Access and Flow

Measure - Dimension: Timely

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% admissions meeting admission target (ready to admission)	C	% / All inpatients	In house data collection / 2425	84.30	80.00	With the implementation of the Ontario Health directive of maintaining an occupany rate of 95% bed availability, there may become a challenge in transitioning patients within the current target of 2 days. Rehab /Complex : within 2 days / TNI : within 14 days In addition to ALC numbers continuing to be on the rise because of community resource contrants, LTC bed accessility and assisted living/retirement living affordability.	Acute Care hospitals , Ontario Health , LTC , Home & Community , Assisted Retirement Living

Change Ideas

Change Idea #1	Maximize strategies related to acute care transitions to post-acute care beds to improve access adn flow efficiencies and assist in resolving system wide patient flow challenges		
Methods	Process measures	Target for process measure	Comments
Data will be collected by the Intake team and decision support to monitor strategies and analyse and report on weekly flow. Methods include 1. Assign patients to off service beds when required. 2. Move the physiatrist/geriatrician consult up front in the referral process to direct the referral and admission process based on medical stability criteria and the RCA framework 3. HDGH will continue to remain diligent in reviewing referrals and working with acute care partners in educating them on eligibility criteria and referral processes. This is especially important to ensure that patients are transitioned safely to the right bed at the right time and in addition avoid unnecessary ALC designations	The occupancy level will be monitored in each inpatient area and reported weekly and monthly . This indicator will be monitored as well by the Performance & Utilization Committee .	The target is 95%.	

Measure - Dimension: Timely

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate Level of Care Throughput Ratio	C	Rate / All inpatients	WTIS / Q2	CB	1.00	HSAA target	Home & Community, acute care partners, ontario health, LTC, Assisted Living

Change Ideas

Change Idea #1	Work with OH and partners to support the establishment of a resolution table specific for patients with developmental diagnoses		
Methods	Process measures	Target for process measure	Comments
Continue to advocate with Ontario Health for resolution table	Plan to establish a resolution table by December 2024. Number of cases reviewed at resolution table	December 2024 Number of Cases - Collecting Baseline case # in 2024. (Q4)	

Change Idea #2	As per the OH Directive for maintaining an ALC throughput ratio of >1, HDGH will re-educate all care providers on the process for ALC designation as per the provincial ALC leading practice guide.		
Methods	Process measures	Target for process measure	Comments
1. Adopt weekly rounds with Home and Community Care Services to identify challenges and barriers for discharge 2. HDGH is building relationships with BPSO and RGP and will be introducing an Elder Life Program to strengthen interactions with our patients and reduce the risk of delirium 3. HDGH has implemented a pilot project called the Geriatric Urgent Response Team (GURT) that will go to patient's homes to assess their cognitive well-being and assist with system navigation to advert ED visits 4. Re-educate staff on ALC definition and leading practice guide.	1. Track weekly rounds adherence with Home & Community Care will be tracked by Intake Manager 2. Target Date for Elder Life Program Establishment 3. # of GURT visits and tracking if adverted ED visit by Intake Manage 4. % of group identified for retraining on ALC designation which includes Hospitalists, Charge Nurses, Managers, Discharge Planners which will be tracked by Intake Manager	1. 100% rounds occurring weekly need targets 2. January 2025 3. # of GURT visits - Collecting Baseline Data 4. 100% by December 2024	

Change Idea #3	Through the sub-region Access and Flow table, patients identified as long stay complex discharges to the community will be discussed via a resolution table whereby all key stakeholders gather to review the case and identify solutions for appropriate and safe discharge.		
Methods	Process measures	Target for process measure	Comments
• One of the greatest barriers for the long stay complex discharge is accessibility to specialized beds including patients needed dialysis and those with cognitive behavioural care needs • Development of referral process and Utilization of resolution table to review long stay complex patients for discharge to appropriate community setting	Review # times patient is referred once the referral process is setup .	Collecting baseline data in 2024	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	0.00	100.00	In alignment with 5 year strategic plan related to training . Target is to complete 100% of identified senior leadership and physician leadership team . Senior leadership will be mandatory for completion by March 2025. Full leadership team and physicians will be optional for 2025 but encouraged to complete and report . These groups will be mandatory in 2025/26. This includes nine modules which includes Anti-Black Racism , Gender Diversity , Indigenous Cultural Awareness (4 modules) and French Language	Ontario Health

