

Indicator #3	Last Year		This Year	
ED visits as first point of contact for MHA-related care: % HRH ED patients without a Primary Care Provider for MHA visits/Total HRH ED visits for MHA.	-	-	**26.7%**	**27.0%**
	Performance (2021/22)	**Target (2021/22)**	**Performance (2022/23)** YTD Q1-Q3	**Target (2022/23)**

Change Idea

Partner with community agencies who could assist patients with finding PCPs. Access to family physicians when FMTU opens in 2023

Target for Process Measure

27.0%

Lessons Learned

This indicator is being monitored only at this time. Very difficult to impact change due to lack of PCPs taking new patients and poor compliance with follow up care within this population. In addition to partnering with a community agency, hoping when FMTU opens in 2023, there will be opportunity to access family physicians for unattached MH & A patients.

Theme II: Service Excellence

Dimension: Patient-Centred

Indicator #4

Percentage of patients who responded "completely" to the 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	
63.4%	57.5%	65.5%	57.5%
Performance (2021/22)	Target (2021/22)	Performance (2022/23) YTD Q1-Q3	Target (2022/23)

Change Idea

Provide specific performance and patient feedback to respective departments

Target for Process Measure

57.5%

Lessons Learned

As part of the change idea implementation, we developed issues to action for the inpatient medicine, with the focus on purposeful rounding, white board, and SMART discharge compliance, reviewing progress regularly with the inpatient medicine unit leadership. Continued to communicate monthly results and use data to drive improvement strategies. In addition, to support patients and families' transition home, Seniors Care program team created and deployed Senior Friendly education materials to augment the SMART discharge package. These materials are related to the 7 key areas aligned with best practices in senior friendly care as well as information on how to transition safely from hospital to home. The patients receive a one pager with a QR code that provides access to these materials on the external HRH website. The response from patients and families has been very positive.

- Target achieved
- Compliance with the SMART Discharge process supported by regular leadership meetings
- Engagement with front line staff and unit leadership

Dimension: Patient-Centred

Indicator #4	Last Year		This Year	
Percentage of patients who responded "completely" to the 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?	**63.4%**	**57.5%**	**65.5%**	**57.5%**
	Performance (2021/22)	**Target (2021/22)**	**Performance (2022/23)** YTD Q1-Q3	**Target (2022/23)**

Lessons Learned (continued)

The Family Satisfaction ICU Survey (FS-ICU) allows for the HRH ICU to continue our partnerships with patient families in our journey to high reliability. Traditionally, the FS-ICU survey was solely completed on an iPad on-site. The stress of the COVID-19 pandemic affected the presence of family members in the ICU along with other socio-limiting factors affecting opportunity of family members to provide feedback while on-site. In response to the challenge, the ICU Reinventing Patient Care Council (RPCC) implemented an alternate method through the utilization of a QR code for family members to complete the survey from home. In addition, a letter with said QR code is sent to patient families that were not present at time of discharge from ICU.

The addition of Mario Castillo Tembaya as our ICU Patient-Family advisor and member of the ICU RPCC spearheaded our commitment to family satisfaction in the ICU.

A review of the FS-ICU scores are included within the ICU RPCC and Joint Critical Care Steering Committee meetings, inspiring opportunities from the survey feedback. A leading initiative in response to these scores placed an emphasis on patient mobilization. To support the increased level of engagement, the program augmented the "Move to Improve" scorecard. These scorecards are motivating in nature and placed in each patient's room. The level of engagement between the care team and patient families' is supported by educational materials at the visitors' unit sign-in desk. All patient families are provided an opportunity complete the survey both onsite or from home.

We do see of the Move to Improve scorecard supporting greater engagement leading to increased family satisfaction scores. In 2022, The Move to Improve initiative was recognized at the Institute of Healthcare Improvement (IHI) Conference.

Dimension: Patient-Centred

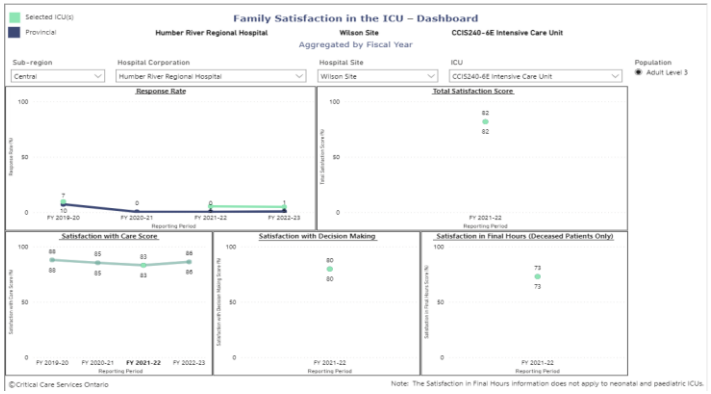
Indicator #4

Percentage of patients who responded "completely" to the 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	
63.4%	**57.5%**	**65.5%**	**57.5%**
Performance (2021/22)	**Target (2021/22)**	**Performance (2022/23)** YTD Q1-Q3	**Target (2022/23)**

