Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	0.90	1.00	equal or more than 10% improvement	St. Josephs Healthcare System, Bayshore Healthcare, WW Regional and OH West Partners, Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) OHT

Change Ideas

Change Idea #1 SMGH Home Care Agency Status, create service(s) to support DC to home from inpatient care

Methods	Process measures	Target for process measure	Comments
Through SMGH's Home Care Agency Status, we will Partner with Bayshore Healthcare to pilot an innovative and seamless hospital to home service. Continue SMGH engagement in regional patient flow tables. Ongoing collaboration with KW4 OHT to support primary care infrastructure.	ALC throughput ratio 7- and 30-Day ED readmission rate PCP connection within 7 Days	Process measures will be identified through service planning with partners.	This is a collaborative QIP indicator with the KW4 Ontario Health Team.

Change Idea #2 Implementation of 4 Choosing Wisely Bundles

Methods	Process measures	Target for process measure	Comments
Implementation of 3 of the Choosing Wisely bundles will enhance quality of care, such that hospital acquired complications that are barriers to discharge are reduced. The bundles are: - Loose the Tube - Pause the Draws - Fewer Sedatives for Your Older Relatives	ALC Throughput ratio CAUTIs per 1000 patient days Total number of routine tests performed per inpatient-day Rate of onset of delirium in hospital	See Choosing Wisely	This is a collaborative QIP indicator with the KW4 Ontario Health Team.

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Collection of Sociodemographic data for identifying equity-deserving populations	C	% / All patients	Local data collection / Most recent consecutive 12-month period	X	80.00	New initiative, no baseline data, new process to be developed for collection. Setting stretch goal of 80%	Grand River Hospital Corporation, St. Josephs Healthcare System

Change Ideas

Change Idea #1 In collaboration with GRH, Implement data collection in Cerner (shared EMR), using the Measuring Health Equity (MHE) data set.

Methods	Process measures	Target for process measure	Comments
Based on the MHE data set, identify new fields required in Cerner to capture the health equity data, build these fields into Cerner, identify the required workflow to capture the data, including using self-reporting in the patient portal, identify required areas to rollout data collection and educate staff in the new workflow.	% fields required that are built in Cerner % patients with required fields at registration % data self-reported on the patient portal	100% fields built 80% patient registration events with fields completed (or pt. declined to do so) 80% portal self-reporting completed	

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (all leadership) who have completed relevant equity, diversity, inclusion, and anti-racism education	C	% / Other	Local data collection / Most recent consecutive 12-month period	X	100.00	Expectation is that 100% of leaders will complete equity education	

Change Ideas

Change Idea #1 All Leadership staff will have completed relevant EDI & Anti-racism education.

Methods	Process measures	Target for process measure	Comments
All Leadership staff will be required to complete the Certificate e-learning modules offered at SMGH, or provide evidence of comparable education.	% SMGH Leaders who have completed SMGH Certificate, or comparable education.	100% Leaders completed certificate in FY 24'25	

Measure - Dimension: Equitable

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (excluding leadership) who have completed relevant equity, diversity, inclusion, and anti-racism education	C	% / Other	Local data collection / Most recent consecutive 12-month period	0.00	5.00	First year target of 5% completion of in house education. Multi year initiative expected.	

Change Ideas

Change Idea #1 SMGH Staff will receive equity training.

Methods	Process measures	Target for process measure	Comments
Capitalizing on existing educational platforms, assess barriers to staff access, develop strategies to promote and facilitate completion of the e-learning education, and continue to assess the provision of an introductory module for all new staff at General Orientation.	% new staff who receive equity education at onboarding % existing staff who have completed the Equity Certificate via e-learning	100% new staff complete EDI training in orientation 5% of staff certificate completion	

Experience

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “definitely yes" to the following question: Did you receive enough information to take care of yourself when you got home?	C	% / All inpatients	Other / Most recent consecutive 12-month period	61.00	75.00	Aligns to previous experience target in FY 23'24	Qualtrics Team, OHA Patient Experience Community of Practice, Grand River Hospital Corporation

Change Ideas

Change Idea #1 Promote newly implemented digital Patient Experience Survey.

Methods	Process measures	Target for process measure	Comments
Support high volume survey completion by monitoring the newly implemented workflow to collect patient’s e mail at registration, and opportunities to promote survey completion. Identify opportunities to expand use of the survey. Meet with Department leadership to share survey results and align with unit specific improvement objectives. Include survey results in Quality and Operations meetings.	% email collected per patient visit, Response rate to survey, % Quality and Ops Meetings reviewing and using Patient Survey results in improvement work, Bounce back rates (target < 2%)	Bounce back rates <2% 75% emails collected per patient visit 100% Quality and Ops meetings have/use survey results	

Change Idea #2 Create a new, patient oriented, discharge education framework

Methods	Process measures	Target for process measure	Comments
Identify stakeholders, including PFAC, to review the current state of discharge patient education, and best practice. Create a new framework to guide discharge education, including the use of technology to bridge gaps in accessibility (i.e. translation, videos). Create a roll-out plan to educate staff, support implementation and ensure continuity, including identifying process measures required.	Percentage of respondents who responded “definitely yes" to the following question: Did you receive enough information to take care of yourself when you got home? Other metrics to be developed during change work.	75% respondents indicated "definitely Yes"	Note - surveying began Dec'23 and Q3 actual of 61% represents a sample size of 37 inpatients.

