Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

SOUTHLAKE
REGIONAL HEALTH CENTRE

4/23/2020 APPROVED

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

This is an open communication to the Patients and Families in our community who we exist to serve in fulfilling our four strategic goals to:

1) *Forge a new path to meet the changing needs of our growing communities*
2) *Champion a culture of exemplary care and deliver clinical excellence*
3) *Create an environment where the best experiences happen*
4) *Own our role to improve the system*

Our intent is to share our Quality Improvement Plan (QIP) in an open and transparent declaration of our pursuit of Quality and Patient Safety. Thank you for taking the time to find and read our QIP. Every year we create a new plan and post it publically which is a part of our commitment to you. At Southlake Regional Health Centre (Southlake), we are committed to continuously improving the quality and safety of the care we deliver to our patients and families and the work environment we provide to our staff, physicians and volunteers. Our QIP is an important element in our commitment to *create an environment where the best experiences happen,* and our ability to achieve quality outcomes and create value in healthcare. The QIP is the foundation to prioritize our Quality and Patient Safety efforts. This year, we have launched our 5 Patient Safety Priorities. These five priorities are within part of our QIP and are also on every quality and patient safety huddle board across the organization. Programs create real time commitments to improving the quality and patient safety for patients and communicate and monitor these important safety priorities on a daily basis. In addition, the results of the QIP are fully analyzed and discussed at minimum, quarterly, at all of our Leadership and Board Committees and each of us is held accountable to achieve the QIP outcomes through our personal Management Performance Plan process. Staff, physicians and volunteers have access to the most up to date data, through our Business Intelligence System, this helps us to monitor our performance. With this system, our staff has the ability to drill down into each report element to monitor portfolio or unit-level real time performance against our goals. At Southlake, we embrace our responsibility to ensure that each of us is aware of and actively pursuing our priorities.

We are proud of the work we do, and we know that we can always improve. We would like to invite you to tell us about your experience with us, good or bad. Please share your thoughts on what we should do more of and/or where we can improve. Your voice is essential to our ongoing journey. One of our values is "*Every Voice Matters*", and therefore, we commit to listen respectfully and take actions accordingly. We thank you for taking the time to help us.

For the 2020/2021 QIP, Southlake has ten indicators that we will maintain and/or improve upon. The following five indicators are our top patient safety priorities, and will be our priority focus this year:

1. Improve the Compliance of Two Patient Identification to 95%

To keep patients safe we want to reduce the errors that could result when not properly identifying a patient's identity. Two-client identification has been determined as an evidence based method to reduce errors during medication administration, treatments, tests and procedures. This means that with every interaction we will use two pieces of information to ensure we have the right patient (e.g.

name and date of birth). In 2020/21, Southlake will continue with audits and feedback for the two-client identification process. As one of our five Patient Safety priorities, corporate results from these audits will be shared broadly, and unit specific data will be posted on Quality and Safety huddle boards throughout the hospital.

2. Improve Medication Reconciliation compliance for patients at discharge in all clinical areas to 80%

It is important that patient's know what medications to take when they leave the hospital or care setting. Often, changes to their medications will need to occur from what they were taking prior to their stay. We help to make this happen by performing medication reconciliation on discharge. We monitor this process by checking the number of patients who had a Best Possible Medication Discharge Plan (BPMDP) created. In 2019/20, implementation roll-out across clinical units occurred. In 2020/21, we will engage a physician champion to help develop additional improvement strategies targeting areas that will have the greatest positive impact for our overall performance. As one of our five Patient Safety priorities, corporate compliance results will be shared broadly, and unit specific data will be posted on Quality and Safety huddle boards throughout the hospital.

3. Reduce rate of Patient Falls in Inpatient Areas Resulting in Harm to 1.25

The majority of inpatients are older adults and falls are a major concern that can prolong their hospital stay. Many falls can be prevented by implementing best practice falls prevention guidelines. Since 2015, the rate of falls resulting in harm had been steadily increasing year over year. As such, it was identified as one of the five Patient Safety priorities for the organization. In 2020/21, Southlake will focus on the individualized care plans for patients who have been identified for high-risk of falls and continue to utilize strategies to prevent falls As one of our five Patient Safety priorities, corporate results will be shared broadly, and unit specific data will be posted on Quality and Safety huddle boards throughout the hospital.

