# Access and Flow

## Measure - Dimension: Timely

| Indicator #9 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| 90th percentile ambulance offload time | P | Minutes / Patients | CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2) | 36.00 | 30.00 | Target established by HRH | |

### Change Ideas

| | |
|---|---|
| Change Idea #1 | 1. Complete the O-zone, EMS, Triage and SA workflow analysis and recommend action items that will improve ED specific metrics. 2. Standardize the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Collaborate with Mental Health Leadership team to identify strategies aimed at optimizing MHU patient flow. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 6 hours. 5. Implement ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times [CTAS 4 and CTAS 5 only]. 6. Collaborate with inpatient managers to reinforce the pull culture when transferring patients to the inpatient unit. 7. Collaborate with the Director of CC to implement QI identified in the Kaizen event regarding the admit to inpatient bedtime. 8. Provide ED staff education, review and implement SCD order sets, identify process to flag the SCD patients in ED and finalize the ED SCD referral process. 9. Organize a Kaizen event to identify actionable items to improve PIA. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Complete a workflow analysis in different areas of ED (EMS, O-zone, SA, Triage) and identify actionable changes. 2. ED Director to work alongside Command Center Director and manager to perform a workflow analysis on ED PFM role in access and flow. 3. Staffing contingency plan to be generated and shared amongst ED PFM group, ED manager, ED director (and admin on call if necessary). 4. Daily Bed Meetings to discuss barriers to patient's transfer from ED. 5. Monthly monitoring of the ED metrics to evaluate progress. 6. Complete – continue to monitor effects of additional bed capacity. 7. Collaborate and provide direction for working groups in existence, (clinical working group, operational working group, executive committees), regarding the Scale AI model that is being generated alongside Deloitte. 8. Collaborate with CC to support the action items identified at the Kaizen event: admit to inpatient bed. | 90th percentile ambulance offload time (AOT) | 30 min [OH target and HRH Target] | |

## Measure - Dimension: Timely

| Indicator #10 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| 90th percentile emergency department wait time to inpatient bed | O | Hours / ED patients | CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2) | 6.88 | 6.00 | Target established by Auditor General / Canadian Association of Emergency Physicians / National Emergency Nurses Affiliation | |

### Change Ideas

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|---|---|
| Change Idea #1 | 1. Complete the O-zone, EMS, Triage and SA workflow analysis and recommend action items that will improve ED specific metrics. 2. Standardize the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Collaborate with Mental Health Leadership team to identify strategies aimed at optimizing MHU patient flow. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 6 hours. 5. Implement ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times [CTAS 4 and CTAS 5 only]. 6. Collaborate with inpatient managers to reinforce the pull culture when transferring patients to the inpatient unit. 7. Collaborate with the Director of CC to implement QI identified in the Kaizen event regarding the admit to inpatient bedtime. 8. Provide ED staff education, review and implement SCD order sets, identify process to flag the SCD patients in ED and finalize the ED SCD referral process. 9. Organize a Kaizen event to identify actionable items to improve PIA. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Complete a workflow analysis in different areas of ED (EMS, O-zone, SA, Triage) and identify actionable changes. 2. ED Director to work alongside Command Center Director and manager to perform a workflow analysis on ED PFM role in access and flow. 3. Staffing contingency plan to be generated and shared amongst ED PFM group, ED manager, ED director (and admin on call if necessary). 4. Daily Bed Meetings to discuss barriers to patient's transfer from ED. 5. Monthly monitoring of the ED metrics to evaluate progress. 6. Complete – continue to monitor effects of additional bed capacity. 7. Collaborate and provide direction for working groups in existence, (clinical working group, operational working group, executive committees), regarding the Scale AI model that is being generated alongside Deloitte. 8. Collaborate with CC to support the action items identified at the Kaizen event: admit to inpatient bed. | 90th percentile emergency department wait time to inpatient bed | 6 hours [HRH target, Attorney General target] | |

## Measure - Dimension: Timely

| Indicator #11 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percent of patients who visited the ED and left without being seen by a physician | O | % / ED patients | CIHI NACRS / Apr 1 to Sept 30, 2024 (Q1 and Q2) | 2.34 | 1.50 | Target established by HRH | |

