Let's Make Healthy Change Happen.

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

UHN
Toronto General
Toronto Western
Princess Margaret
Toronto Rehab
Michener Institute

4/1/2019

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

University Health Network's (UHN) 2019/20 Quality Improvement Plan (QIP) reflects our quality commitments to patients, community and ourselves as we embark on our vision for A Healthier World.

Our primary value is that the needs of patients come first. To uphold this value, we continue working closely with patients and their caregivers as we join provincial efforts to focus on improved patient experience and better connected care. In addition to learning from patient engagement surveys, UHN works together with its Patient Partner group – a group of more than 150 patients and caregivers – to shape interventions. In November 2018, we reached our goal of having a Patient Partner on every safety and quality committee at UHN. These platforms help us work on challenges together, through open and transparent dialogue, a laser focus on person-centred care, unwavering support from the organization and an openness to new ideas.

This QIP was developed in collaboration with our Patient Partners to align with the provincial priorities and UHN's seven Essentials. As key component of UHN's 2019-23 Strategic Plan, UHN's Essentials represent our central responsibilities as Canada's largest academic health sciences centre. They are: Compassionate Care and Caring, Operational Excellence, Partnerships, People and Culture, Quality & Safety, Technology and Environments. When people come to UHN, they can and should expect the highest quality in our seven Essentials – and it's our privilege to deliver on them.

The key areas of focus for our QIP are as follows:

- Patient Experience: Did you receive enough information from the hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?
- Number of workplace violence incidents
- Serious safety event rate
- Pressure injury rate
- Surgical site infection rate
- Same day surgical cancellation rate
- Emergency department wait time for inpatient bed
- Alternate Level of Care (ALC) rate
- Readmission rate to UHN within 30 days

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

The Psychiatric Emergency Services Unit (PESU) at Toronto Western Hospital (TW) provides care to people experiencing mental health crisis. For many patients, the healthcare journey occurs in chapters, different parts happening at different places. The following success story demonstrates how PESU addresses the importance of reassurance about next steps, particularly for those being treated for mental health.

Prior to 2018, PESU's discharge practice involved giving patients three different documents – a discharge care plan completed by the physician, an empowerment card, and contact information for UHN Patient Relations. That was challenging for patients and staff to keep track of. In 2018, PESU actively sought a "one-stop shop" of information that patients could easily reference, and the unit could easily document. Through quick teamwork, PESU adopted Patient Oriented Discharge Summary (PODS) a tool that was developed by UHN OpenLab – a design and innovation group dedicated to finding creative healthcare solutions. PODS was designed for patients with limited health literacy, language barriers or who are hard to reach after they leave the hospital due to

homelessness or other social issues. PODS uses plain language, large fonts and pictures to create a discharge summary patients can easily understand. When The PESU team adopted the tool, they included a section for patients to summarize why they were admitted to the unit. "Using a patient's own words gives us a lot of insight into their experience and mental state in PESU," explains Mohammed Oruvampurath, Manager, PESU. "It helps us base the prescribed next steps on the patient's understanding and assumptions rather than the clinician's. The tool has really helped patients better understand where they are in their journey." The PODS includes details on any prescribed medications and when to take them, follow-up appointments and a list of crisis resources. Any belongings are returned and the patient signs the last section to confirm receipt. The patient gets a copy, with a duplicate kept in the hospital chart. PODS integrated easily into PESU's work flow, accompanied by daily audits to ensure they became a standard part of the team's discharge practice. They have also become a quality metric for the team's daily Safety Huddle, creating an opportunity for discussion and real-time feedback. Only 14% of PESU patients were discharged with PODS in October 2018, but it quickly became regular practice, rising to 92% in December. PESU is the first emergency psychiatric program in Ontario to implement PODS successfully.

Patient/client/resident partnering and relations

UHN's Patient Experience team works with UHN patients and caregivers (Patient Partners), in order to contribute to important hospital planning and decision-making activities. From April 2018 to December 2018, UHN has held 107 Patient Partner engagement activities across the organization, consulting with them through in-person meetings and surveys; learning from their experience and knowledge in presentations; and collaborating with them in working groups, hiring panels, committees and Quality & Safety Councils and Board committees. Over the past year, we worked closely with our Patient Partners to ensure that UHN's Strategic Priorities reflect the needs of those we serve and the people who support them – 150+ patients and families helped us create UHN's 2019-23 Strategic Plan.

