Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% transitioned in accordance to targets from "Ready/Eligible " in Acute Care to "Admission " to HDGH .	C	% / All patients	In house data collection / 22-23 YTD (April - December 2022)	87.00	87.00	Currently: Rehab - 90% meeting 2 day Complex: 87% meeting 2 day TNI - reviewing data WE are targeting to maintain current performance - with surge and pressures from acute care and continued pressure for us to open up admission criteria, we anticipate higher occupancy and potential for challenges around meeting targets for this indicator in 23/24 Targets will remain same for Rehab/Complex - within 2 days. TNI will maintain 14 days Overall Meeting Target: Target: transition within two days (48 hours) of "ready/eligible"	

Change Ideas

Change Idea #1 Maximizes strategies related to internal transitions from complex to rehab to help address flow issues to CMC.

Methods	Process measures	Target for process measure	Comments
Intake department to facilitate the coordination of timely transitions to Rehab to maximize functional gains for patients and transition to Rehab to create flow and reduction of wait time for CMC beds.	Monitor referral process and wait time from ready status transition from CMC to Rehab	90% transitioned from CMC to Rehab within 2 days of "ready" status. (Internal transfers)	

Change Idea #2 Review wait times collection processes and optimize accuracy of data

Methods	Process measures	Target for process measure	Comments
Decision support team to work with intake staff who collate wait time data to review data quality and establish a consistent collection process across the organization and review opportunities to enhance the quality of the wait time data.	Complete review of data and provide a work plan for improvement of wait time data collection with quarterly milestones by June 30 , 2023 . Review % of work plan items completed quarterly.	85% of work plan items identified that are completed each quarter.	

Measure

Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate Level of Care (ALC) days expressed as % of all inpatient days in the same period	C	% / All inpatients	Other / April - December 2022	13.00	14.50	The target of 14.5 has been used for the past two years. Due to surge planning and transfers of ALC from acute care to address acute care ALC , our ALC rates will remain at current or higher for 23/24 as the development of a sfCare strategy is identified and approved within the strategic planning of the organization.	

Change Ideas

Change Idea #1	AS per the ALC leading practice guide from Ontario Health, we will be developing a sfCare strategy and plan and integrating that as a foundation of care across the organization . This is focused on Organizational Leadership & Support and Older Adult & Caregiver Communication and Involvement . In alignment with Accreditation Canada standard that "services are co-designed to meet the needs of an aging population" and is considered high priority criteria.

Methods	Process measures	Target for process measure	Comments
Development of three year sfCare strategy Plan with identified milestones for each year.	Development of work plan to support sfCare Strategy Plan completed by December 2023 . % of milestones achieved annually in the approved work plan.	Achievement of 80% of identified milestones identified annually, by the end of each fiscal year	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I think the services provided here are of high quality -Inpatient Mental Health OPOC	C	% / Discharged patients with mental health & addiction	Other / Q1-Q2 22/23	92.50	93.00	current target - 93% . YTD previous was 92%	

Change Ideas

Change Idea #1 Development of monthly structured rounds with a checklist and trial of new version of rounds

Methods	Process measures	Target for process measure	Comments
Develop plans for sharing information with patients and look at possibly inclusion where appropriate of patient into formal rounds. Setting of EDD (Expected Discharge Date) during a patients stay to help mitigate unexpected discharges.	1. EDD targets discussed and/or set where applicable within 30 days of admission (to be developed) 2. MH Rounds attendance will be tracked for physicians (to be developed) 3. Monitor OPOC (Ontario Perception of Care) results " #12-I was involved as much as I wanted to be in decisions about my treatment and support " (baseline: 73 % Agree/Strongly Agree) 4. Monitor OPOC results " #10 - I received clear information about my medication " (baseline: 80% Strongly Agree/Agree)	1.% of patients with an EDD discussed within 30 days post admission. (To be developed) 2.% attendance at rounds monthly (to be developed) 3. OPOC indicator #12 - involved in care - increase by 5% 4.OPOC indicator #10 - I received clear information about my medication - increase by 5%	The main goals will be implementing structured rounds and sharing of information and greater interaction with patients related to decision making andunderstanding of medications.

Change Idea #2	Develop a plan around increasing activities available to patients(i.e nurse led grounds, input from patients on what activities they are interested in having)

Methods	Process measures	Target for process measure	Comments
Through review of patient OPOC surveys and direct feedback/input from patients Monitor Code White incidents (time of day) to identify where additional activities may be required.	Monitor OPOC indicator related to enough activities from patient perspective. Monitor # of code white to determine if activities help reduce the number of incidents (due to boredom)	1. Increase OPOC indicator for " #33- there were enough enough activities of interest to me during my free time " target to increase strongly agree/Agree by 5% . 2. Develop a target for Code White reduction by September 2023.	Through Mental Health Transformational Planning activities , review of OPOC results and experience indicators most impacting patient experience related to quality care will be included in program review.

Measure

Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded "Completely/Always" 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. (discharged)	C	% / All inpatients	In-house survey / Jan 2022-Dec 2022	88.00	90.00	Previous year - 89.2% and current fiscal 88%. Our current target is 87%. We will target a 2% increase from current YTD, based on the planned actions.	