### Change Ideas

Change Idea #1 1. Complete the O-zone, EMS, Triage and SA workflow analysis and recommend action items that will improve ED specific metrics. 2. Standardize the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Collaborate with Mental Health Leadership team to identify strategies aimed at optimizing MHU patient flow. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 6 hours. 5. Implement ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times [CTAS 4 and CTAS 5 only]. 6. Collaborate with inpatient managers to reinforce the pull culture when transferring patients to the inpatient unit. 7. Collaborate with the Director of CC to implement QI identified in the Kaizen event regarding the admit to inpatient bedtime. 8. Provide ED staff education, review and implement SCD order sets, identify process to flag the SCD patients in ED and finalize the ED SCD referral process. 9. Organize a Kaizen event to identify actionable items to improve PIA.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Review the current LWBS policy and update as needed. 2. Conduct 30 chart reviews for patients who LWBS in ED and identify any action items. | Percentage of patients who visited the emergency department and left without being seen (LWBS) by a physician | 1.5 % [HRH target] | |

## Measure - Dimension: Timely

| Indicator #12 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| 90th percentile emergency department length of stay for nonadmitted patients with low acuity | O | Hours / ED patients | CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2) | 5.98 | 4.00 | The Ontario Health target for this indicator from the Pay for Results program is 4 hours. | |

### Change Ideas

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|---|---|
| Change Idea #1 | 1. Complete the O-zone, EMS, Triage and SA workflow analysis and recommend action items that will improve ED specific metrics. 2. Standardize the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Collaborate with Mental Health Leadership team to identify strategies aimed at optimizing MHU patient flow. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 6 hours. 5. Implement ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times [CTAS 4 and CTAS 5 only]. 6. Collaborate with inpatient managers to reinforce the pull culture when transferring patients to the inpatient unit. 7. Collaborate with the Director of CC to implement QI identified in the Kaizen event regarding the admit to inpatient bedtime. 8. Provide ED staff education, review and implement SCD order sets, identify process to flag the SCD patients in ED and finalize the ED SCD referral process. 9. Organize a Kaizen event to identify actionable items to improve PIA. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Complete a workflow analysis in different areas of ED (EMS, O-zone, SA, Triage) and identify actionable changes. 2. ED Director to work alongside Command Center Director and manager to perform a workflow analysis on ED PFM role in access and flow. 3. Staffing contingency plan to be generated and shared amongst ED PFM group, ED manager, ED director (and admin on call if necessary). 4. Daily Bed Meetings to discuss barriers to patient's transfer from ED. 5. Monthly monitoring of the ED metrics to evaluate progress. 6. Complete – continue to monitor effects of additional bed capacity. 7. Collaborate and provide direction for working groups in existence, (clinical working group, operational working group, executive committees), regarding the Scale AI model that is being generated alongside Deloitte. 8. Collaborate with CC to support the action items identified at the Kaizen event: admit to inpatient bed. | 90th percentile of ED LOS for non-admitted patients with low acuity | 4 hours [OH target and HRH target] | |

## Measure - Dimension: Timely

| Indicator #13 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| 90th percentile emergency department length of stay for nonadmitted patients with high acuity | O | Hours / ED patients | CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2) | 8.00 | 7.00 | The Ontario Health target for this indicator from the Pay for Results program is 7 hours. | |

### Change Ideas

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|---|---|
| Change Idea #1 | 1. Complete the O-zone, EMS, Triage and SA workflow analysis and recommend action items that will improve ED specific metrics. 2. Standardize the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Collaborate with Mental Health Leadership team to identify strategies aimed at optimizing MHU patient flow. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 6 hours. 5. Implement ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times [CTAS 4 and CTAS 5 only]. 6. Collaborate with inpatient managers to reinforce the pull culture when transferring patients to the inpatient unit. 7. Collaborate with the Director of CC to implement QI identified in the Kaizen event regarding the admit to inpatient bedtime. 8. Provide ED staff education, review and implement SCD order sets, identify process to flag the SCD patients in ED and finalize the ED SCD referral process. 9. Organize a Kaizen event to identify actionable items to improve PIA. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Complete a workflow analysis in different areas of ED (EMS, O-zone, SA, Triage) and identify actionable changes. 2. ED Director to work alongside Command Center Director and manager to perform a workflow analysis on ED PFM role in access and flow. 3. Staffing contingency plan to be generated and shared amongst ED PFM group, ED manager, ED director (and admin on call if necessary). 4. Daily Bed Meetings to discuss barriers to patient's transfer from ED. 5. Monthly monitoring of the ED metrics to evaluate progress. 6. Complete – continue to monitor effects of additional bed capacity. 7. Collaborate and provide direction for working groups in existence, (clinical working group, operational working group, executive committees), regarding the Scale AI model that is being generated alongside Deloitte. 8. Collaborate with CC to support the action items identified at the Kaizen event: admit to inpatient bed. | 90th percentile of ED LOS for non-admitted patients with high acuity | 7 hours [OH target and HRH target] | |