During the development of UHN's 2019/20 QIP, our Patient Partners collaborated with UHN's subject matter experts to discuss key local and system wide gaps specifically underlying timely and efficient transitions and safe and effective care. Through surveys and a half-day working session, our Patient Partners provided their perspectives and ideas on how to address current gaps. Patient Partners were prepared in advance of what a Quality Improvement Plan entails and the indicators that were identified. The gaps and problems were then discussed for each; followed by a brainstorming activity to gather the various types of change ideas they have to help address the gap. Time was given to then hear the experiences that were associated with each change idea so that subject matter experts understood the context and lived experiences regarding those gaps. A key take-away from this exercise was patients' reflection on how each indicator was related to other indicators and should not be addressed in silos. A detailed summary report of the discussion was provided to UHN's subject matter experts in order to integrate Patient Partners' ideas into UHN's 2019/20 QIP. Key themes highlighted from this session are highlighted below.

- Providing a holistic approach to care: "Treat me and see me as a whole person, not only my disease"
- Transparent and timely communication regarding care
- Clear explanation of what to expect throughout the care journey
- Coordination of care through hospital and follow-up once discharged to the community
- Communication of care plan and discharge in a way that patients can understand
- Information to include connections, resources, peer support and professional follow-up post-discharge
- Care provided in a dignified manner, no matter what

Workplace Violence Prevention

Workplace violence is not only a priority for UHN, but is also a key component of our safety transformation. UHN recognizes that most acts of violence are preventable within the workplace. Creating a culture that supports this philosophy will inevitably reduce and eliminate harm experienced by violent acts. Naturally, understanding why these events occur is key to preventing future events. Encouraging reporting and situational awareness are two factors that are critical in the development of effective preventative measures. The goal is to move from being reactive to building systems that support early detection and correction. UHN tracks and reviews workplace violence with the leadership team on a quarterly basis and in turn the Board of Trustees – in 2019/20, UHN will expand this discussion to include all workplace incidents; not only those resulting from violence. UHN's Workplace Violence Prevention Plan aims to reduce the rate of harm experienced by workers at UHN. Our series of targeted prevention strategies include but are not limited to the following:

- Analysis of data to determine where and how violence is experienced and the effectiveness of preventative measures;
- Application of a risk methodology that quantifies level of risk related to violence based on probability and severity of harm;
- Implementation of a multi-tiered approach to education which includes situational learning to mitigate risks related to violence, aggression and responsive behaviours; and,
- Development and implementation of behavioural management strategies that include how to recognize, communicate and manage those individuals who demonstrate behaviours that are likely to result in harm to others.

Workplace violence is a key component of UHN's Organizational Scorecard – this measure is actively monitored and reviewed with the leadership team on a quarterly basis and in turn reported to the Board of Trustees. These discussions enable us to stay aligned across the organization in our focus to address workplace violence.

Executive Compensation

The following indicators were selected to be linked to executive compensation as they reflect UHN's Essentials.

- Total Workplace Violence Incidents (HQO – mandatory indicator)
- Pressure Injury Rate
- Same-day Surgical Cancellation
- Serious Safety Event Rate
- Surgical Site Infection Rate

The following portions of variable compensation will be linked:

• President and Chief Executive Officer	25%
• EVP Clinical Support and Performance	20%
• EVP Human Resources and Organizational Development	20%
• EVP Education and Chief Medical Officer	20%
• EVP Technology & Innovation	20%
• EVP Science & Research	20%
• VP Patient Experience & Chief Health Professions	20%
• Site Vice Presidents	20%
• Chiefs	20%

The three targets will be equally weighted. The following incentives will be available for each target:

- Target achieved 100%
- Improvement over previous year (target not achieved) 80%
- Same as previous year (minimum threshold achieved) 50%

Contact Information

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Sign-off

The following individuals have approved UHN's Quality Improvement Plan:

Mr. Brian Porter, Chair, Board of Trustees
Dr. G. Ross Baker, Chair, Safety and Quality Committee of the Board
Dr. Kevin Smith, Chief Executive Officer

University Health Network - 2019/20 Quality Improvement (QIP) Workplan

Indicator type as defined by Health Quality Ontario: M = Mandatory (all Ontario hospitals are required to report on this) P = Priority (Health Quality Ontario priority) C = custom (aligns with UHN's 2019-23 Strategy; Essentials)

Quality dimension provided by Health Quality Ontario	Measure/Indicator	Measure/Indicator Definition	Type	Unit / Population	Source / Period	Current performance	Target	Target justification	External Collaborations	Planned improvement initiatives	Methods	Process measures	Target for process measures	Comments
Patient Experience	Patient Experience: Did you receive enough information from the hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (Question 38).	Percentage of respondents who responded positively to question 38 in the Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey - (CPES).	P	% / Survey Respondents	CIHI CPES / Most recent consecutive 12 - month period.	64%	70%	The average score since 2016 is 60%. We are making efforts to further align areas across the organization to increase our target to 70% this year.	NRC Picker Canada (NRCC) survey distribution.	1) myUHN Patient Portal Expansion.	Continue to onboard patients and caregivers to myUHN Patient Portal to increase patient access to personal health information post-discharge.	# of patients who register for the myUHN Patient Portal.	100,000 patients and/or families registered for the myUHN Patient Portal by March 31, 2020.	
										2) Teach Back and Plain Language Capacity Building.	Teach back training will be offered as a support for patient teaching and discharge activities at UHN. Health literate principles and quality standards will be applied to all UHN Patient Education and Engagement resources.	Ensure quality standards are applied to all UHN Patient Education brochures by ensuring they adhere to the quality audit process and engage patients in the development of new patient education materials. Deliver Teach Back training for clinicians that includes patient perspectives and input.	100% of UHN Patient Education brochures updated every 3 years, according to quality standards. 100% of UHN patient education resources will be developed with patient engagement during the development process; provide Teach Back training with a Patient Partner as co-educator in 10 units at UHN.	

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Safe	Number of workplace violence (WPV) incidents - **mandatory**	Number of workplace violence reported incidents/Workplace violence incidents as defined by the Occupational Health and Safety Act.	M	Count / Full Time Employee total	Parklane / Jan. - Dec. 2018	428	407	Target a 5% reduction in total WPV while ensuring robust levels of WPV incident reporting.	Public Services Health & Safety Association (PSHSA) and Ontario Hospital Association (OHA)	1) Introduce refresher training for Safety Management Group (SMG) and Crisis Intervention Training (CIT) for workers in high and moderate risk areas.	Occupational Health and Safety (OH&S) department will maintain scheduling and track training compliance (total and at unit level) for CIT training.	Training compliance will be tracked monthly.	90% training compliance by Dec. 31, 2019.	Currently benchmarking data for total WPV with Full Time Equivalent data does not exist for Ontario hospitals. Target of 407 is based on internal trending from 2017-2018.
										2) Conduct training needs assesment, develop and roll-out WPV training for workers in lowrisk areas.	Training needs assessment will be conducted based on WPV incident reports and WPV frequency at unit level. Number of persons trained to be tracked.	Training compliance will be tracked monthly.	85% training compliance by Dec. 31, 2019.	
										3) Ensure WPV Risk Assessments (RA) maintained / updated for high and moderate risk areas and complete WPV RA for low risk clinical areas.	WPV RA tool is developed in accordence with Public Services Health & Safety Associations WPV RA tool. Conduct high, moderate and low WPV RA with OH&S and unit Managers with results maintained centrally by OH&S.	WPV RA scheduled; completion / compliance assessed monthly.	100% of high risk and moderate risk WPV RA completed and 80% of low risk areas by Dec. 31, 2019.	
										3) Conduct apparent cause analysis (ACA) and root cause analysis (RCA) for select WPV incidents based on severity.	Reported incidents reviewed by OH&S and identified for severity based on Workplace Safety & Insurance Board (WSIB) defined Lost Time / Health Care. ACA/RCA conducted as per inclusion criteria with unit managers and other stakeholders.	Number of ACA/RCA tracked monthly.	Complete 100% of ACA/RCA for reported incidents meeting inclusion criteria.	