Change Ideas

Change Idea #1	Implementation of Education for Senior executive team (SMC) - Mandatory 100% completed. Leadership FOrum - Optional - Collect baseline by March 2025 Physicians - Optional - Collect baseline for OH Identified Training. RCC (Regional Childrens Center) - Rainbow Health Training - Optional (RCC will be funded by Lead Agency)		
Methods	Process measures	Target for process measure	Comments
a. TAHSN Anti-Black Racism e-Module Training b. Intro to Gender Diversity c. OPTIONAL: Rainbow Health Ontario Foundations Course d. Indigenous Relationship and Cultural Awareness Courses (All 4 below) i. First Nations, Inuit and Métis Culture Colonization and the Determinants of Health ii. Indigenous History and Political Governance iii. Cultural Competence in Healthcare iv. Truth and Reconciliation Commission of Canada (TRC) and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)). (90 minutes) e. One of the following: i. https://flsonlinetraining.ca/ ii. https://www.activeoffertraining.ca/	% education completed in identified employee groups. 1. Senior Management - Mandatory 2. Leadership - Optional for 2024 3. Physician - Optional for 2024 4. RCC - Rainbow Training - Optional - all staff (funded by Lead Agency)	1. SMC - 100% by March 2025 2. Leadership - Optional to complete March 2025 - Collecting Baseline 3. Physicians - Optional to complete March 2025 - Collecting Baseline 4. RCC - Rainbow training	

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Staff were sensitive to my cultural needs	C	% / Other	Hospital collected data / Q2	3.54	4.00	Uses 4 point Likert Scale. 3=Good, 4=Very Good. We are starting with a small sample size and leverage learnings to scale to other areas. Clients need to understand the definition of cultural needs. We are targeting 4.0 to target , when applicable , we strive to be "very good" and place of excellence. If selected not applicable , they are not included.	

Change Ideas

Change Idea #1 Increase sample size of completed OPOC surveys in RCC and provide education to clients on cultural needs definition . Many patients indicate not applicable .

Methods	Process measures	Target for process measure	Comments
1. Develop process for increasing use of OPOC, Use OPOC across wider range of RCC programs. 2. educating clients on how cultural needs are defined 2. In consultation with RCC PFAC , develop engagement strategy related to education for cultural needs awareness.	1. # Completed OPOCs per quarter and Monitor Response Rates 2. Completion of PFAC consultation and plan strategy by September 2024	1. Increase to 25 completed OPOCs per quarter. 2. Strategy development by Sept 2024 for education plan.	Aim to get consistent OPOC completion throughout the year in order to provide reliable baseline data to be used in future QI initiatives.

Measure - Dimension: Equitable

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Increase awareness of of Diversity, Equity and inclusivity through implementation of approved Project Plan - % milestones achieved	C	% / Health providers in the entire facility	Hospital collected data / 24/25	CB	100.00	the expectation is that once the final plan is approved by Senior Management , the milestones set for each fiscal year, in conjunction with Strategic Plan and Implementation quarterly goals will be met.	Ontario Health , Regional EDI leads- Regional Partners

Change Ideas

Change Idea #1 Implementation of EDII work plan that will drive initiatives in alignment with strategic plan

Methods	Process measures	Target for process measure	Comments
Monitoring of milestones for Year 1 approved work plan	% of milestones achieved (milestones completed /milestones identified)	100% of identified milestones identified for Year 1 , by end of fiscal year March 2025.	The work plan identifies milestones identified for the next three years in alignment with our strategic plan .

Experience

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?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	97.19	95.00	Actual Performance last year was 88% , target set at 90 for this year. The higher trend is only in two quarters (Q1, Q2) , Q3 was 92% . We are setting it at 95% which we feel is more realistic and still a stretch target with increasing and higher occupancy rates. The higher % also may be reflecting a pilot project with a post discharge transition call which we are hoping to put back into place during this fiscal year with Charge Nurse changes in Spring /summer 2024.	Home & Community Care

Change Ideas

Change Idea #1	Through collaboration , the Quality Advocate , who conducts real time patient experience surveys on discharge and the Discharge Transition Nurse , will ask for details if they indciate they did not receive enough information or information was missing on discharge. These details will continue to be analyzed to identify possible trends and developed improvement initiatives accordingly. The Quality Advocate will ensure if the answer is sometimes or No, that comments are obtained and tracked through the discharge survey for every patient on what information is missing or would be helpful.