## Measure - Dimension: Timely

| Indicator #14 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| 90th percentile emergency department wait time to physician initial assessment | P | Hours / ED patients | CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2) | 4.28 | 2.00 | Target established by HRH | |

### Change Ideas

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|---|---|
| Change Idea #1 | 1. Complete the O-zone, EMS, Triage and SA workflow analysis and recommend action items that will improve ED specific metrics. 2. Standardize the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Collaborate with Mental Health Leadership team to identify strategies aimed at optimizing MHU patient flow. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 6 hours. 5. Implement ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times [CTAS 4 and CTAS 5 only]. 6. Collaborate with inpatient managers to reinforce the pull culture when transferring patients to the inpatient unit. 7. Collaborate with the Director of CC to implement QI identified in the Kaizen event regarding the admit to inpatient bedtime. 8. Provide ED staff education, review and implement SCD order sets, identify process to flag the SCD patients in ED and finalize the ED SCD referral process. 9. Organize a Kaizen event to identify actionable items to improve PIA. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Collaborate with Research team to evaluate the opportunity of revising the ED physician schedule. 2. Organize a Kaizen event to identify actionable items to improve PIA. 3. Collaborate with Research team to develop an data driven AI algorithm. predictable model to guide the ED staff schedule including the ED physician schedule. | 90th percentile ED wait time to physician initial assessment (PIA) | 2 hours [HRH target] | |

## Measure - Dimension: Timely

| Indicator #15 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m. | P | Number / ED patients | CIHI NACRS / Apr 1 to Sep 30, 2024 (Q1 and Q2) | 2.22 | 0.00 | Target established by HRH | |

### Change Ideas

Change Idea #1 • Optimize TOA content and train for awareness • Relocate IPAC Coordinator & EVS Discharge Supervisor to the Command Centre • Optimization of bed assignment process • Development and implementation of iPOM for ED to inpatient TOA to include target time and escalation / resolution pathway • Development of designated inpatient check-in location and process for porters on all inpatient units

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| • Development of EDPFM CC profile for monitoring of ED P4R metrics, delays in care/procedures, TOA and portering • Daily Bed Meetings to include data sharing by unit re time to inpatient bed from prior day • Working groups for implementation of Time to Inpatient Bed Kaizen action plan and QIP initiatives | • E-TOA content updated • IPAC and EVS Discharge Supervisor based in command centre • Time from Admit order to Bed Assigned • Percentage of time ED nurse transporting patient to inpatient unit • Unit level time to inpatient bed 90th percentile | • E-TOA content updated – 100% complete • IPAC and EVS Discharge Supervisor based in command centre – 100% complete • Time from Admit order to Bed Assigned – 30 minutes • Percentage of time ED nurse transporting patient to inpatient unit - <2% • Unit level time from bed clean to patient in inpatient bed 90th percentile – 1.5 hours | It is important to note risk that may influence the performance in this QI plan. • ALC rates and pressures related to ongoing system capacity pressures in CCC, LTC and post-acute settings |

## Measure - Dimension: Timely

| Indicator #16 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| 90th percentile emergency department length of stay for admitted patients | O | Hours / ED patients | CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2) | 17.72 | 25.00 | The Ontario Health target for this indicator from the Pay for Results program is 25 hours. | |