4. Improve Patient Satisfaction Score related to Discharge from the Hospital (Inpatient Care) to 58.3%

It is recognized that when a patient leaves the hospital they need understand what care plans have been made and should be put in place. Effective communication of hospital discharge information is required for future health, function and quality of life of our patients. As part of our patient satisfaction survey we measure the success of appropriate discharge communication with patients from one of the questions: "*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?*" (Four point scale). We analyze the feedback that is provided to help improve our processes. Next year, we will have the Patient Oriented Discharge Summary (PODS) on all inpatient units across the Hospital. PODS is a communication booklet that provides patients with a summary of all of the information they need for their care after they leave the hospital. The PODS booklet was developed with Patient and Family Advisors. As one of our five Patient Safety priorities, corporate results will be shared broadly, and unit specific data will be posted on Quality and Safety huddle boards throughout the hospital.

5. Reduce rate of Hospital Acquired Pressure Injuries to 1.4 percent

In 2018/19 Southlake created processes to measure the prevalence and incidents of pressure injuries. As part of this work, a trigger tool was developed using best practice guidelines. This tool helped flag pressure injuries within the hospital so that appropriate actions could be taken by the interprofessional team for patient care. Our goal for this year is to maintain our improvement in this area. We will explore opportunities to maximize the use of our therapeutic surfaces (beds) using our Versus monitoring system. In addition, we will share results from our patient incident management system at a unit level to help increase awareness and improvement at a unit level. As one of our five Patient Safety priorities, corporate results will be shared broadly, and unit specific data will be posted on Quality and Safety huddle boards throughout the hospital.

Below are two posters for our 5 patient safety priorities. These can be found throughout the hospital, and on the Quality and Patient Safety huddle boards. The first one is patient facing and the second one is for providers.

In addition to the five Patient Safety Priorities we are committed to these additional five indicators:

6. Maintain current performance for Alternate Level of Care (ALC) Days for Patients discharged to home with support through Southlake@home at 1.4 days.

Southlake will also look to understand root causes of ALC days to home, and develop strategies to address common issues that are identified. Additionally, in partnership with patients, families and rehabilitation providers Southlake will implement a strategy to ensure rehabilitation equipment in the home is fully utilized by patients.

7. Reduce Time to Inpatient bed to 31 hours.

Southlake has been focusing on how we can improve the flow of patients from the emergency to inpatients beds. This is a multifaceted initiative. We will highlight three of the change ideas that we will be working on over the next year. First, Southlake will try to increase the number of appropriate discharges from inpatient units. Secondly, there will be a trial of a new patient flow system where a limited number of patients will be sent up to the medicine units in anticipation of their bed being ready. Finally, we hope to help patients prevent deconditioning, as this can lead to longer stays in hospital, by increasing mobilization and increasing the use of physiotherapy, occupational therapy and physiotherapy assistants.

8. Increase Discharge Summaries Sent from Hospital to Community Care Provider within 2 days of discharge to 72%.

Southlake will engage physicians to drive improvements at a provider level. This strategy create awareness amongst physicians and will help create a catalyst for change as we focus on where the greatest achievements can be made.

9. Maintain the Overall Incidents of Workplace Violence at 314.

Next year, Southlake plans on investigating special cause variation of workplace violence incidents. In addition, we will expand the Workplace Violence Prevention training to other high risk groups based upon a risk assessment.

10. Improve Patient Satisfaction score to 62.6%.

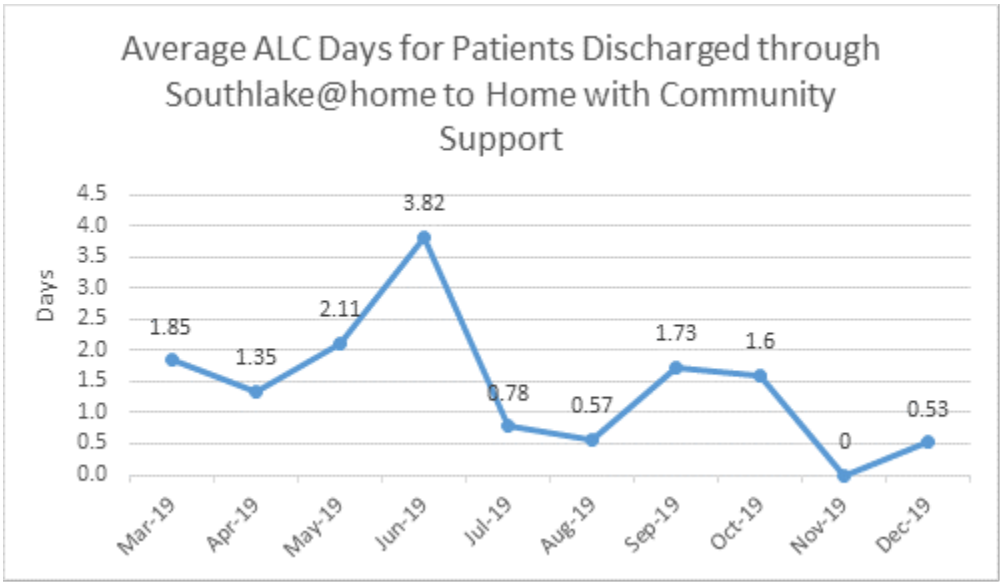
In 2020/21, Southlake will have implemented the patient-ambassador volunteer program across all inpatient units. The goal of this program is to enhance the experience of patients and their families/caregivers while in the hospital. Patient ambassadors provide information about parking, food services, accessing the Patient Handbook and welcome video, as well as provide support in using the "smart tv".