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	Serious Safety Event Rate (SSER)	Rolling 12-month average of serious safety events per 10,000 adjusted patient days. A Serious Safety Event (SSE) is harm that ranges from critical to severed patient harm or death (SSE1-4). SSE's at UHN are classified using a Safety Event Classification system that measures preventable harm.	C	Serious Safety Event Rate / All patients at Toronto Western Hospital, Princess Margaret Hospital and Toronto Rehab sites.	Events that have been reported in the UHN Incident E-Reporting system / Q1-Q3 2019/20	0.38	0.31	Other multi-site high-reliability organizations have set their target at 20%, which we believe to be achievable over the next fiscal year.	Not Applicable - the SSER is an internal indicator that UHN uses to measure preventable harm.	1) Improve the analysis of serious safety events (SSE's).	Continue implementing the RCA program, which includes completing RCAs on all SSE1-3 to identify system and corporate level recommendations.	% of SSE1-3 that undergo an RCA.	100%	Dependencies include ongoing Error Prevention Tool education for new staff and roll out of Hospital Acquired Condition Prevention Bundles.
											Standardize the debriefing process for events across all sites by sharing the Debrief tool kit and posting it on the Caring Safely website.	% of Clinical Managers who were provided the debrief tool kit.	100%	
											Collect data from multiple reviews through the Common Cause Analysis (CCA) process to understand trends across events that, once addressed, can reduce error rates.	Completion of Common Cause Analysis (CCA)	Completed	
										2) Share learnings from event reviews to reduce reoccurrence.	Establish a process for communicating lessons learned from RCA's and debriefs across the organization	% of RCA learnings shared across the organization.	100% of RCA learnings shared across the organization	
										3) Develop a reference tool of UHN SSEs to support standardized classification decision making; develop a classification algorithm to guide classification when there is a lack of consensus re: SSE classification.	SSE team meets weekly to review and discuss classification of events. Classification reference tool is updated as appropriate.	Adherence to the classification algorithm when there is a lack of consensus around SSE classification.	100% adherence to the classification algorithm when there is a lack of consensus around SSE classification	
											SSE team utilizes classification algorithm.	N/A		

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	Pressure injury (PI) rate	Number of pressure injuries (all stages) per 1,000 length of stay days .	C	Acute inpatient units / All inpatients	Discharge Abstract Database (DAD) / April 2018 - Dec. 2018	0.18	0.17	We have seen a PI rate increase (of 10%) in FY18/19 due to more consistent pressure injury documentation in the electronic patient record. This has been an unanticipated improvement in electronic documentation with the implementation of the PI prevention bundle. This has likely resulted in a more accurate reflection of the true PI incidence at UHN. We expect the PI rate may increase further as we improve our electronic documentation system and continue to implement the PI prevention bundle. We hope to counterbalance this increasing PI rate with concurrent PI reduction and management efforts in high PI density rate inpatient units. This will include further analysis to understand PI preventability and targeted interventions for different patient populations.	N/A	1) Further analysis of top 10 acute units with the highest identified PI incident density rate to understand trends and identify root causes.	Conduct detailed retrospective data analysis of electronic patient record data, detailed chart reviews, and real time observations.	Completion of detailed analysis, chart reviews, and observations for 10 identified units.	100% completion by Nov. 30, 2019.	
										2) Implement unit/population-specific interventions and evaluate effectiveness.	Update resources and job aids; implement unit/population-specific interventions in the following populations: palliative, critical care, general internal medicine, oncology, cardiac.	Unit/population-specific interventions identified and testing initiated with top 10 units.	Unit/Population-specific interventions identified and testing initiated by March 31, 2020.	