### Change Ideas

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|---|---|
| Change Idea #1 | 1. Complete the O-zone, EMS, Triage and SA workflow analysis and recommend action items that will improve ED specific metrics. 2. Standardize the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Collaborate with Mental Health Leadership team to identify strategies aimed at optimizing MHU patient flow. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 6 hours. 5. Implement ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times [CTAS 4 and CTAS 5 only]. 6. Collaborate with inpatient managers to reinforce the pull culture when transferring patients to the inpatient unit. 7. Collaborate with the Director of CC to implement QI identified in the Kaizen event regarding the admit to inpatient bedtime. 8. Provide ED staff education, review and implement SCD order sets, identify process to flag the SCD patients in ED and finalize the ED SCD referral process. 9. Organize a Kaizen event to identify actionable items to improve PIA. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Complete a workflow analysis in different areas of ED (EMS, O-zone, SA, Triage) and identify actionable changes. 2. ED Director to work alongside Command Center Director and manager to perform a workflow analysis on ED PFM role in access and flow. 3. Staffing contingency plan to be generated and shared amongst ED PFM group, ED manager, ED director (and admin on call if necessary). 4. Daily Bed Meetings to discuss barriers to patient's transfer from ED. 5. Monthly monitoring of the ED metrics to evaluate progress. 6. Complete – continue to monitor effects of additional bed capacity. 7. Collaborate and provide direction for working groups in existence, (clinical working group, operational working group, executive committees), regarding the Scale AI model that is being generated alongside Deloitte. 8. Collaborate with CC to support the action items identified at the Kaizen event: admit to inpatient bed. | 90th percentile emergency department length of stay (LOS) for admitted patients | 15 hours [HRH target] [OH target: 25 hours] | |

# Equity

## Measure - Dimension: Equitable

| Indicator #1 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Average ED wait time to physician initial assessment (PIA) for individuals with sickle cell disease (CTAS 1 or 2) | O | Minutes / ED patients | CIHI NACRS / April 1 to September 30, 2024 (Q1 and Q2) | 145.16 | 15.00 | Target established by Health Quality Ontario | |

### Change Ideas

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|---|---|
| Change Idea #1 | 1. Complete the O-zone, EMS, Triage and SA workflow analysis and recommend action items that will improve ED specific metrics. 2. Standardize the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Collaborate with Mental Health Leadership team to identify strategies aimed at optimizing MHU patient flow. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 6 hours. 5. Implement ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times [CTAS 4 and CTAS 5 only]. 6. Collaborate with inpatient managers to reinforce the pull culture when transferring patients to the inpatient unit. 7. Collaborate with the Director of CC to implement QI identified in the Kaizen event regarding the admit to inpatient bedtime. 8. Provide ED staff education, review and implement SCD order sets, identify process to flag the SCD patients in ED and finalize the ED SCD referral process. 9. Organize a Kaizen event to identify actionable items to improve PIA. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Reinforce triage/ED staff education by placing a greater focus on sickle cell-related content, ensuring the inclusion of proper triage classification. 2. Work in collaboration with external partners (e.g., UHN, SCAGO, NYGH, Black Creek) to identify a referral pathway. 3. Review and update the SCD ED order set. 4. Explore the utilization of Meditech's special indicators to generate individualized care plans for patients with sickle cell disease. 5. Collect data regarding patient who present in ED with sickle cell disease to monitor and course correct. 6. Review the CSD metrics monthly to evaluate progress. | Average emergency department wait time to physician initial assessment (PIA) for individuals with sickle cell disease (CTAS 1 or 2) | CTAS 1- immediately, CTAS 2- 15 min [OH and HRH target] | |

## Measure - Dimension: Equitable

| Indicator #2 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Rate of ED 30-day repeat visits for individuals with sickle cell disease | O | % / ED patients | CIHI NACRS / Index visits from April 1 to September 30, 2024 (Q1 and Q2) | 28.81 | 30.00 | Target established by HRH | |