Methods	Process measures	Target for process measure	Comments
• % 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 programs and Managers.	Track % of negative responses at have comments provided starting in Q2; 100% completion of quarterly analysis and feedback process to programs and Managers.	80% of sometimes/no responses have a comment provided. 100% quarterly analysis and infographic and survey details provided to managers quarterly.	Total Surveys Initiated: 462 Note that Patient Experience results will also be shared quarterly with PFAC for any feedback /suggestions.

Change Idea #2	Review strategy to include scheduling of primary care follow up appointment, prior to discharge , 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. Standard work to complete this task to be established by May 2024.	Where an appointment for primary care is identified, track the % of patients who have their primary care appointment booked prior to leaving the hospital.	Target : 50% of eligible population by Q4 24/25	Eligible population includes: discharged home or vulnerable/at risk for re-admission

Change Idea #3	Explore strategy to have Charge Nurse phone patient's post discharge to assess how transition home went and answer any clinical /discharge questions they are worried about .

Methods	Process measures	Target for process measure	Comments
Establish standard work and script for follow up call, as well as links to support services in community if required. Complete Standard work by May 2024	Percentage of patients who do not have enough information and require access to other community services over total patients called	Target : < 20% of patient by Q3/Q4 fiscal year end , and will include only those discharged home or identified as at risk population .	

Measure - Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Overall Perception of Care - MH Inpatient	C	% / Mental health patients	Other / 2324	3.03	3.33	Targeting an overall perception of care improvement of 10% . This is in alignment with planned improvements as a result of MOC changes for TNI . The target is by Q4, 24/25	

Change Ideas

Change Idea #1 "Implement the revised staffing model as part of the TNI Transformation Develop standardized processes to attach patients to relevant group programming as part of the TNI Transformation ". Focus on opportunities for improvements identified in OPOC surveys

Methods	Process measures	Target for process measure	Comments
Increase activities for patients for afternoons and weekends Increase involvement of patients in decision making - OPOC #12 - current : 78.6% Increase staff knowledge and competence through MOC changes - OPOC #17 : 87%	OPOC #33 - There were enough activities of interest to me during free time OPOC #12 - I was involved as much as I wanted to be in decisions about my treatment and support OPOC # 17 - I found staff knowledgeable and competent OPOC # 1 - the wait time for services was reasonable to me	5% improvement in each of the four identified process measure indicators 1. OPOC 33- current 75.5% , target - 79.5% 2. OPOC 12 - current 78.6 , target - 82.5 3. OPOC 17 - current 87% , target - 91.4% 4. OPOC 1 - current 76.3%, target - 80%	The process measures identified to improve the overall perception of care are those identified in the OPOC as Areas of involvement and based on top average scores of disagree and strongly disagree. These are the four key areas /questions will be focusing on to improve overall perception of care.

Measure - Dimension: Patient-centred

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
MH OP Indicator -- Overall experience	C	% / Mental health patients	Other / 2324	CB	CB	The goal for 24/25 will be to identify best practice MH OP survey tool and increase use of survey tools and response rates in order to then target specific improvement initiatives for following year. It has bee identified that OPOC tool is not working well for this population.	

Change Ideas

Change Idea #1 Future state to look at metric that are specific to MH (safety, and flow). Creation of a consistant method for collection of data. Increasing the number of feedback from MH population specifically OP

Methods	Process measures	Target for process measure	Comments
1. Conduct a best practice review on the best survey tool to use in specialty sub acute care MH OP program setting . 2. develop process for increasing use of feedback survey; implement in all OP MH programs	1. Best practice review completed and survey tool selected through consultation with staff, clients & physicians 2. Implementation completed in all identified MH OP programs .	1.Complete best practice review by June 2024 and conduct consultation sessions by September 2024 2. 75% identified MH OP programs identified implemented by fiscal year end . (Q4)	Need consistent completion and responses to feedback surveys and a tool to support this population and programs in order to develop baseline data to then in Year 2 and 3 target specific quality improvements from a patient experience lens.