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	Surgical site infection (SSI) rate	Risk-adjusted rate of SSIs of patients who had undergone surgery.	C	% of patients (predicted observed rate) who developed a SSI, within the NSQIP category of "All cases". / "All cases" comprises the following surgical divisions: General Surgery, Gyne-Oncology, Otolaryngology, Plastics, Urology, Neurosurgery, & Orthopedics	ACS NSQIP (National Surgical Quality Improvement Program of the American College of Surgeons) and ON - NSQIP (Ontario collaborative). Current performance was obtained from the ACS NSQIP Interim Semiannual Report (April 2017 - March 2018.) / Q1 - Q3	8.49%	6.79%	UHN's target is a 20% reduction in the rate of SSI for each site: TGH: 8.49% to 6.79% TWH: 3.47% to 2.78% PMH: 2.12% to 1.70%	N/A	1) Appropriate hair removal: Develop UHN Hair Clipping Guidelines to support hair removal outside of the Operating Room (OR).	• Identify surgeon champions within each division • Share literature and best practices with surgical divisions and perioperative teams • Develop hair clipping guidelines • Implement hair clipping guidelines in the immediate preoperative setting (POCU) at TGH and TWH • Evaluate uptake and effectiveness of hair clipping guidelines	1. At least 1 surgeon champion identified within each surgical division 2. Literature review / best practices shared with 100% of surgical and perioperative staff 3. Hair Clipping Guidelines completed and implemented at TGH and TWH 4. Audit hair clipping practice to ensure hair removal occurs preoperatively whenever possible	≥90% of hair removal activities to occur in the immediate preoperative setting by Apr. 2020.	Dependencies include: surgeon champions, OR leadership team support, and OR attendant availability to support hair clipping.
										2) Surgical Wound Management: Guidelines for the management of surgical wounds intra-operatively and post-operatively developed.	• Identify surgeon champions within each division • Informed by *Best Practice in Surgery* Guidelines, develop UHN surgical wound management guidelines • Develop implementation plan across intraoperative and post-operative care areas	1. At least 1 surgeon champion identified within each surgical division 2. UHN surgical wound management guidelines developed 3. Implementation plan for guidelines developed and timelines established	By Mar. 31, 2020, UHN surgical wound management guidelines will be completed and a detailed implementation plan will be established.	Dependencies include: surgeon champions, Surgical Wound Management CUSP team participation, senior professional practice leads across all sites to support roll out.
										3) Perioperative Skin Antisepsis: Audit current practice related to skin prep and draping. Identify opportunities for improvement.	• Informed by best practices, develop skin prep and draping audit tool • Audit practices related to skin prep and draping across sites • Identify opportunities for improvement • Share learnings and best practices with surgical divisions and perioperative teams	1. Audit of current practice completed and opportunities for improvement identified 2. Disseminate learnings to 100% of surgeon champions and perioperative teams	By Mar. 31, 2020, a site-wide audit of practices is completed across all surgical divisions. Audit findings and opportunities for improvement will be disseminated broadly.	Dependencies include: surgeon champions, OR leadership team to facilitate site-wide auditing

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										4) Skin Closure Protocols: Evaluate and improve usage of skin closing trays for applicable surgical cases.	• Identify surgeon champions within each applicable division • Finalize closing tray usage report • Share report at divisional quality meetings and explore barriers and facilitators to using a closing tray	1. At least 1 surgeon champion identified within each applicable surgical division 2. Closing tray report finalized and approved by surgeon champions and stakeholders 3. Identify barriers and facilitators to using a closing tray though focus groups and interviews 4. Develop a report on findings and share broadly with surgeon champions and perioperative teams	By Mar. 31, 2020, applicable surgical divisions receive regular closing tray reports to monitor ongoing adherence to usage. A report will also be developed that highlights usage, barriers and facilitators. We aim to achieve ≥90% compliance from staff following surgical closure protocols.	Dependencies include: surgeon champions, OR leadership team support.
										5) Perioperative Normothermia: Ensure surgical patients body temperature remains within normal range across the course of surgery	• Disseminate normothermia audit findings to stakeholders • Identify barriers and facilitators to timely forced-air warming application intraoperatively • Implement OR Temperature and Humidity Policy across all sites • Conduct random audits of OR temperature and humidity across all sites through the Building Automated System (BAS) and/or through observational auditing	1. At least 1 surgeon champion identified within each applicable surgical division 2. Audit findings disseminated to stakeholder groups 3. At least 2-3 change ideas identified to improve timeliness of forced-air warming application intraoperatively 3. OR Temperature and Humidity Policy implemented across all sites and disseminated to stakeholders	• 2-3 change ideas identified to improve timely forced-air warming application intraoperatively • By Jun. 1, 2019, OR Temperature and Humidity Policy implemented and disseminated to 100% of stakeholders • By Mar. 31, 2020, audits on OR temperature and humidity completed. Goal of ≥90% adherence to policy standards.	Dependencies include: surgeon champions, OR leadership team support, support from Facilities to produce report on OR temperature and humidity through the BAS system.