Describe your organization's greatest QI achievement from the past year

We would like to share with you one of our successful achievements from the past year. Southlake@home is a program designed to provide care in the best place possible for our patients which is often in their home. Patients who are designated Alternate Level of Care (ALC) traditionally have medically or socially complex issues that make their hospital stay longer (an average of 14.5 days) as they need more assistance when discharged. Southlake@home is a team of health care professionals who work together to transition people safely out of the hospital with supports in place, thereby decreasing the risks associated with a longer hospital stay such as a decline in mobility or contracting a hospital-acquired infection. Southlake@home's achievements are best measured in the voices of the patients and the providers.

"Nice to have features of hospital care at home. Comfort of being at home for me was important" – Patient

Timely discharge of ALC designated patients opens up available acute care hospital beds for those needing it and helps to decrease overcapacity. The program analyzes quality measures monthly to reduce time spent in acute care when not medically needed so that patients can get home safely. Using the IHI Quadruple Aim as the framework, the program works to improve patient experience, population health, cost efficiencies, and health care provider work life. Southlake@home owes its success to the dedicated group of patients, families and providers who have the courage to think differently and commitment to work differently. Thank you to the patient and family advisors who contributed to the success of the design of our program.



Collaboration and integration

The Southlake Community Ontario Health Team (OHT) was announced in the fall of 2019, after a rigorous self-assessment and full application to the Ministry. Organizations that make up the Southlake Community OHT are Southlake Regional Health Centre, Aurora Newmarket Family Health Team, Bayshore Healthcare, Canadian Mental Health Association York and South Simcoe, CHATS, Enhance Care Clinic, Extendicare, Georgina Nurse Practitioner Led Clinic, LOFT, SE Health, Southlake Academic Family Health Team, and York Region. It is important to highlight that Patient and Family Advisors continue to participate in the design, development and implementation of the OHT. The Southlake Community OHT serves a population of approximately 341,000 from surrounding municipalities with a priority focus on 1) older adults with multiple comorbidities and complex needs and 2) adult mental health and addictions.

The overarching goal is to address the most pressing challenges in the current system and make significant improvements to each element of the Quadruple Aim; improved health outcomes, improved patient experience, improved provider satisfaction, and increased value.

Improving health outcomes will be achieved through population health management. Improved coordination across sectors will close care gaps and unnecessary delays found in the current system.

Improving patient experience using enhancing communication, warm handoffs, and providing 24/7 navigation access will improve patient outcomes. A 'digital first' strategy with a focus on digital access to health tools and patient access to information, a decrease in wait time for first home care service from hospital and community, and offering care in the most appropriate settings to decrease Emergency visits for conditions best managed elsewhere will improve patient experience and outcomes.

Improved provider satisfaction through enhanced communication processes will streamline administrative work and increase provider confidence in continuity of care and care transitions.

Increased value will be realized with a shift to paying for value not volume using a shared risk and value-based procurement process. Coordinated planning and budgeting with shared risk contracting while moving from an organizational to a shared model will offer clear incentives and supports the business case for integrated care.

Southlake is excited to be participating in this collaborative effort to bring improved transitions and quality care to our patients and families.

Patient/client/resident partnering and relations

In the development of our 2019 – 2023 Strategic Plan, we spoke with thousands of our staff, physicians, volunteers, patient and family advisors, hospital partners, community partners and patients, families and caregivers. We reviewed relevant documents (i.e. Accreditation Canada standards, previous QIPs, Integrated Quality and Patient Safety Plan, and the Risk Management Plan), as well as having two members of our Corporate Patient and Family Advisory Committee (Corporate PFAC) on our Strategic Planning Steering Committee. As part of Southlake's 2020/21 Quality Improvement Plan development process, we have ensured that the QIP goals continue to align to the quality agenda and Southlake's strategic goals created through the engagement process mentioned above.