Safety

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Implementation of Four Choosing Wisely Bundles	C	% / Other	Local data collection / Q4 2024-25	CB	100.00	Total number of identified bundles to be implemented.	

Change Ideas

Change Idea #1 Implement the Choosing Wisely bundle "Lose the Tube" to reduce unnecessary urinary catheters at SMGH

Methods	Process measures	Target for process measure	Comments
Identify stakeholders, including physicians and nurses. Assemble a working group to determine the appropriate recommendations for implementation, introduce Lose the Tube's recommendations and the following changes: develop consensus criteria for leaving a urinary catheter in place on the ward, promote pro-active removal of those urinary catheters no longer meeting one of these acceptable indications, and standardize post-catheter care following urinary catheter removal. Using identified metrics, measure performance, review and modify approach as required.	Catheter days per patient days CAUTIs per 1000 patient days Number of urinary catheter re-insertions compared to baseline (balancing)	10% reduction and 0% balancing measure increase	

Change Idea #2 Implement the Choosing Wisely bundle "Pause the Drawer" to reducing repetitive routine blood draws at SMGH			
Methods	Process measures	Target for process measure	Comments
Identify stakeholders, assemble a working group to understand the problem at SMGH, determine the appropriate recommendations for implementation, finalize metrics, obtain leadership buy-in and support, develop and implement chosen change strategy. Measure performance, review and modify approach as required.	Total number of routine tests performed per inpatient-day Proportion of all CBCs (Cr, lytes, etc.) that are run after 3 consecutive normal and/or stable values Proportion of targeted blood tests requested as STAT blood draws requested before vs. after change strategy implementation on target units (balancing measure)	20% reduction and 0% balancing measure increase	

Change Idea #3 Implement the Choosing Wisely bundle "Drop the Pre-op" to reduce unnecessary visits and investigations in SMGH's pre-operative clinics.			
Methods	Process measures	Target for process measure	Comments
Identify stakeholder and assemble a working group to: determine the appropriate recommendations for implementation, develop a SMGH Clinical Decision Tree (CDT) using evidence- and consensus- based criteria, circulate the CDT to key stakeholders and modify based on feedback, use multiple avenues to inform staff about the CDT, build use of CDT into day-to-day processes. Using identified metrics, measure performance, review and modify approach as required.	Number of patients attending pre-operative clinic Number of investigations ordered in pre-operative clinic Number of re-scheduled or delayed procedures due to perceived missing investigations and/or sub-optimally worked-up medical conditions found on day of surgery (balancing)	10% reduction and 0% balancing measure increase	

Change Idea #4	Implement the Choosing Wisely bundle "Less Sedatives For Your Older Relatives" to reduce inappropriate use of benzodiazepines and sedative-hypnotics among older adults in hospitals.		
Methods	Process measures	Target for process measure	Comments
Identify stakeholder and establish an interprofessional working group to determine the appropriate recommendations for implementation, create a consensus criteria for appropriate indications for BSH initiation, implement non-pharmacological strategies to promote sleep, so as to restrict initiation of BSH. Create a roadmap to implement these changes, including identified metrics to measure performance, and a process to review and modify approach as required.	The number of patients prescribed any BSH for sleep in hospital, excluding patients who are home BSH users Falls per 1000 patient days Sleep quality survey Prescription rates of other sedating medications (e.g., quetiapine, trazodone, dimenhydramine) – balancing measure	10% reduction and <5% balancing measure increase	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Implement the Senior Friendly Framework	C	% / Other	Local data collection / Q4 2024-25	CB	100.00	Distinct framework to implement	

Change Ideas

Change Idea #1 Implement Senior friendly Framework

Methods	Process measures	Target for process measure	Comments
Establish a working group of key stakeholders, complete a gap analysis, develop an action plan to implement required components of the framework, complete with a timeline (multi year), road map, appropriate outcome/performance metrics, and plan for ongoing assessment/improvement.	Existence of an evidence informed action plans and road map, with outcome metrics.	100% required action plans and road maps in place.	

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of delirium beginning during hospitalization	C	% / All patients	Other / Q3	16.50	20.00	Expect an initial increase based on increased reporting before impact of planned improvement is realized.	

Change Ideas

Change Idea #1 Per Choosing Wisely and Senior Friendly Framework

Methods	Process measures	Target for process measure	Comments
Establish a working group of key stakeholders, complete a gap analysis, develop an action plan to implement required components of the framework, complete with a timeline (multi year), road map, appropriate outcome/performance metrics, and plan for ongoing assessment/improvement.	Additional metrics: Restraint rate/ 1000 inpatient days, Conservable Days, Count of security used for 1:1 constants	5% reduction in all	

Measure - Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of Delirium that Increased LOS	C	% / All inpatients	Other / Q3 actual performance	1.86	2.00	Expect an initial increase based on increased reporting before impact of planned improvement is realized.	

Change Ideas

Change Idea #1 Per Choosing Wisely and Senior Friendly Framework

Methods	Process measures	Target for process measure	Comments
Establish a working group of key stakeholders, complete a gap analysis, develop an action plan to implement required components of the framework, complete with a timeline (multi year), road map, appropriate outcome/performance metrics, and plan for ongoing assessment/improvement.	Additional metrics: Restraint rate/ 1000 inpatient days, Conservable Days, Count of security used for 1:1 constants.	5% reduction in all	