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										6) Bathing Before Surgery: Expand bathing before surgery guidelines to inpatient units	• Share bathing before surgery guidelines with inpatient units • Support inpatient surgical units in rolling out related education on guidelines, in identifying strategies, and in achieving adherence to guidelines • Audit adherence to bathing before surgery for inpatients and outpatients	1. 100% of surgical inpatient units across all sites receive bathing before surgery guidelines 2. 100% of surgical inpatient units implement guidelines 3. Random audit completed to assess adherence to bathing before surgery guidelines for inpatients and outpatients 4. Audit findings disseminated to applicable stakeholders	• By Mar. 31, 2020, 100% of surgical inpatient units will receive guidelines and implement recommendations • By Mar. 31, 2020, an audit of adherence to guidelines is complete. Goal of ≥90% adherence to bathing before surgery guidelines for both inpatient and outpatient groups. Audit findings disseminated to 100% of applicable stakeholders	Dependencies include: capacity of inpatient units to rollout education related to bathing before surgery guidelines / support from surgical unit nurse educators, capacity of inpatient unit nurses to implement guidelines for inpatients going to surgery, OR leadership team to facilitate auditing.
										7) Antimicrobial prophylaxis use: Align with *Best Practice in Surgery (BPIS)* Guidelines for surgical antibiotic prophylaxis	• Disseminate antibiotic audit findings with stakeholders • Update UHN prophylactic antimicrobial selection and dosing guidelines and supporting tools	1. At least 1 surgeon champion identified within each surgical division 2. Previous audit findings disseminated to stakeholder groups 3. 100% of UHN guidelines and supporting documents updated to reflect current BPIS guidelines 4. By Q3/Q4, repeat audit of antimicrobial prophylaxis completed to reassess adherence to BPIS guidelines	• By Mar. 31, 2020, 100% of UHN guidelines and supporting documents have been updated to reflect current BPIS guidelines • By Mar. 31, 2020, a repeat audit of antimicrobial prophylaxis demonstrates ≥90% adherence to BPIS guidelines for antibiotic choice, dosing, timing, and redosing	Dependencies include: surgeon champions, OR leadership team support for auditing, Antimicrobial Stewardship Program support with reviewing audit findings, support from webpage owners to update various documents/webpages on UHN intranet.

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										8) Perioperative Glucose Control: Develop intraoperative decision support tool for Anesthesia to manage and treat abnormal blood glucose values	• Relocate glucometers to OR area to facilitate increased point of care measurement at TGH and TWH sites • Develop intraoperative decision support tool (IDST) and validate with stakeholders • Test IDST with target population (TGH - Cardiac and vascular surgery) • Begin work to expand the IDST across all divisions and all sites	1. Additional glucometers available within OR areas 2. IDST developed and validated with stakeholders 3. IDST piloted with target population. 4. If successful, start expansion of IDST across all divisions, all sites	Adequate number of glucometers available to support increased intraoperative measurement (site-specific) by Q3; Pilot tool within target population completed. Goal to reduce percentage of blood glucose measurements above 10mmol/l from 20% to 10% in cardiac/vascular surgical patients by Mar. 31, 2020. Balancing measures to be captured include: glucose <4, nursing workload, physician workload and satisfaction, infusion pump shortages; Report developed to synthesize learnings from pilot and recommendations developed to support rollout of tool across all divisions, all sites	Dependencies include: support from Anesthesia project lead, Point of Care Testing team to support relocation of glucometers within OR area, support from Glucose CUSP team, programming support to establish platform for intraoperative decision support tool, adequate number of infusion pumps available to support intravenous insulin administration, Decision Support to assist with data collection activities.