Lessons Learned (continued)

- Standing topic to in-program committee meetings to report survey engagement and overall satisfaction scores
- Engagement with front line staff and unit leadership to support the implemented initiatives - inform staff of their role within the QIP.
- Dissemination of responses to program leadership and front-line staff
- Education materials are highlighted by the clinical (nursing/allied) team to encourage feedback
- Providing options for ease of access (QR code to complete survey at home or on-site iPad)



Theme III: Safe and Effective Care

Dimension: Effective

Indicator #5

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.

Last Year		This Year	
75.0%	**81.0%**	**76.0%**	**81.0%**
Performance (2021/22)	**Target (2021/22)**	**Performance (2022/23)** YTD Q1-Q3	**Target (2022/23)**

Change Idea #1

Re-Establish Medication Reconciliation Committee to formalize current requirements and further identity gaps and opportunities.

Change Idea #2

Review definitions and data analysis of medication reconciliation discharge rates and other quality indicators with committee

Change Idea #3

Continue with education and training for MDs with refreshers for targeted areas with low rates of medication reconciliation at discharge

Change Idea #4

Review additional resources and models to increase rates with committee

Target for Process Measure

81% of patients to be reconciled at time of discharge

Lessons Learned

The change idea was not fully implemented as intended. Re-establishing a medication reconciliation committee and meeting on a continuous basis was the ideal goal but proved to be challenging due to staff availability. Staffing issues continue to be difficult to navigate, even though population rates of COVID-19 are dissipating. As staffing levels increase to pre-pandemic levels, the hope is that focus on medication reconciliation at discharge will be renewed.

Dimension: Effective

Indicator #5

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.

Last Year		This Year	
75.0%	**81.0%**	**76.0%**	**81.0%**
Performance (2021/22)	**Target (2021/22)**	**Performance (2022/23)** YTD Q1-Q3	**Target (2022/23)**

Lessons Learned (continued)

As the effects of COVID-19's impact on workflow slowly lessen, focus can shift back to quality indicators such as medication reconciliation at discharge. Improving this indicator must be an interprofessional endeavour as only certain members of the discharge team can complete certain actions. Physicians much check off confirmation of a discharge medication reconciliation being completed for inclusion in the statistical sample. Further education to staff regarding this measure will increase compliance and improve outcomes.

Dimension: Safe

Indicator #6
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12-month period.

Last Year		This Year	
111	**120**	**95**	**120**
Performance (2021/22)	**Target (2021/22)**	**Performance (2022/23)** YTD Q1-Q3	**Target (2022/23)**

Change Idea

Deferred to QIP 2023/2024 Work Plan - Finalize implementation of special indicator in outpatient areas for workplace violence. Continue to conduct root cause analysis for workplace violence incidents.

Target for Process Measure

120

Lessons Learned

• In progress for 2023 – Complete WPV Meditech outpatient violence indicator.
• Done as of April 2022 - OHS created workflow to ensure coordination and collaboration between OHS and HR in the event of worker to worker violence reporting. Further consultations with stakeholders and union representatives have resulted in valuable recommendations regarding role of management and supervisors which will be implemented in Q4 2022/2023
• Communication plan to all stakeholders implemented to ensure investigations are completed in a timely manner.
• Safety and de-escalation training and peer-to-peer effective communication online modules developed and implemented. Roadshows conducted at Wilson and RCC sites to communicate launch of modules and promote staff incident reporting.
• Non COVID-19 Meditech changes/implementation during the pandemic proved to be a challenge due to resourcing.
• Lost time incidents were reduced due to a combination of prompt modified work offers and various safety initiatives such as higher WPV risk assessments completion rates and safety planning risk assessments.
• Improved documentation of meetings and training plans would have helped new team members transition/takeover current and paused initiatives more efficiently

Dimension: Safe

Indicator #6

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

Last Year		This Year	
111	**120**	**95**	**120**
Performance (2021/22)	**Target (2021/22)**	**Performance (2022/23)** YTD Q1-Q3	**Target (2022/23)**

Lessons Learned (continued)

• Key learning: engaging other departments such as HR and individual managers to ensure modified work offers, risk assessments, investigations are completed and on time.

• Ensure timely follow-up with staff members reporting workplace violence incidents to review safety measures and promote reporting near-miss incidents.

• Additional training tools were deployed to all staff and physicians through the de-escalation and peer-to-peer effective communication LiME modules.