Measure - Dimension: Patient-centred

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
MH RCC % overall quality care	C	% / Pediatric Patients	Other / April 1- March 31	43.80	60.00	50% rated Agree so overall 93.8% positive . The target is to move to "Strongly Agree"	

Change Ideas

Change Idea #1 Focus on specific OPOC questions for improvement planning to impact the overall quality of care indicator . compile strong baseline data to inform future QI initiatives.

Methods	Process measures	Target for process measure	Comments
1. Monitor OPOC results throughout program changes occurring this fiscal (IOT expansion and closure of live-in treatment) 2. increase sample size of completed OPOCS.	1. Monitor # of completed OPOC's per quarter 2. Monitor response rates 3. Monitor Q3 : I felt that i was a valued member of the care team for my loved one . 4. Q30 - The services and supports my loved one received helped them deal more effectively with the challenges in their life 5. Q31 I think the services or supports provided here are of high quality .	1. Increase by 25 surveys quarterly by Q3 , 2024 2. Response Rate - target 25% 3. OPOC Questions - improve each questions by 5% from baseline (April 1, 2023 -January 2024) by end of Q3 24/25	

Measure - Dimension: Patient-centred

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rehab Outpatient Experience Indicator - Outpatient Rehab clients feel they have met their goals prior to discharge for the program	C	% / Other	Other / YTD 23-24	60.00	70.00	We are targeting a 10% improvement . The perception is patients do not want to leave the program so a focus will be on communication and understanding of the program and setting goals for program that are realistic .	

Change Ideas

Change Idea #1 Gain a better understanding of why clients feel they didn't meet their goals •

Methods	Process measures	Target for process measure	Comments
1. Develop patient literature and standard messaging for clients and their families as well as links to support services in community upon discharge when required 2. Analysis completed quarterly on response data. Trending information provided to the indicator lead for development of quality improvements to be shared with programs and Managers	1. % of comments received that indicate the client did not achieve their established goal and identify what goals were not met to better understand why they feel are not meeting goals.2. comments analyzed quarterly and information provided to indicator lead, program and managers to develop improvement plans	100% of comments reviewed, analyzed and shared quarterly .	

Safety

Measure - Dimension: Effective

Indicator #1	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.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	95.68	97.00	In alignment with current target and impact of action plan for 24/25	

Change Ideas

Change Idea #1 Establish clear definition, role and scope for Medication Reconciliation on Discharge for Physicians and Pharmacists. Identify "Physician Champions" for each program: Rehab, CMC and MHA where regular performance updates can be reported and process improvements put in place.

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	Working with CNE /Chief of Staff to identify Physician champion for each program.

Change Idea #2 Establish a process for Pharmacy consult to be generated for patients upon discharge to assist with Medication Reconciliation and patient education.

Methods	Process measures	Target for process measure	Comments
Establish criteria to trigger Pharmacist consult and standard process. Identify Pharmacist champions established to help create standard work and process.	1. # of patient's who meet eligibility for pharmacy consult, versus actual # of patients who have pharmacy consult on discharge	1. 85% of patients eligible for pharmacy consult received pharmacy consult	

Measure - Dimension: Safe

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	1.00	0.00	our target is zero , as in alignment with our workplace violence strategic stance of zero tolerance	

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 continue to experience a large decline in incidents of the past years from 74 incidents in 20/21 to 32 incidents in 21/22 to ?43 incidents in 22/23 and (fiscal year end forecast) 32 incidents in 23/24. Fiscal Year was used.

Methods	Process measures	Target for process measure	Comments
Monitor impacts of full resumption of all in-patient, residential and ambulatory services and resumption of regular visitor and Designated Care Partner programs across the organization and impacts on incidents against employees.	1. % of incidents with/without injury 2. Monitor # of incidents by program/time period - baseline .	1. 100% without injury is target 2. 20% reduction in # incidents overall by program/service categories.	We continue to experience a decline in reported workplace violence incidents against employees despite the resumption of more normalized operations at HDGH post-COVID. Full resumption of visitor and Designated Care Partner programs have also not impacted incidents against employees. Through 23/24 we returned to providing verbal de-escalation and physical disengagement refresher training for all HDGH employees, and introduced PPE Safety Packs to RCC employees given the number of incidents we continue to see coming from that specialized program. We continue to emphasize education to all patients and visitors regarding zero tolerance for violence towards employees which is further supported by the HDGH Security team and our Safe Workplace Advocate