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Timely	Same day surgical cancellation rate	The number of same day cancellation and number of scheduled cases each month (excluding “organ unacceptable” and “organ unavailable” for transplant patients).	C	The same day cancellation rate is calculated by dividing the number of same day cancellations (minus "organ unacceptable" or "organ unavailable") by the total number of scheduled cases.	ORSOS / Q1-Q3 2019/20	5.57%	5.00%	SETP Provincial Access to Care target	N/A	1) Focus on reducing cancellation for no beds and case overload	UHN'S Surgical Program has engaged with the Institute for Healthcare Optimization (IHO) to look at process redesign both in the OR and for surgical beds during 2019/20.	% reduction in cancellations due to no 1) inpatient bed and 2) case overload	50% reduction in cancellations due to no 1) inpatient bed and 2) case overload	Both TG and TW OR have increased the number of emergency OR rooms as of Q4 2018/19. We expect to see the same day cancelllation rates drop at both sites as a result and to achieve the provincial target in 2019/20.
	Emergency department wait time for inpatient bed - **mandatory**	90th percentile Time from inpatient admission to inpatient bed	M	Hours / All patients	CIHI NARCS / Oct. 2018 - Dec. 2018	21.35	19.40	Current blended target between TG / TW. TG is ranked 22nd, TW 38th amongst provincial hospitals.	N/A	1) Implementation of managing for daily improvement.	Daily review of patients who exceed our internal target of 16.5 hours, to identify root causes and implement changes to address. Flow team huddles and structured problem solving.	Opportunities for Improvement (OFIs) identified and actioned by staff related to transfer delays.	7 OFIs identified and implemented per month.	Both sites are challenged with availability of isolation rooms, these patients waiting 55% longer at the 90th percentile, twice as long at the median, over non-isolated patients.
										2) IHO work will reduce elective surgical variability and overflow in beds by elective procedures.	Surgical variation is tracked daily, and will integrate based on IHO methods, which are not known at this time.	N/A	50% of all patients know an anticipated date of discharge within 48 hours of admission.	Structural challenge at TW with limited available telemetry beds. Increasing inpatient telemetry (capital investment) would reduce long stay patients in the ED.
										3) Continued focus with Overcapaity protocol and tighter integration among all Network resources.	Implementation of High Reliability Discharge standards, led by Flow in partnership with Operations at each site. Partnership with Division Heads to lead change with physicians. Determine baseline for anticipated day of discharge on unit Whiteboard and Patient Grease Board. Each program to develop a plan to improve to 50% and implement by Fiscal year end.	50% of patients have an anticipated discharge date on the unit Whiteboard and in the Patients room. Current collection is manual, working on a simplified way to capture. Program baselines to be established (current survey <40%). 10% improvement per quarter, all programs starting in Q2.	In place and data verified Jan. 2020.	These efforts will tie to the Patient centred indicator as teams wil become more proactive with discharge planning.
										4) Making our discharge process more proactive and patient centric.	Developing a dashboard for flow to integrate all unit whiteboards to provide a holistic view of discharge planning, specifically the number of patients with an anticipated discharge date.	Automatic collection of discharge dates from electronic systems in place.	Monthly review and reporting of outcome measure	

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Efficient	Alternate level of care (ALC) rate	Inpatients days that beds were occupied by patients who could have been receiving care elsewhere.	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHTLC / Jul. - Sep. 2018	8.23	8.00	Provincial rate is 16.0%, Toronto Central LHIN is 12.5%.	N/A	1) Develop and implement escalation protocols with timelines, focusing on proactive identification of patients at risk for ALC, reduction of social admits, and tighter timelines for resolution of ALC cases. Initiating a community table to help address some situations	1) Implement mechanism to identify and track social admits at the sites.	N/A	Tracking in place by end of Q1.	We are currently reviewing change ideas from William Osler, who have had great success with ALC management.
											2) Define and implement a process for proactive identification of high risk ALC patients before they are ALC.	Monitor the number of patients who become ALC, who do not have an active discharge plan initiated. (Not related to Rehab patients.)	Tracking in place by end of Q1. Goal <10% of total ALC by Q2.	
											3) Develop and implement standard escalation protocols outlining actions, timelines and roles and responsibilities for potential complex ALC patients. Protocols balance potential organizational risk with patient access.	Legal review of proposed escalation process to understand organizational risk and any potential risk for physicians in Q1. Standards developed and approved by senior leadership by end of Q2. Initial focused introduction GIM Q3 TW all programs by Q4. Remaining sites to follow.	50% of new ALC patients meet escalation guidelines (including timelines) by end of Q4.	
											4) Automatic transfer of patients within the UHN network to the Right Place (rehab and CCC beds)	Tracking mechanism to be determined.		

