Theme I: Timely and Efficient Transitions

Measure **Dimension:** Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Access to and use of Coordinated Care Plans for Couchiching OHT Target One Population patients.	C	% / Patients	Local data collection / Monthly	CB	CB	Previous attempts to Collect Baseline performance were interrupted through the pandemic.	Couchiching FHT

Change Ideas

Change Idea #1 Validate anecdotal sense of improved information sharing and decision making as a result of Coordinated Care Plan access and use.

Methods	Process measures	Target for process measure	Comments
Conduct a short survey of Care Providers, collecting Likert-Scale responses of perceived improvement and free-text feedback and enhancement opportunities.	Survey response rate; Positive Response;	>40% survey response rate; 75% overall positive response, valuable free-text feedback	Efforts since the inception of this work suggest that improvement is being made, however performance has been difficult to measure consistently.

Change Idea #2 Validate anecdotal sense of improved patient experience as a result of Coordinated Care Plan access and use.

Methods	Process measures	Target for process measure	Comments
Conduct a short survey of eligible patients and/or family members, collecting Likert-Scale responses of perceived improvement (ie: improved access to care, etc) in their care experiences.	Survey response rate; Positive response	>40% survey response rate; 75% overall positive response	Efforts since the inception of this work suggest that improvment is being made, however performance has been difficult to measure consistently.

Change Idea #3 Integrate appropriate data into a relevant scorecard to better observe and report process and outcome measures associated with this work.

Methods	Process measures	Target for process measure	Comments
Develop and embed appropriate scorecard measures into a single scorecard to allow team members and stakeholders to identify cause and effect relationships within the overall process.	Integration of scorecard data into OHT dashboard reporting	December 31, 2022	This QIP Measure is directly relevant to the collaboration of the Couchiching OHT and these scorecard indicators will be valuable in reporting on one of the Couchiching OHT's early commitments.

Change Idea #4 Refine the definition of the Target One population.

Methods	Process measures	Target for process measure	Comments
Review and define the criteria of application for Target One population	Greater specificity in identifying the criteria of the Couching OHT's Target One population.	Definition refined by March 31, 2023	One of the principal challenges of establishing an outcome measure for this work has been the ambiguity of defining the Target One population for the measurement application of this important work. This definition will serve to develop an outcome measure and is not intended to limit the services provided to patients.

Measure

Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data.	C	Rate per 100 inpatient days / Patients	Hospital collected data / Most recent 12 months	20.00	21.00	Based on sustained 2021-2022 performance, anticipated HSAA target.	

Change Ideas

Change Idea #1 Increase the number or patients supported by the WayHome@Home program

Methods	Process measures	Target for process measure	Comments
Ongoing identification of patients eligible for referral to the WayHome@Home program	Referrals to WayHome@Home Program eligibility assessment; patients accepted into the program	Increase in % of eligible program participants.	

Change Idea #2 Refine ALC Indicator focus to acute patient population

Methods	Process measures	Target for process measure	Comments
Monitor and collect baseline data to inform focused improvements for consideration	Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment.	Monitoring only	This will prepare improvement teams for future QIP initiatives

Change Idea #3 Demonstrate effectiveness of AHF partnerships

Methods	Process measures	Target for process measure	Comments
Regular identification of patients to be assessed for eligibility through ongoing forums such as ALC Rounds, daily bed meetings	Occupancy of Alternate Health Facility beds with community partners	100% occupancy (actual or in-transfer) of AHF beds	

Change Idea #4 Demonstrate the effectiveness of the Geriatric Emergency Nurse

Methods	Process measures	Target for process measure	Comments
Support admission avoidance and/or decreased length of acute care stay	Number of patients assessed and supported; patient admission avoided	Reduced number of admissions from Long Term Care Homes; % of Total patient interactions with GEM Nurse.	

Measure **Dimension:** Efficient

Indicator #3	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.	C	Hours / Patients	Hospital collected data / Most recent 12 months	22.40	25.00	Based on sustained strong 2021-2022 performance	

Change Ideas

Change Idea #1 Mental Health beds in ED and on C6

Methods	Process measures	Target for process measure	Comments
Renovate existing hosptial space to provide additional care for Mental Health Patients in ED	Increase dedicated space and resources for Mental Health care in the emergency department	Completion of renovated rooms, staff provision for occupancy by August 30, 2022	

Change Idea #2 Review of staffing in ED

Methods	Process measures	Target for process measure	Comments
Ongoing review of scheduling, recruiting, retention, interviewing and attendance management practices. Hire above complement	Stability of staff schedule	Reduction of ED "short staff" days	

Change Idea #3 Re-institute Patients in Motion meetings

Methods	Process measures	Target for process measure	Comments
Collaborate on emerging barriers to patient flow from Emergency Room	Resumed meetings with revised Terms of Reference	Meetings resumed by March 2023	

Change Idea #4 Continue AHA focus on pre-midnight transfers from ED to floors

Methods	Process measures	Target for process measure	Comments
Ensure After-Hours-Administrators are familiar with patient flow practices, follow up on post-midnight transfer anomalies and trends. An empty bed is an admission.	Volume of transfers completed before midnight	>4 out of 5 nightly transfers completed before midnight	

Change Idea #5 Continue weekend bed meetings

Methods	Process measures	Target for process measure	Comments
Sustained commitment to coordinated patient flow practices 7 days a week	Regular bed meetings on weekends	1 Weekend Bed Meetings per weekend day	

Theme II: Service Excellence

Measure **Dimension:** Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded positively to the 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?	C	% / Survey respondents	Other / Most recent 12 months	81.30	75.00	The target was proposed as an internal target for this indicator during the collection of baseline data. Upcoming changes to the survey tool may affect performance; historical target used for reference.	

