Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate Level of Care (ALC) rate	C	% / All inpatients	Other / 2022	8.26	12.70	HSAA is 12.7%. Provincial benchmark is 14.2% (FY 2021-2022) WRH has been among the top ALC performers in Ontario and below provincial benchmark.	Windsor Essex Ontario Health Team, Home and Community Care, Hotel Dieu Grace Healthcare

Change Ideas

Change Idea #1 • Ongoing collaboration with Home and Community Care (HCC) for Intensive Hospital to Home (IHH) services • Daily, provide timely, patient level data tracking ALC's • Continue to develop and apply targeted strategies to individualized discharge plans to decrease ALC length of stay across all adult acute care • ALC escalation meetings with Hospital and Home and Community Care leadership

Methods	Process measures	Target for process measure	Comments
• Conduct daily ALC/discharge huddles with hospital utilization team, social work, and HCC coordinators, to identify barriers to discharge • Provide education to patients/families about acute care and HCC services, including the requirements under the More Beds, Better Care Act, 2022 (Bill 7) • Daily, weekly and monthly review of ALC's	• Daily, the number of patients designated ALC by most appropriate discharge destination • Weekly and monthly average number of patients designated as ALC	• Continued % reduction in the overall number of patients designated as ALC • 100% of patients and/or families provided education about the appropriateness of acute care services and the availability of community support services	

Measure

Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of individuals for whom the emergency department was the first point of contact for mental health and addictions care per 100 population aged 0 to 105 years with an incident MHA-related ED visit.	C	Rate per 100 / ED patients	Other / FY2021-22	17.50	17.50	First year baseline data used as target due to this indicator being a collaborative QIP (cQIP) indicator with the Windsor Essex Ontario Health Team (WEOHT)	Windsor Essex OHT, Mental Health and Addictions Network Table (Windsor-Essex)

Change Ideas

Change Idea #1 • Working group with community mental health service providers, EMS and Windsor Police Services to review ED diversion strategies • Work with the Mental Health and Addictions Network (MHAN), a sub-committee of the Windsor Essex Ontario Health Team (WEOHT), to advance coordinated access to mental health and addiction services. • Post-Discharge Mental Health Clinic 7 day follow to ensure community mental health/addiction services are accessed in a timely manner

Methods	Process measures	Target for process measure	Comments
• Identify trends among those presenting to the emergency department as the first point of contact and develop outreach initiatives • Identify service gaps in community and work with the MHAN Table to develop plans to address	• Monthly tracking of emergency department first time visit rates	• First year baseline data established as target for this new and developing indicator in collaboration with the Windsor Essex Ontario Health Team (WEOHT)	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	59.81	63.00	Target set at 5% improvement from previous year results, and benchmarked against Ontario Inpatient results (60.0% FY 21-22)	

Change Ideas

Change Idea #1 • Monthly reporting of patient satisfaction survey results (including interim short form survey rolled out in 2022/2023) • Standardized Leadership Rounding on all inpatient units with leaders asking about concerns/ needs patient has about going home • In-room white boards provide communication to those involved in the circle of care • Leverage the electronic health information management system and Discharge Huddle process to ensure care team provides the appropriate information

Methods	Process measures	Target for process measure	Comments
• Monthly reporting of results from patient satisfaction surveys and Leadership Rounding across the organization ensuring that appropriate contact information has been collected from patients and issues are addressed in real time where possible •On-going monitoring of completion of in-room patient white boards • Leverage our new electronic information management system and discharge huddle process to confirm that appropriate health information has been provided to patient prior to discharge	• % of patients who respond positively to this question	• 63.0% or greater as established target	Total Surveys Initiated: 209

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #4	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 / Oct–Dec 2022 (Q3 2022/23)	91.15	91.20	Target set using prior year results	

Change Ideas

Change Idea #1 • Standardize medication reconciliation process at both sites utilizing the new electronic health information system with identified reporting responsibilities for nursing, physicians (ED and MRP) and pharmacists/pharmacist technicians

Methods	Process measures	Target for process measure	Comments
• Audit the compliance and accuracy monthly	• % of patients with medication reconciliation completed at discharge.	• 91.2% or greater as established target	

Measure

Dimension: Safe

Indicator #5	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 / Jan 2022–Dec 2022	308.00	308.00	Target set using prior year results as these initiatives aim to reduce the overall number of incidents while encouraging the reporting of incidents	

Change Ideas

Change Idea #1 • Workplace violence results reported weekly at Monday Morning Huddle • Incidents reviewed weekly by Workplace Violence Working Group • Code White/Safety Manager Group (SMG) de-escalation training provided to all staff in high risk areas • Safe Workplace Working Group has cross department multi-disciplinary representation including high risk areas e.g. Emergency Department and Mental Health

Methods	Process measures	Target for process measure	Comments
• Standard work created for prevention, investigation and debriefing of incidents • Weekly monitoring of results with clinical leadership team at Monday Morning Huddle and review of every incident in real time with leadership, the process improvement team and the bargaining unit leadership as required • Monitoring staff completion of Code White/Safety Manager Group (SMG) de-escalation training program.	• % of incidents reported are reviewed by care team, leadership and Workplace Violence Working Group in real time and overall weekly • % completing code white training from high risk areas	• 100% of incidents reported are reviewed by care team, leadership and Workplace Violence Working Group • High completion rate of Code White/Safety Manager Group (SMG) training from high risk areas: 100% of staff from the Mental Health Program and >90% of staff from the Emergency Department	FTE=3451