Our chair of the Corporate Patient and Family Advisory Committee is a member of the Board Committee on Quality and the committee has been continuously involved with the development of our QIP. Our Patient and Family Advisor member provide the patient perspective. For example, the community members' and Corporate PFAC's feedback and experience around the capacity challenges have driven us to pursue an aggressive performance target to improve wait time of the Alternate Level of Care (ALC) placement to home with services.

Our patient satisfaction surveys and Patient Experience Real Time Surveys provide valuable information to embed your voice in our improvements. Patient and Family Advisors sit on nine program level teams where goals, objectives and scorecards are developed. In addition to our

Corporate PFAC we have organization wide and program specific committees where patients work in collaboration with the health care team.

The Corporate PFAC serves as a forum for patients and families to partner with our staff, physician, and volunteers to provide input and influence on ways to improve the patient experience. The Corporate PFAC supports Southlake in honoring its core commitments, strategic goals and objectives "for creating an environment where the best experiences happen". The Corporate PFAC fosters a culture where our values of serving patients "*always with compassion*" and "*every voice matters*" are recognized in everything we do, and from the patient's perspective they are cared for. Our drive to achieve our Quality Improvement Plan goals for 2020/21 will be supported with collaboration between dedicated staff, physicians, volunteers and patients/family.

Workplace Violence Prevention

Southlake is committed to addressing safety concerns of staff, physicians and volunteers; reducing the risk of workplace violence; and creating a safe environment for all. We routinely monitor the number of incidents, security response time, and severity of incidents and our leadership team and our safety officer regularly engage staff in safety dialogue to hear their perspectives.

We have a robust incident investigation and analysis strategy. Processes are in place to manage the risk of violence while ensuring safety for patients and staff. Our staff and our Joint Health and Safety Committee (JHSC) are very engaged in careful and inclusive reporting, investigation and analysis of incidents.

Our annual core curriculum is completed by 100% of our staff every year and clinical core curriculum is completed by 100% of our clinical staff. Many staff, and all of our most at-risk staff, have completed Crisis Prevention Intervention (CPI) training. We have also engaged in simulation exercises with York Region EMS and York Regional Police followed by debriefing exercises.

Signage is displayed throughout the hospital describing zero tolerance for workplace violence. An annual environmental risk assessment is performed corporately and repeated when there is a change in use of a specific area. Access to the Emergency Department for all patients and visitors is through a security controlled entry.

Patients are assessed at registration for a history of or risk of violence using a violence assessment tool and a purple identification arm band is applied to those positively identified. All staff wears a safety pendant that will provide an immediate alert to security identifying the location and staff at risk. Our patient tracking board displays if there is a risk for violence. We know that by working together to keep everyone safe, we can "create an environment where the best experiences happen".

Alternate Level of Care

Southlake Regional Health Centre has made great strides this year in reducing the Alternative Level of Care (ALC) rate, for patients awaiting ALC to home. Underpinning this achievement are enhanced partnership efforts, more robust tracking, and optimizing patients' strengths. The Rehabilitation Continuing Care (RCC) and Southlake@home actively partner with patients and their families to optimize a person's functional capacity, for example, transferring home by stretcher and working together until the patient graduates from Southlake@home using a rollator walker. Increased adoption and application of quality practices related to ALC prevention and management includes implementing iPLAN, vigorous daily management of patient flow, and revitalized Joint Discharge Rounds (JDR). Most importantly, this achievement was attained through developing meaningful relationships with community partners. For example, behavioural rounds, a partnership between Southlake, LOFT, LHIN Homecare, and Southlake@home was implemented and expanded to all hospital sites. Partnerships with CHATs and other community providers brought much needed understanding of how community resources increase caregiver resiliency thus reducing or mitigating caregivers' burden. Moreover, the compounding effect of modifying the approach to patient care planning; enhancing our ALC management and prevention strategies; and meaningfully engaging partners have all contributed to this achievement. With this invigorated strategy to better transition patients to the right place of care; Southlake is able to reconsider its ALC activities by applying these same principles to all bed utilization. Southlake has expanded the ALC focus to all patients who are not in the ideal care location, whether that be ALC for Rehab services or care in a non-conventional space. These outcomes were achieved through the power of many.