Quality dimension provided by Health Quality Ontario	Measure/Indicator	Measure/Indicator Definition	Type	Unit / Population	Source / Period	Current performance	Target	Target justification	External Collaborations	Planned improvement initiatives	Methods	Process measures	Target for process measures	Comments
Effective	Readmission rate to UHN (8 HIGs including CHF, COPD, CAP, liver disease GI)	The Hospital Service Accountability Agreement (HSAA) is the 30 day readmission rate for patient cohorts for 8 Health Based Allocation Model Group (HBAM) Inpatient Group (HIGs) including Chronic Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Community-acquired pneumonia (CAP) and Gastrointestinal (GI) patients with Liver Disease, who come back to UHN after being discharged.	C	HSAA 30-day reamission rate	TC LHIN IntelliHealth and UHN Decision Support / Q1 - Q3	15.60%	13.70%	Targets were established by TC LHIN	N/A	1) UHN has begun implementing standardized Care Pathways for COPD and CHF. These Care pathways include Patient Order Discharge Summaries (PODS) with medication reconcilation and teach-back training. These are being implemented for CAP over the next few months. Audits and performance metrics exist to assess how well adoption of these Care Pathways are occuring. Discharge Summaries have been fine tuned and performance metrics have been established to aim for distribution to Family GP within 48 hours as well as UHN helping to set up follow-up appointments with these patients within 7 days.	Performance metrics are pulled both manually and through automation with Decision Support to assess the readmission rates for each disease type (CHF, COPD, CAP and Liver Disease GI). Patient chart reviews and audits are also performed by our transitional care specialists under supervision by our Senior Clinical Director for GIM/ED to assess how well the clinicians have completed their Care Pathways, how many have used both Order Sets and PODS. Follow up appointments within 7 days, discharge summaries sent to Family GP within 48 hours are also tracked.	30 day reamission rates for each disease (CHF, COPD, CAP, Liver Disease GI) both for MLAA and HSAA. Percent Completion tracked for; Care Pathway completion, Order Set usage, PODS usage, discharge summaries sent to GP within 48 hrs, follow-up appointments scheduled within 7days, usage of community services such as Hospital @ Home, Home at Last.	MLAA target of 15.5%, HSAA target of 14.7% for UHN, Care Pathway completion target is >90% of for all activities, PODS completion target is >70% (issues with language still)	The objective would be to have more than 90% of these actions completed within timeframe. Issues arise as Transitional care specialists are reponsible for these activities and unfortunately there are too many cases for them to keep up with. Either more FTE resources needed or automation within new HIS to provide more time for them for specific patient interaction.
										2) Standardized order sets have been created for these disease states and have been implemented at both sites. Issues still persist with their adoption elctronically given poor ease of access with current HIS. Clinicians often use basic GIM paper order sets instead. Ongoing clinical education with Medical Residents is occuring.			Order Set usage target is N/A. Current usage is less than 30%, awaiting HIS procurement before we set up reasonable target for this one.	

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										3) Post Discharge clinics/Rapid access clinics have been established as a means to address symptoms with these patients instead of going directly to ED. UHN has a Pulmonary Rehab Clinic at TWH for COPD, a post-discharge heart failure clinic at Mount Sinai as well as the Prevent-R program at UHN liver clinic for Liver Disease patients.			Discharge Summaries to GP within 48 hours target is >95%, Follow up appointments scheduled within 7 days is >50% (resourcing issue)	