## Change Ideas

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|---|---|
| Change Idea #1 | 1. Complete the O-zone, EMS, Triage and SA workflow analysis and recommend action items that will improve ED specific metrics. 2. Standardize the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Collaborate with Mental Health Leadership team to identify strategies aimed at optimizing MHU patient flow. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 6 hours. 5. Implement ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times [CTAS 4 and CTAS 5 only]. 6. Collaborate with inpatient managers to reinforce the pull culture when transferring patients to the inpatient unit. 7. Collaborate with the Director of CC to implement QI identified in the Kaizen event regarding the admit to inpatient bedtime. 8. Provide ED staff education, review and implement SCD order sets, identify process to flag the SCD patients in ED and finalize the ED SCD referral process. 9. Organize a Kaizen event to identify actionable items to improve PIA. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Reinforce triage/ED staff education by placing a greater focus on sickle cell-related content, ensuring the inclusion of proper triage classification. 2. Work in collaboration with external partners (e.g., UHN, SCAGO, NYGH, Black Creek) to identify a referral pathway. 3. Review and update the SCD ED order set. 4. Explore the utilization of Meditech's special indicators to generate individualized care plans for patients with sickle cell disease. 5. Collect data regarding patient who present in ED with sickle cell disease to monitor and course correct. 6. Review the CSD metrics monthly to evaluate progress. | Rate of emergency department 30-day repeat visits for individuals with sickle cell disease | 30% [HRH target:30%] | |

## Measure - Dimension: Equitable

| Indicator #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of ED visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2) | O | % / ED patients | CIHI NACRS / April 1 to September 30, 2024 (Q1 and Q2) | 79.49 | 75.00 | Target established by HRH | |

### Change Ideas

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|---|---|
| Change Idea #1 | 1. Complete the O-zone, EMS, Triage and SA workflow analysis and recommend action items that will improve ED specific metrics. 2. Standardize the ED PFM role to optimize bed management strategies to expedite patient admission, discharge, and transfers. 3. Collaborate with Mental Health Leadership team to identify strategies aimed at optimizing MHU patient flow. 4. Work with other departmental directors to create surge capacity on the floors when ED admissions surpass 6 hours. 5. Implement ScaleAI – queuing technology aimed to improve patient experience by reducing in hospital wait and PIA times [CTAS 4 and CTAS 5 only]. 6. Collaborate with inpatient managers to reinforce the pull culture when transferring patients to the inpatient unit. 7. Collaborate with the Director of CC to implement QI identified in the Kaizen event regarding the admit to inpatient bedtime. 8. Provide ED staff education, review and implement SCD order sets, identify process to flag the SCD patients in ED and finalize the ED SCD referral process. 9. Organize a Kaizen event to identify actionable items to improve PIA. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Reinforce triage/ED staff education by placing a greater focus on sickle cell-related content, ensuring the inclusion of proper triage classification. 2. Work in collaboration with external partners (e.g., UHN, SCAGO, NYGH, Black Creek) to identify a referral pathway. 3. Review and update the SCD ED order set. 4. Explore the utilization of Meditech's special indicators to generate individualized care plans for patients with sickle cell disease. 5. Collect data regarding patient who present in ED with sickle cell disease to monitor and course correct. 6. Review the CSD metrics monthly to evaluate progress. | Percentage of emergency department visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2) | 75% [HRH Target] | |

## Measure - Dimension: Equitable

| Indicator #4 | 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 | 100.00 | 100.00 | Target established by HRH | |

## Change Ideas

| Change Idea #1 | Evaluate module completion rates at the leadership level Ensuring leadership buy-in and awareness helps drive overall completion and fosters a culture of continuous learning and inclusion. | | |
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| Methods | Process measures | Target for process measure | Comments |
| Monitor Cultural Competence and Safety in Healthcare: Understanding Indigenous Perspectives module completion rates. Include completion metrics in leadership dashboards or regular performance reviews. Provide Executive Leaders with key messages to engage leaders who have not yet completed the module by communicating the benefits and relevance of the training. | Module Completion Rate Number of leaders engaged in EDI Manager-led refresher session Number of Visits/Downloads of Manager Huddle Script and FAQ. | 75% completion by September 31, 2025<br>100% completion by December 31, 2025 | The Cultural Competence and Safety in Healthcare: Understanding Indigenous Perspectives eLearning module is a 90-minute self-learning program, certified by the College of Family Physicians of Canada for 1.5 Mainpro+ credits. The course aims to address the ongoing impact of racism and culturally insensitive healthcare experiences reported by First Nations, Inuit, Métis, and urban Indigenous populations. Leaders are encouraged to promote the module, track completion rates diligently, and create an environment where discussions about cultural safety are ongoing and supported by relevant resources. |