Change Ideas

Change Idea #1 Implement and monitor the effectiveness of the updated Patient Experience survey tool (defined by the OHA)

Methods	Process measures	Target for process measure	Comments
Update of Patient Experience Survey to new OHA selected patient survey vendor	Comparison of metrics to previous vendor survey; # of completed surveys, comments offered	Return/participation rate of approximately 35 surveys completed/month; actionable opportunities for improvement based on identified trends.	Initiation subject to OHA and new vendor timelines, reported possible delays

Change Idea #2 Capture patient email addresses for electronic survey tool

Methods	Process measures	Target for process measure	Comments
Trial of collection and utilization of patient email addresses as option for patient survey participation	Number of valid email addresses received, number of respondents to email mode of survey.	50% of surveys returned in email mode.	Initiation subject to OHA and new vendor timelines and implementation

Change Idea #3 Amend the length of the patient experience survey

Methods	Process measures	Target for process measure	Comments
Trial of shorter survey format	Number of online surveys declined or "abandoned".	Collecting Baseline	Initiation subject to OHA and new vendor timelines and implementation; this indicator will be subject to implementation of electronic collection methods and access to survey distribution.

Change Idea #4 Explore opportunity to capture site specific improvement opportunities from survey responses.

Methods	Process measures	Target for process measure	Comments
integrate more site specific questions into the survey to better inform program quality improvement and patient self and experience focus.	Comparison of metrics to previous vendor survey; # of completed surveys, comments offered	Return/participation rate of approximately 35 surveys completed/month; data that can measure QI initiatives more directly and begins to capture patient context and environmental scan	Initiation subject to OHA and new vendor timelines and implementation; opportunity to explore notion of gender based analysis, health equity, diversity and inclusion measures moving forward.

Change Idea #5 Review of PREMS (Patient Reported Experience Measures) and PROMS (Patient Reported Outcome Measures) in context of OSMH's provided services

Methods	Process measures	Target for process measure	Comments
Understanding the depth and improvement relevance of data reported by CIHI as PREMS and PROMS	Attending information sessions provided by CIHI to better understand the inputs to the PREMS and PROMS indicators	Relevant team members educated in interpreting PREMS and PROMS data as reported by CIHI	OSMH is an early adopter of CIHI's PREMS and PROMS data collection and will leverage this opportunity to improve patient experience.

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October 2021– December 2021	83.47	82.00	Sustained performance from 2021-2022 QIP Target	

Change Ideas

Change Idea #1 Continue to educate prescribers on Med Rec practices and expectations

Methods	Process measures	Target for process measure	Comments
Create a youtube video (similar fashion to current staffing orientation model) and embed video in package sent to new prescribers during orientation.	Ask them to take picture of certificate (from video) and email to Lynn (credentialed staff HR support) to collate	0-80% by March 31	

Change Idea #2 Continue to educate staff on Med Rec practices and expectations

Methods	Process measures	Target for process measure	Comments
Prepare and send out more education on Med Rec definitions (BPMH, PMH, transfer, discharge)	Monitor, socialize performance of MR of Admission to improve quality of MR on Discharge	82% on admission and discharge across organization	

Change Idea #3 Continue focus on OBS as this unit is still hybrid and does not solely use Cerner for medication activities

Methods	Process measures	Target for process measure	Comments
develop a Plan to complete BPMH upon prenatal visit	Determine how to measure in Cerner (TBD)	82% completion of BPMH (admission MR)	May require ongoing commitment to manual review.

Change Idea #4 Continue focus on Paeds as this unit is still hybrid and does not solely use Cerner for medication activities

Methods	Process measures	Target for process measure	Comments
partner with pharmacy and unit to develop a plan to complete BPMH upon admission	review Med rec on admission monthly report	82% completion of BPMH (admission MR)	

Measure

Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	P	Count / Worker	Local data collection / January - December 2021	344.00	344.00	Aligned with 2021-2022 performance	

Change Ideas

Change Idea #1 Implement upgrades to Code White System

Methods	Process measures	Target for process measure	Comments
Create/update necessary infrastructure to support the electronic Code White alert system	System tested and implemented throughout hospital	All tests complete	FTE=1200 Upgrades to the system have been in process for years, the pandemic has further delayed progress.

Change Idea #2 Develop and test mini Work Place Violence Assessment Checklist

Methods	Process measures	Target for process measure	Comments
A focus group will develop a tool designed to assess risk of workplace violence by reviewing common contributing factors that can be mitigated to decrease risk. (ie: lighting, working alarms, phone access, patient disposition, etc)	Piloted use of completed checklist and corrective actions logged in response to identified risks.	1 pilot complete with learnings for scale and spread	

Change Idea #3 Refine reporting of Workplace Violence Incidents in the Incident Reporting System

Methods	Process measures	Target for process measure	Comments
Review incident reports from previous year to understand where gaps exist in reporting and classifying incidents as Work Place Violence related.	List of recommendations from the review of previous WPV reports.	Recommendations presented to WPV Committee by end of Q3 2022/2023.	Leveraging the increased reporting from the past years, we will explore areas to refine reporting

Measure

Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The number of lost time incidents due to workplace violence injury	C	Count / Worker	Hospital collected data / Quarterly	5.00	6.00	Based on 2021-2022 QIP Performance	

Change Ideas

Change Idea #1 As per "Number of workplace violence incidents reported by hospital workers" indicator.

Methods	Process measures	Target for process measure	Comments
As per "Number of workplace violence incidents reported by hospital workers" indicator.	As per "Number of workplace violence incidents reported by hospital workers" indicator.	As per "Number of workplace violence incidents reported by hospital workers" indicator.	Countermeasures used to increase the number of reported workplace violence incidents will form the basis of work for this indicator.