Change Ideas

Change Idea #1	Gather details from patient experience surveys and through the Discharge Transition nurse follow up call process, from those who feel they did not receive enough information. use language that corresponds with the information they receive (i.e., purple HDGH folder)		
Methods	Process measures	Target for process measure	Comments
Through collaboration, the Quality Advocate who conductst the real time patient experience surveys and the Discharge Transition Nurse will ask patiens for details if they indicate they did not receive enough information or information was missing on discharge. These details will be analyzed to identify possible trends and develop improvement initiatives accordingly. Ensure if answer sometimes or no, that comments are obtained and tracked for every patient on what information is missing or would be helpful.	% of comments received for answers that do not indicate the person received enough information. Analysis completed quarterly on response data and suggestions. Trending information provided to the indicator lead for development of discharge information improvements and shared with program Unit Based Councils as well as PFAC (Patient Family Advisory Committee)	1. 80% of negative responses will have comments starting in Q2. 2. 100% completion of quarterly analysis and feedback process to programs, Unit Based Councils & PFAC	Decision Support & Quality /Performance team will provide the analysis and trending results quarterly.

Change Idea #2	Review strategy to include scheduling of primary care follow up appointment within 7 days of discharge (prior to leaving the hospital and included in discharge package)		
Methods	Process measures	Target for process measure	Comments
Identify a process in which follow up appointments for primary care is arranged prior to discharge from the hospital. A method and who will complete this task to be established by June 2023.	Where an appointment for primary care is identified, track the % of patients who have their primary care appointment booked prior to leaving the hospitals. A process will be identified and tested in a pilot phase for 6 months to collate data and evaluate effectiveness.	Target to be identified once the strategy is developed and pilot is completed to establish a baseline.	This supports the system as primary care tracks and must report on % seen by primary care within 7 days of discharge from hospital. This change idea supports the patient's continuity of care and transition but also the system as a whole.

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #5	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–Dec 2022 (Q3 2022/23)	CB	97.00	Currently YTD 97% - previous year 91.9% . Focus on Sustainment of improvements and continued work on transitions.	

Change Ideas

Change Idea #1 Pharmacy /Physician Leads to continue to review monthly completion of medication reconciliation and follow up with individual physicians as required.

Methods	Process measures	Target for process measure	Comments
Focus on re-education and monitoring of "transitions" by program. Review incomplete Medication Reconciliation errors and follow up with individual physicians for learnings and improvements. This will include a workflow review for "HOLD" medications pending results process.	1. % transitions that have Medication Reconciliation completed 2. number (#) of incomplete medication reconciliation due to med rec error	1. Reduce number of transitions incomplete by 50% by fiscal year end. 2. Reduce the number of incomplete due to error by 50% by end of fiscal year.	We have kept the same action plan as previous year as this is the continued area for improvement - transitions within facility and medication errors. There was an improvement from previous year of 6% YTD and our goal this year is to sustain those improvements in these two areas and strive for continued improvement.

Measure

Dimension: Safe

Indicator #6	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.	P	Count / Worker	Local data collection / Jan 2022–Dec 2022	43.00	0.00	Current YTD: 33 cases (Q1/Q2/Q3) Previous Year: 32 cases (21/22) Continue to target zero cases as our organizational philosophy. Note: Our numbers when comparing to other QIP data is among the lowest. Will continue to monitor comparison's when 23/24 QIP's are released.	

Change Ideas

Change Idea #1 Our target for violence incidents is zero as an organizational strategic goal and set to be consistent with our message of zero tolerance . We continue to have a process to review each incident and apply learnings. We have experienced a large decline in incidents over the past years from 74 incidents in 20/21 to 32 incidents in 21/22 and 33 incidents in 22/23. Fiscal Year was used.

Methods	Process measures	Target for process measure	Comments
Monitor impacts of increasing clinics and programs and the increase of visitors/Designated Care Partners back into the building and impacts on incidents against staff.	% of incidents with/without injury Monitor # of incidents by program/time period.	100% without injury is target 20% reduction in # incidents overall by program/service categories.	FTE=937 There have been significant declines over the past years in incidents against employees during COVID and related service and program disruptions. Understanding any learnings from this decline and factors contributing to it are important in sustaining and continuing to reduce incidents across the organization as our organizational functions return to the pre-pandemic levels.

Equity

Measure

Dimension: Equitable

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Increase awareness of diversity, equity, and inclusivity; project development milestone goals	C	% / Worker	In house data collection / not applicable	CB	CB	The aim is to improve Equity, Diversity, Inclusion and Indigeneity (EDII) awareness and practices within HDGH. A work plan will be created and milestones identified.	

Change Ideas

Change Idea #1 Establishing an EDII work plan that emphasizes key areas of learning and development and contribute meaningfully to organizational strategic direction.

Methods	Process measures	Target for process measure	Comments
Through the established EDII Alliance, establish and EDII work plan to increase awareness and EDII practices at HDGH .	Development of strategic plan that embeds EDII in all that we do by September 2023 Creation of EDII work plan that will drive EDII initiatives and education in alignment with the strategic plan	Implementation of finalized EDII work plan and milestone identification for the next three years in alignment with strategic plan	Once the work plan has been developed, the progress towards identified milestones will be tracked and reported on as % identified milestones achieved and reported quarterly . Work plan items may include education plans and targets, HR related EDI practices, system improvements in health information system etc)