Virtual care

Ontario is at the forefront of a massive health system transformation and digital health is a significant enabler. In alignment with our Strategic Plan and the strategic objectives of our Southlake Community Ontario Health Team (OHT), accelerating the implementation and adoption of digital and virtual care programs and technologies is core to addressing system changes as well as our local overcrowding and fragmentation issues. With wide spread availability of virtual care options, more preventative, ambulatory care and chronic disease management can be delivered in the community and at home. In addition to alleviating acute and ALC issues, virtual care programs also favourably impact how patients experience and interact with the health system in a way that is akin to other industries (e.g., banking, shopping) and jurisdictions.

Organizationally and in partnership with our SHINE hospitals, virtual care is one of the priorities in our Digital Health Strategy. This presents an opportunity to leverage and elevate existing programs and services as well as the opportunity to identify and implement additional integrated virtual visit programs and solutions to meet the needs of our patients and the community. These include, but are not limited to, the OTN telemedicine program (also known as PCVC or OTN Hub) and its expansion for outpatient clinics, the OTN telehomecare program, a clinically supported remote monitoring program for patients with COPD and CHF, and eConsults which supports primary care to specialist electronic consults.

As we examine opportunities to redesign care delivery in the context of our OHT and our priority patient populations, integrated virtual visit technologies and their accelerated use with existing and new clinical workflows will support alternate, integrated, collaborative channels for care delivery. To this end, Southlake has positioned itself to lead two distinct initiatives in FY2020/21: (1) a ministry funded proof-of-concept project to establish a single identity, authentication, and authorization (IAA) service and platform, which would provide patients with a single, trusted, digital front-door to access available (virtual care) services and information; and (2) OTN's innovative provider video program, which leverages a 3rd party video solution integrated with Meditech to provide patients with the option of receiving integrated virtual care (e.g., for post-surgery follow up, regular outpatient visits).

Taken together, Southlake is committed to advancing the virtual care agenda, in part, because of its tangible benefits to patients and it's per unit cost of care delivery, but also because of its strategic alignment to forging a new path to meet the changing needs of our growing communities. Specifically, virtual care in many ways involves establishing strategic partnerships to improve access, create capacity, and reinvent how care is planned and delivered. As such, we will build on our existing virtual programs and capacity while investing in the design, development, and testing of innovative virtual care programs and solutions, which will provide a rich basis that we can continue to build on over time. Ultimately, these initiatives will offer more choice to patients and their families on how care can be delivered.

Executive Compensation (Q&R)

Quality Improvement Plan Part C: The Link to Performance-based Compensation of Our Executives
The purpose of performance based compensation is to drive accountability for the quality improvement plans.

What is required for ECFAA compliance:

- Compensation must be linked to achievement of quality improvement targets for CEO, COS, CNE and Senior Management reporting directly to the CEO (or person with position equivalent to the CEO)
- Legislation and regulations do not include senior specific requirements regarding the percentage of salary that should be linked, the number of targets, weighting of targets however, the government has the opportunity to mandate a specific percentage at any time
- There should be a clear link between performance-based compensation and the QIP indicators and performance based compensation should be expressed as a percentage of annual salary (vs. dollar amount)
- Senior Management Team who do not report directly to the CEO may also be included in performance-based compensation, although not a requirement for ECFAA

Recommendation for the Executive Compensation Related to the 2020/21 QIP:
It is recommend that the strategy for 2019/20 Executive Performance-Based allocation be adopted for the 2020/21 fiscal year.

Manner in and extent to which compensation of our executives is tied to achievement of targets

For Senior Executives and Directors at Southlake:

1. There is total envelope of funds set aside by Finance for Senior Executives and Director Compensation. Total variable pay linked to performance based compensation aligning to requirements in ECFAA plus the Management Performance Plans will vary in percentage
2. Twenty percent of the total variable pay will be linked specifically to achievement of the QIP component of the overall Management Performance Plan
3. Eighty percent of the total variable pay will be linked to achievement of the additional operational objectives aligned to Southlake's strategic goals and identified in each individual's Management Performance Plan
4. The allocation linked to the QIP will be calculated utilizing the following terms:
    - All Corporate Priority QIP indicators will be linked to variable pay
    - Achievement will be based on the percentage complete based on the formula below:

Corporate Priority Indicators	Baseline FY 19/20 YTD (Q1-Q3)	Target (2020/21)
Two Client Identification Compliance	69%	95%
Medication Reconciliation on Discharge	55.5%	80%
Inpatient Falls Resulting in Harm	1.25	1.25
Did you receive enough information on discharge?	58% (Q3 data not complete)	58.3%
New Pressure injuries	2.3	1.4
Approach/Formula		
For selected QIP 2020/21 indicators, the score would be calculated based on outcome indicator performance and progress of project milestone completion (includes review of process measures)		

Improve Indicators	
Criteria	Score
If Current Performance: < Baseline + All Activities Not Completed	0
If Current Performance: < Baseline + All Activities Completed	2.5
IF Current Performance: ≥ Baseline < Target + All Activities Not Completed	2.5
IF Current Performance: ≥ Baseline < Target + All Activities Completed	5
If Current Performance: ≥Target + All Activities Not Completed	7.5
If Current Performance: ≥Target + All Activities Completed	10
Maintain Indicators	
If Current Performance: < Baseline + All Activities Not Completed	0
If Current Performance: < Baseline + All Activities Completed	2.5
If Current Performance: ≥ Baseline/Target + All Activities Not Completed	2.5
If Current Performance: ≥ Baseline/Target + All Activities Completed	5

Contact Information

Other

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair

Board Quality Committee Chair

Chief Executive Officer

2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

Southlake Regional Health Centre 596 Davis Drive, Newmarket , ON, L3Y2P9

Lower is Better
Higher is Better

AIM	Measure				Change				
Quality dimension	**Measure/Indicator**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Timely	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 2 days of patient's discharge from hospital	72%	72%	Target based on 2019/2020 YTD performance up to Q3 (Apr. - Dec. 2019) Current performance study period: Apr. 2019 - Dec. 2019	Develop a physician engagement strategy, to drive improvements at provider-level.	Develop a feedback mechanism to provide data at physician-level. Understand processes and develop improvement strategies for physicians that could have the greatest positive impact on the overall performance.	Feedback mechanism rolled out and data provided at physician-level.	Feedback mechanism in place.	The engagement strategy will not only ensure physicians are aware of their timeliness of discharge summaries, but help create a catalyst for change in driving improvements. Using provider-level data, it will allow for a targeted focus where greatest improvements can be seen.
	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.	**32.5**	**31**	Target based on 2019/2020 YTD performance up to Q3 (Apr. - Dec. 2019) Current performance study period: Oct. 2019 - Dec. 2019 (as provided by HQO)	Increase number of discharges on weekends	By using nurse practitioners and physician assistants in the medicine program, increase the number of patients discharged on weekends, resulting in more timely flow of patients in the ED requiring admission.	Increase weekend discharges from baseline.	20%	The largest portion of patients admitted from the ED go to the medicine program. By increasing the weekend discharges by 20% from baseline, it will mean patients will be moved to the unit sooner, spending less time in ED.
					Trial of new patient flow system	Before 10am each day, select up to 5 patients waiting in the ED to be admitted to the medicine program, and move them in advance of their bed being ready.	Number of days where 0 patients are moved to the medicine unit prior in anticipation of a ready bed on the unit, prior to 10am	0	The largest portion of patients admitted from the ED go to the medicine program. Traditionally, patient flow is based on a "pull" system in the medicine unit (patients are moved only when a bed is ready). The introduction of a "push" system (where patients meeting IPAC clearance are moved to unit in anticipation of bed being ready) will improve flow by minimizing empty bed time between patients, and decrease the time these patients spend in ED.
					Decrease length of stay through prevention of deconditioning	Prevent patient deconditioning by increasing the use of PT, OT, and PTAs outside traditional areas and hours.	Develop measure to track early mobilization strategies.	Mechanism to measure in place.	When patients are immobile, it can cause deconditioning which often results in increased length of stay. This ultimately impacts patient flow, and creates a backlog in the ED for patients needing to be admitted. By improving mobilization (trial in ED for all patients, and on weekends in medicine program), it can help decrease length of stay.
Efficient	Average ALC days for Southlake@home patients	1.4	1.4	Target based on 2019/2020 YTD performance up to Q3 (Apr. - Dec. 2019) Current performance study period: Apr. 2019 - Dec. 2019	Implement strategy to ensure rehab equipment in the home is fully utilized by patients.	In partnership with patients, families and rehab professionals (hospital and community based) co-design a most required list of rehab equipment for discharge.	For each patient discharged with rehab equipment, the number of pieces of equipment used by the patient /number of pieces of equipment ordered.	80%	In 2019/2020 it was identified by the community rehabilitation professionals that many pieces of rehab equipment recommended by the hospital rehab professionals were unused by the patients. In addition, the community rehab professionals identified that much of the equipment recommended was not required to meet the patient's goals. Further, in bundled care programs, efficiency and effectiveness of services and equipment is a responsibility shared by all partners. Thus it is in the best interest of the program to develop tools to ensure all pieces of rehab equipment provided by the program are fully utilized.
					Understand root causes of ALC days to home, and develop strategies to address common issues identified in 2020/2021.	Synthesis of root cause analyses will be provided to Champions Group and where appropriate Hospital Leadership tables to co-develop plans to address underlying issues.	Percentage of patients discharged through Southlake@home with ALC days > 0, that are investigated and assigned a primary root cause.	100%	Southlake@home is an integrated, bundled care program for patients with frailty, social and medical complexity. Thus addressing the root-causes of ALC days associated with these patients is multi-factorial. It is important to determine the root causes associated with ALC for the Southlake@home population and theming these causes. This work will inform both the future opportunities for the program and enhance the overall local knowledge of ALC prevention and management with the hospital. In addition, emerging new barriers should be more readily identified and addressed.

