Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
ALC Bed Equivalent - the total number of patient days where a patient is designated as ALC (acute and post acute)/total number of days in the reporting period.	C	Days / ALC patients	In house data collection / April 2019 - March 2020	80.20	92.00	Target set to reflect our increased ALC rate experienced as a result of the pandemic and the anticipated impact of ongoing reduced community support capacity.	St. Lukes Place, Parkwood Mennonite Home, LHIN , Waterloo Wellington Local Health Integration Network, St. Mary's General Hospital

Change Ideas

Change Idea #1 Multi-Departmental ALC rounds will be held and ALC patients will be reviewed. Appropriateness of ALC designation will be reviewed by the committee and goal directed strategies created to reduce ALC length of stay.

Methods	Process measures	Target for process measure	Comments
ALC rounds will be held twice a week. Discrepancies will be discussed and resolved by committee. ALC patients designated inappropriately with less then a 5 day length of stay will be identified. Inappropriately designated ALC designation will have follow ups conducted with ordering provider.	Reduce the Number of weekly ALC discrepancies. Reduce the number of short stay ALCs.	Achieve a reduction in the total number of short stay (1-5 day) ALC patients. Reduce 0 day ALCs to 0%.	

Change Idea #2 Create a ALC champion education series based on ALC leading best practices with input from ethics and legal consultations.

Methods	Process measures	Target for process measure	Comments
Create an ALC Education Program. Deliver focused education seminars and assessments to key stakeholders biweekly x4, then with monthly follow up assessments x4.	Track pre-post ALC knowledge through assessment scores derived from ALC champion testing.	Reduce the number of inappropriately designated ALC patients by 80%.	

Change Idea #3	Implement the Blaylock tool to identify patients with complex discharge requirements. use the results of the tool to trigger immediate allied health consultations.		
Methods	Process measures	Target for process measure	Comments
Incorporate Blaylock into HIS. Educate the the inter-professional team on how to use the tool and implement it into routine admission practices.	Measure the completion rate of the Blaylock tool within the first 24-48 hours. Increase the number of allied health consultations within the first 48 hours of admission.	80% of admitted patients greater then 55 years old will have the Blaylock completed within 48 hours of admission.	

Change Idea #4	Explore and expand opportunities with current community partners and seek additional partnerships to provide the right care at the right time in the right location		
Methods	Process measures	Target for process measure	Comments
Partner with St. Luke’s Place to provide the right care within the right environment for eligible ALC patients Explore opportunities with Parkwood Seniors Community to improve the transition of patients with dementia and behavioral needs from acute care to LTC.	Number of community partners engaged in partnerships.	Increase the number of community partners engaged in collaboration.	

Measure

Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Conservable beds equivalent - the total number of acute LOS days - expected LOS days for an acute patient (excluding those where the value is negative)/total number of days in the reporting period using the HIG methodology.	C	Other / All acute patients	Other / April 2019 - March 2020	42.80	39.00	Target reflects additional bed capacity added during pandemic, targeting 25th percentile performance	

Change Ideas

Change Idea #1 Implement daily afternoon discharge huddles to identify, organise and prioritise the removal of discharge barriers.

Methods	Process measures	Target for process measure	Comments
Each unit across the medicine service will implement a team discharge huddle lead by a attending team member on a daily basis. Scripted topics will be reviewed for each patient.	The daily discharge huddles will be reviewed by the project team daily until goals are met then month audits will ensure the initiative is sustained.	100% of scripted discharge items will be reviewed for 100% of the unit census on a daily basis.	

Change Idea #2 Improve communication between Physicians and unit staff. Physician Pending Discharge-Unit Connection will occur to identify patients who have become medically stable and/or are eligible for pending next day discharge.

Methods	Process measures	Target for process measure	Comments
Cerner will be leveraged for the physician to input a medical stability order to alert unit staff to prepare for discharge. These patients will be highlighted during discharged huddles and documented within the discharge organisation tool.	Number of physicians reporting to the unit's resource nurse and the number of that day and next day pending discharges identified. Documentation of this connection and identified patients will be completed upon the discharge organisation tool and audited daily by the quality team until stable targets are achieved, then audited monthly by unit leadership.	80% of MRPs will provide a discharge update connection between the hours of 1400-1500 and collectively 2 patients will be identified as pending discharges for the next day. 80% of these identified patients will be discharged before 1100.	

Measure

Dimension: Efficient

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Emergency Department time to physician initial assessment in hours - 90th percentile	C	Hours / ED patients	CIHI NACRS / April 2019 - March 2020	4.90	3.00	Aligns with ED Pay for Results target	Windsor Regional Hospital, St Marys General Hospital

Change Ideas

Change Idea #1 Identify and prioritize bottlenecks with significant impact on ED LOS/ PIA and pilot initiatives to improve performance

Methods	Process measures	Target for process measure	Comments
Analyze ED patient arrival patterns and resource demands to allocate P4R funds to initiatives targeting bottlenecks (i.e. dedicated ED lab tech). Optimize utilization of ACA (Ambulatory Care Area)/ Fast Track Area. Adjust ED Provider schedule to meet demands based on ED arrival patterns	Reduction in PIA for all ED patients, reduction in ED LOS for CTAS 1-5 and reduction in LWBS rates	A 2 hour reduction in LOS of CTAS IV, V by Q3. Greater than or equal to a 3% reduction in left without being seen rate by Q3, 2020	

Measure

Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	M	Hours / All patients	CIHI NACRS, CCO / Oct 2019– Dec 2019	19.93	17.00	To achieve 25th percentile performance	

Change Ideas

Change Idea #1 Implement a discharge organisation tool to engage the night staff in the removal of barriers to pending discharged and to ensure all discharge related tasks have been identified and/or completed in a timely manner to promote greater patient flow during peak ED admission times.