| Change Idea #2 | Provide leaders with educational tools and resources to generate awareness and increase uptake. Equipping leaders with clear, concise, and culturally appropriate resources can enhance their understanding of Indigenous cultural competence. | | |
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| Methods | Process measures | Target for process measure | Comments |
| • Develop a Manager Huddle Script with FAQ focusing on cultural competence, safety, and Indigenous perspectives to address common questions or concerns derived from the course. • Provide the Manager Huddle Script along with the FAQ in leadership and manager forums and ensure its availability on the EDI SharePoint site. • Offer EDI Manager-led “refresher” sessions or micro-trainings to reinforce key concepts from the eLearning module. | • Module Completion Rate • Number of leaders engaged in EDI Manager-led refresher session • Number of Visits/Downloads of Manager Huddle Script and FAQ. | • 75% completion by September 31, 2025 • 100% completion by December 31, 2025 | |

# 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 | 89.43 | 75.00 | Target established by HRH | |

### Change Ideas

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| Change Idea #1 | Further improve metric of patients feeling they have received enough information at discharge related to their condition and treatment by continuing the focus on patient and family engagement through improvements in SMART Discharge and warm hand-offs to community partners. |

| Methods | Process measures | Target for process measure | Comments |
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|---|---|---|---|
| IP Units strategies: 1. Structured discharge planning with tailored education and instruction to the needs of patients. 2. Ensure EDD is on the whiteboards to support heightened awareness and engagement of families with EDD (includes audits) 3. Review PDCC results with teams – huddles – quality “crosses” to engage staff in discussion 4. Use of teach back methodology with SMART discharge 5. Verified tools for assessing health literacy levels and cultural sensitivity when creating education tools. 6. Multimodal education – written, video/ABT and didactic classroom education where appropriate 7. Post discharge calls for PCI/CHF patients done by Cardiac Nurse Clinician 8. Maximum utilization of community resources (rapid response nurse, heart@home, telehealth follow up) 9. Include family with education, SMART discharge package on admission to IP units – patient label/sticker on package Critical Care: 1. Create a new document ‘leaving the ICU’ with RPCC/PFAC approval to support discharge from ICU and transitions in care 2. Move to Qualtrics with discharge from ICU – 3. Pilot with 8EW in longer/complex patient transfers from ICU – including meeting with both Managers/RPs and Social workers. 4. Working with WP as partners for improving TOA / transfer process from chronic vent patients from HRH ICU to WP CVP (TOA documents for nursing and RRT) | 1. Percentage of Medicine Units implementing their new SMART Discharge packages and processes 2. Percentage of PCI/CHF discharges that receive a call back by Cardiac Nurse Clinician 3. Completion of new ICU tool 4. Implementation of Qualtrics in the ICU | 1. 100% 2. Surveillance Measure 3. Complete 4. Fully implemented | Total Surveys Initiated: 3956 |

# Safety

## Measure - Dimension: Safe

| Indicator #6 | 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 | 81.09 | 81.00 | Benchmark target recommended by Health Quality Ontario | |

### Change Ideas

Change Idea #1 Collaborate with the ABI team to refine the methodology for capturing discharge medication reconciliation rates by incorporating weighted averages based on discharge volumes.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Currently, the aggregate discharge med rec rate is calculated as a simple average across all applicable units, without any consideration for discharge volumes. Units with fewer discharges contribute equally to the average as units with more discharges, resulting in disproportionate impact to the overall rate. | Incorporate historical discharge rates to calculate a weighted average for the overall organizational discharge medication reconciliation rate. | Achieve 100% completion of a weighted-average model by incorporating historical discharge volumes per patient care area by end of Q1 2025/26. | Discharge Medication Reconciliation is currently at the target rate of 81% (YTD 2024-25). Calculating weighted averages accounts for variations in discharge volumes across units, thus providing a more accurate representation of organizational rates. |

Change Idea #2 Use automation/reminders in Meditech to increase uptake of completed best possible medication discharge plans.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Physicians who do not complete a best possible discharge medication plan still utilize the “discharge order” functionality to discharge a patient. While not as effective as forcing function, automation and reminders can be helpful tools to increase the success of an intervention | Percentage of patients in whom a physician completed a best possible discharge plan after receiving a prompt/reminder when entering a discharge order. | Achieve 20% compliance rate for completion of a best possible discharge plan after receiving prompt/reminder by end of Q2 2025/26. | Based on primary literature, when discharge med rec was first implemented: Development of a tool within the electronic medical record to facilitate medication reconciliation after hospital discharge \| Journal of the American Medical Informatics Association \| Oxford Academic The tool was used in 12–18% of eligible patients during the first 6 months, and in 41% for the last 6 months after implementing a pop-up reminder, clinical outreach, and education. |