		Lower is Better Higher is Better							
AIM	**Measure**				**Change**				
Quality dimension	**Measure/Indicator**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Patient-centred	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?	56.6%	58.3%	Target based on benchmark data provided by NRC, using OHA average in Q3 (Oct. - Dec. 2019). Current performance study period: most recent 12 consecutive months (Aug. 2018 - Nov. 2018, Apr. 2019 - Nov. 2019)	Corporate roll out of PODS (Patient Oriented Discharge Summary). PODS is a paper-based communication mechanism to provide patients with a summary of the information they need post-discharge.	By the end of 2020/21, PODS will be rolled out on all inpatient units in the hospital.	Percentage of inpatient units where PODS is rolled out on.	100%	PODS was developed with input of Patient and Family Advisors (PFACs). After 6 months of use, an evaluation will take place to determine if changes are required in the tool.
Safe	**Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.**	**314**	**314**	**Target based on current performance study period.** **Current performance study period: Jan. 2019 - Dec. 2019**	Investigate special cause variation of workplace incidents.	Use the last 2 years of baseline data to understand normal variation of reported workplace violence, and determine an upper tolerance level. Any month where reported incidents are above the tolerance level, complete a full investigation to understand root cause(s).	Determine upper tolerance level for monthly workplace violence incident.	Tolerance level established	Collect monthly statistics on reported workplace violence, and share with JHSC and WPV Prevention Committee, showing comparison to tolerance level. Frequency and Severity rates reported quarterly as a cumulative number, to collect baseline data at this level of detail.
							Number of investigations completed, divided by the number of months where reported incidents were above tolerance level.	100%	JHSC and WPV Prevention Committee will be involved in investigations and the follow-up of corrective actions.
					Expand WPV Prevention training to other high risk groups based on a risk assessment.	Have all departments complete a risk assessment, to identify gap in education needs	Number of departments completing risk assessment by June 30 2020, divided by the number of departments.	100%	To understand and address gaps in education relating to workplace violence
						Optimize class enrollment in WPV training sessions	Number of people participating in the classes divided by the number of spots available.	90%	For those requiring additional education, ensure class enrollment is optimized
	Patient Identification	69%	95%	Previous year's target (theoretical best) not met. Improve current performance by ~ 25%. Current performance study period: Apr. 2019 - Dec. 2019	Continue with audit and feedback mechanism developed in 2019/20.	Complete random audits on compliance to Two Patient Identification Policy, and report data back at both corporate level and unit level.	Percentage of audited units provided with unit-specific data on a quarterly basis for posting on quality and patient safety huddle boards.	100% of audited units provided with quarterly data for posting on huddle board.	Patient Identification has been identified as one of the top 5 Patient Safety priorities for the organization. Through a marketing campaign and the enhancement of communication relating to audit performance, we have already seen improvements. By continuing with visual management at the unit level, we expect to continue to see performance by driving awareness.
					Identify and share learnings relating to incidents resulting from patient identification errors.	Standardize the mechanism to identify and share learnings relating to incidents resulting from patient identification errors.	Mechanism in place and followed.	Yes	By identifying and sharing learnings from incidents relating to errors in patient identification, it will help put into context the importance of the process, and communicate the negative impact that can result if not properly done.