Methods	Process measures	Target for process measure	Comments
The tool will be added to nursing documentation and completed daily. This documentation will be provided with the end of shift TOA to allow the night shift team to better plan for the next day.	The number of completed tools and signed tools after TOA as reviewed by the quality team on a weekly basis until the goal is sustained then the process will be audited monthly by unit leadership.	100% of patients with an EDD of less then 48 hours will have the tool completed by nursing at the end of each shift.	

Measure **Dimension:** Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Emergency Department Length of Stay Non Admitted High Acuity (CTAS I-III)	C	90th percentile / ED patients	CCO iPort / April 2019 - March 2020	8.40	8.00	Aligns with ED Pay for Results target	Windsor Regional Hospital, St. Mary's General Hospital

Change Ideas

Change Idea #1 Work with key stakeholders of inpatient programs and the ED to address inpatient flow (i.e Bed utilization committee, flow steering committee) and optimize utilization of space in the main care area of the ED to create bed space for ED assessment and treatment.

Methods	Process measures	Target for process measure	Comments
Create surge thresholds for inpatient units and activate inpatient surge bed utilization when threshold met. Support initiatives targeting extended hours of hospitalist services.	Reduction in ED LOS of high acuity patients, reduction in PIA and LWBS rates	A reduction in LOS by 0.5 hours for CTAS I-III by Q3,2020	

Measure **Dimension:** Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Emergency Department Length of Stay Non Admitted Low Acuity (CTAS IV-V)	C	90th percentile / ED patients	CCO iPort / April 2019 - March 2020	6.50	4.00	Aligns with ED Pay for Results target	Windsor Regional Hospital, St. Mary's General Hospital

Change Ideas

Change Idea #1 Identify and prioritize bottlenecks with significant impact on ED LOS and pilot initiatives to improve performance

Methods	Process measures	Target for process measure	Comments
Analyze ED arrival patterns and resource demands to allocate P4R funds to initiatives targeting bottlenecks (i.e. dedicated ED lab tech, evening surge NP shift). Continue PDSA cycles for Fast Track concept in ambulatory care. Adjust ED provider schedule to provide additional shift on the busiest day of the week.	Reduction in ED LOS for low acuity patients, reduction in PIA and LWBS rates	A reduction in LOS by 2 hours for CTAS IV/V by Q3, 2020	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	P	% / Survey respondents	CIHI CPES / Most recent 12 months	61.89	72.00	10% improvement over current performance	

Change Ideas

Change Idea #1 Analyze results to identify and prioritize programs with significant impact on indicator "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?" and pilot initiatives to improve performance

Methods	Process measures	Target for process measure	Comments
Identify areas with positive variance in results, understand what allows them to achieve better results, and mobilize that knowledge to areas with lower performance	Analysis completion, results sharing with individual programs to guide strategy and implement action items to improve "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?" scores	Analysis completion and results shared by Q1,2020 Strategy formulation and implementation by Q2-Q3,2020	Total Surveys Initiated: 963

Change Idea #2 Implement new Co-health App for children’s and childbirth program

Methods	Process measures	Target for process measure	Comments
Identify the needs, define requirement and add patient education material related to discharge teaching to the app to help improve access to discharge information and warning signs, and medication knowledge. Development/customization with key stakeholders as program leadership, Communications team, research and innovation team, pediatric and obstetrical providers (obstetricians, pediatricians and midwives) as well as patient and family advisers. Engage with primary providers to provide initial uptake information in offices to utilize the app.	Co-health app development/ customization, implementation and ongoing patient & family feedback	App development/ customization and implementation complete by Q1/Q2, 2020	

Theme III: Safe and Effective Care

Measure

Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	M	Count / Worker	Local data collection / Jan - Dec 2019	182.00	176.00	Targeting a 5% improvement over projected year end performance.	

Change Ideas

Change Idea #1 Further develop our Code White policy and associated training

Methods	Process measures	Target for process measure	Comments
a) Review and update the GRH Code White Policy. b) Develop a code white and de-escalation training matrix,which clearly outlines staff training requirements related to violence prevention. c) Participate in the WSIB Health & Safety Excellence Program d) Optimize the threat alert flagging system within Cerner.	Decreased number of code whites called.	Code whites will decrease by 10%	FTE=2481

Change Idea #2 Provide education regarding respectful workplace to leadership and staff

Methods	Process measures	Target for process measure	Comments
a) Develop/provide an in-person manager/supervisor respectful workplace training course. b) Update the on-line staff respectful workplace training course.	Number of leaders trained in respectful workplace	50% of leadership will complete training within 1 year.	

Change Idea #3 Develop a mechanism to improve employee incident reporting of violence

Methods	Process measures	Target for process measure	Comments
Transition from a paper employee incident reporting system to electronic	Number of employee incidents that are reported correctly	80% of employee incidents of violence will be reported electronically by year end.	