## Measure - Dimension: Safe

| Indicator #7 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Rate of delirium onset during hospitalization | O | % / Hospital admitted patients | CIHI DAD / April 1 to September 30, 2024 (Q1 and Q2), based on the discharge date | 0.17 | 0.20 | Target established by HRH | |

### Change Ideas

Change Idea #1 • Implementation of 1 change idea from DASH Year 2 Project focus (still to be determined) • Refresh of HRH Mobilization strategy • Development of bed assignment strategy for patients over age 64 to reduce bed moves • Sustain change ideas implemented in 24/25

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| • Continue DASH monthly working group to develop and implement workplan and accountabilities for change initiatives • Development of iPOM related to minimization of bed moves for patients over age 64 • Huddles and skills day training re Mobilization strategy, expectations and monitoring • Continue monitoring of process measures from 24/25 and new measures for 25/26 | - Rate of Sedative-hypnotic orders - Rate of Sedative-hypnotic orders PRN - Rate of Delirium Order Set Use - CAM compliance within 24 hours (%) - CHASM compliance (at least 1 intervention) (%) - % nursing staff attended Mobilization Huddles - % nursing staff attended Nursing Skills Day | - Rate of Sedative-hypnotic orders 13.3% - Rate of Sedative-hypnotic orders PRN 5.5% - Rate of Delirium Order Set Use 66% - CAM compliance within 24 hours (%) 95.7% - CHASM compliance (at least 1 intervention) (%) 87.9% - % nursing staff attended Mobilization Huddles 80% - % nursing staff attended Nursing Skills Day 80% | Year 2 focus for DASH community has not been specified, but Humber will participate in Year 2. |

## Measure - Dimension: Safe

| Indicator #8 | 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 | 0.06 | 0.20 | Target established by HRH | |

### Change Ideas

**Change Idea #1** Standardize violence flagging across RCC Sites with Partner hospitals to minimize exposure of violence to HRH Support Services.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Conduct a Gap Analysis to determine what criteria RCC partners currently use to initiate a violence indicator flag for their patients. Consider streamlining from various different signage to one standardized sign. | Completion of Partner Hospitals roll out effective signage and risk assessment for initiating a violence flag. | Observe a reduction in WPV HC/LT incidents experienced by HRH Support Services Staff from Patients on the Partner Hospital Units. | |

**Change Idea #2** Continue to work towards rollout of Meditech outpatient violence special indicator – improvement of communication to staff to inform them of violent patients.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Determine effective criteria/risk assessment for triggering a Violence Flag on an outpatient personnel. Include training of all CPLs, Managers and Supervisors on placing violence special indicator. | Frequency of Meetings determined along with agenda items aimed to highlight areas of most concern for WPV Incidents. | 100% of workplace violence incidents resulting in FA, HC and LT have a violence special indicator reviewed on a monthly basis. | |

Change Idea #3 Establish a Workplace Violence Task Force to address trending areas like Violence experienced in the Emergency Department

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Proceed with a Call for Members, develop a Terms of Reference and establish a regular meeting structure for the Task Force to meet and address issues. Ensure the committee is made up of both Worker and Management reps for optimal points of view. | Frequency of Meetings determined along with agenda items aimed to highlight areas of most concern for WPV Incidents. | See a reduction in current performance of 0.24 from 2024/25 towards the goal of 0.20 in rate of lost time injury by collaborating to minimize exposure to Workplace Violence hospital wide but with an emphasis on areas of most concern like the Emergency Department. | |

Change Idea #4 Continue completing Workplace Violence Incident Audits to ensure the loop has been closed by both OHSW and Management.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Review all WPV reported incidents to ensure OHSW follow up, Manager follow up and appropriate corrective actions are in place to minimize exposure to WPV to affected and non-affected staff. | OHSW and Management follow up completed along with Corrective Actions in place for each WPV Incident. | 100% completion of follow up on both OHSW and Management side for all WPV Reported incidents, especially for those that result in HC or LT within 5 business days of the incident. | |