		Lower is Better Higher is Better							
AIM	**Measure**				**Change**				
Quality dimension	**Measure/Indicator**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Safe	Pressure Injuries	2.3%	1.4%	Previous year's target not currently met. Continue target from 2019/2020 into 2020/2021. Current performance study period: Apr. 2019 - Dec. 2019	Improve system to monitor location of therapeutic surfaces (beds)	Use the Versus monitoring system to track therapeutic surfaces in the hospital. At all times, the location of these surfaces should be known. Develop mechanism to ensure assets do not lose visibility at 30-day.	Percentage of times that all beds can be located through versus system, when audited.	100%	Therapeutic surfaces (beds) help maintain skin integrity for those at risk for pressure injuries, through pressure relief. At times, there is a delay in acquiring the appropriate beds for those at risk, due to inaccurate asset tracking. If a bed has not moved for 30+ days, there is no longer visibility of the asset, which makes them more difficult to locate. This change idea will help improve monitoring of asset locations.
					Enhance data sharing of reported Pressure Injuries	Using data from our Incident Management software, provide unit level data, to increase awareness of trends, and drive commitments and improvements at the unit level.	Data used to inform unit commitments relating to decreasing pressure injuries	Yes	In addition to the Prevalence and Incidence study data which feeds the QIP indicator, unit level data from our incident management software will be used to increase awareness about emerging trends. Units can use this information to help inform their unit/program commitments, to be discussed at daily huddles.
					Complete a pressure injury process map and identify strategies for improvement.	Identify primary contributing factors leading to pressure injuries and strategies to mitigate.	Process map completed	Yes	A process map will help inform where gaps exist, and identify areas of further opportunities in prevention of pressure injuries
	Inpatient Falls resulting in Harm	1.33	1.25	Previous year's target not currently met. Continue target from 2019/2020 into 2020/2021. Current performance study period: Apr. 2019 - Dec. 2019	Continue feedback mechanism developed in 2019/20.	Report falls data at both corporate level and unit level on a quarterly basis.	Percentage of inpatient units provided with unit-specific data on a quarterly basis for posting on quality and patient safety huddle boards.	100% of inpatient units provided with quarterly data for posting on huddle board.	Falls reduction has been identified as one of the top 5 Patient Safety priorities for the organization. Data will be provided on a quarterly basis to units for posting on quality huddle boards. By continuing with visual management at the unit level, it will increase awareness and encourage conversations at daily huddles.
					Monitor compliance of falls risk identification.	Develop a mechanism to audit whether appropriate falls risk identifiers are in place for patients at highest risk for falls.	Mechanism in place and used to audit.	Yes	In addition to falls prevention strategies such as individualized care plans for patients at risk of falls, Southlake uses visual falls risk identifiers to increase staff awareness of these patients, which help keep them safe. Examples include a yellow sign above their bed, a yellow patient armband, non-slip socks (where appropriate), and falls risk being flagged on huddle board/MPV board.

Lower is Better
Higher is Better

AIM	Measure				Change				
Quality dimension	**Measure/Indicator**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Effective	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.	55.5%	80%	Previous year's target (theoretical best) not met. Improve current performance by ~ 25%. Current performance study period: Apr. 2019 - Dec. 2019	Continue to improve and refine processes and measures that were introduced in 2019/20.	Complete a deeper dive into areas where there is a suspected gap between what the data shows and what is believed to be occurring. In areas where improvements are required, use a physician champion to support process improvement.	Engage a physician champion to help develop improvement strategies for other physicians that could have the greatest positive impact on the overall performance.	Physician champion in place.	There are some areas where it is believed that Medication Reconciliation at Discharge is occurring 100% of the time, but the data is not reflecting that. In these areas, the data will help identify where improvements in the measure may be required. A physician champion will help support a targeted focus where greatest improvements can be seen.
	Patient Satisfaction	66.5%	62.6%	Target based on benchmark data provided by NRC, using OHA average in Q3 (Oct. - Dec. 2019). Current performance study period: most recent 12 consecutive months (Aug. 2018 - Nov. 2018, Apr. 2019 - Nov. 2019)	Corporate roll out of patient-ambassador volunteer program.	By the end of 2020/21, patient-ambassador volunteer program will be rolled out on all inpatient units in the hospital.	Percentage of inpatient units where patient-ambassador volunteer program is rolled out on.	100%	The goal of patient-ambassador volunteers is to enhance the experience of patients and their families/caregivers while in hospital. Patient-ambassadors provide information about parking, food services, ensure patients know how to access the patient handbook (which includes information on safety) and welcome video, as well as provide support in using the "smart tv". Limitations include patients on precautions and those where volunteer safety is at risk.