Objective	Measure/Indicator	Unit/Population	Source/Period	Current Performance	Target Performance	Target Justification	Priority Level
Reduce clostridium difficile associated diseases (CDI)	**CDI rate per 1,000 patient days:** Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000, consistent with publicly reportable patient safety data.	Rate per 1000 patient days / All Inpatients	Publicly reported, MOH/ Jan – December 2015	0.36[1]	0.35	TEGH aims to exceed the average CDI rate for the LHIN and ensure that less than 3 hospital acquired C.diff cases develop monthly.	**IMPROVE**
	Planned Improvement Initiatives		**Methods**		**Process Measures**		**Goals for change ideas**
	Improve provider hand hygiene compliance before patient contact		The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100.		% of all healthcare providers who are complaint with hand hygiene compliance prior to patient contact		**90% or greater**
	Increase team capacity, by empowering and educating Personal Care Assistants to identify, document and isolate patients suspected of clostridium difficile		To ensure the proactive isolation of suspected c.difficile patients, staff will be supported to improve the charting of patient fecal type using the Bristol stool scale.		% of clostridium difficile cases with effective documentation.		**100% monthly compliance**
	Utilize ultraviolet disinfectant technology to clean rooms which have been isolated due to C.diff positive patients upon discharge and test the efficacy of sanitation using an ATP audit		Terminal cleans of C.diff isolated rooms will require the utilization of UV disinfection. Staff will be educated and trained on when and how to utilize the equipment. After a terminal clean of each C.diff isolated room an ATP audit will be conducted to verify the surface sanitation.		% of isolated C.diff patient rooms that have been terminally cleaned using UV light disinfectant technology and received an ATP audit.		**85% monthly compliance**

[1] Although TEGH achieved a c.diff rate of 0.28 during the 2014 calendar year, it was challenged with an outbreak of nosocomial C.diff cases at the end of the calendar year which continued into the start of the 2015. A measure of our most recent quarter's performance is a more accurate reflection of our organizational baseline.

Objective	Measure/Indicator	Unit/Population	Source/Period	Current Performance	Target Performance	Target Justification	Priority Level
Avoid patient falls	**Falls with harm:** Total number of falls divided by the number of patient days, multiplied by 1000.	Rate per 1000 patient days / All Inpatients	Hospital collected data / Jan 2015 – December 2015	0.42	0.42	TEGH aims to maintain and minimize patient falls with harm while promoting increased patient mobility.	**MAINTAIN**
	Planned Improvement Initiatives		**Methods**		**Process Measures**		**Goals for change ideas**
	Sustain and hardwire falls prevention standard work		Designated 'Falls prevention Champions' on each clinical unit will audit the unit's compliance and quality on the falls prevention standard-work to help ensure the sustainability of the program.		% compliance on unit audits of falls standard work		**85%** (monthly compliance)
	Increase staff capacity and engagement by empowering Personal Care Assistants (PCA) to design and implement a unit specific falls prevention strategy		PCAs will design and develop a falls prevention strategy uniquely tailored to their unit. The strategy will be led by the PCAs, allowing them to be empowered and engaged in the falls prevention program.		% of targeted units with a fully implemented PCA-led falls prevention strategy		**100%** by April 2016
	Prevent the deterioration of patient mobility by ensuring the implementation of a mobilization strategy for each patient		The implementation of a mobility strategy will be electronically documented in high risk units for each patient and reported daily at the unit level.		% of targeted units with an implemented patient mobility strategy		**100%** by April 2016

Objective	Measure/Indicator	Unit/Population	Source/Period	Current Performance	Target Performance	Target Justification	Priority Level
Increase proportion of patients receiving medication reconciliation on discharge	**Medication Reconciliation on Discharge**: Total number of medically complex discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion of the total number of medically complex patients discharged.	% / All inpatients[2]	Hospital-collected data / Most recent quarter	**65%**	**68%**	TEGH aims to achieve a 3% improvement driven by developing program specific education and improvement strategies.	**IMPROVE**
	Planned Improvement Initiatives		**Methods**		**Process Measures**		**Goals for change ideas**
	Increase proportion of patients receiving medication reconciliation on admission		Medication reconciliation at admission is a critical enabler for medication reconciliation at discharge. To drive compliance on the former, an action will continue to monitor and complete improvement projects to hardwire this behavior.		% of patients with a best possible medication history completed on admission		**80% Monthly Target**
	Define and standardize a clear process and expectations for medication reconciliation on discharge		The interdisciplinary team of medication reconciliation on discharge practitioners will collaborate to develop a standardized process. The proportion of targeted practitioners trained on the process and its accompanying electronic documentation will be tracked on a monthly basis.		% of targeted practitioners who have been trained on standardized medication reconciliation on discharge process		**65%** training compliance achieved by April 2016
	Drive performance improvements in targeted units which display compliance below the organizational average		Developing program and unit specific improvement strategies are critical for driving compliance and quality in medication reconciliation at discharge. Each unit preforming bellowing an organizational threshold will develop targeted unit specific strategies.		% of units with a compliance lower than 50% that have implemented a unit specific improvement strategy		**100%** achieved by April 2016

[2] Exclusion:

- Indicator excludes hospital discharge that is death, newborn, or stillborn.
- Surgery patients discharged in less than 48 hours & Patients discharged in less than 24 hours.

Objective	Measure/Indicator	Unit/Population	Source/Period	Current Performance	Target Performance	Target Justification	Priority Level
Identify and address inequity in patient outcomes	**Patient Survey Participation Rate:** Number of patients who participate in the TC-LHIN Health Equity survey divided by the total number of patients surveyed	% / All Contacted Patients	Hospital-collected data / Most recent quarter	60%	70%	TEGH aims to meet the TC-LHIN average for survey participation.	**IMPROVE**
	Planned Improvement Initiatives		**Methods**		**Process Measures**		**Goals for change ideas**
	Progress: Implement patient surveying process across all coded inpatient areas of the hospital		All coded inpatient regions of the hospital have been targeted to implement a surveying process to collect responses for the TC-LHIN health equity survey. Implementation of an effective surveying process in these areas will ensure that over 60% of all hospital patients are surveyed.		% of all coded inpatient areas with a fully implemented surveying process for the TC-LHIN health equity survey.		**100%** implementation by March 2016
	Contact Rate: Ensure that patients are provided a TC-LHIN health equity survey in targeted regions of the hospital		Sustaining the implementation of the surveying process in targeted regions requires the monitoring of process. Measuring the contract rate by looking at the proportion of patients who have received a TC-LHIN health equity survey as a proportion of all hospital patients allows us to ensure that a wide range of patients are being contacted to complete the survey.		% of all hospital patients who have received a TC-LHIN health equity survey.		**60%** achieved by March 2016
	Information Rate: Establish process and communication platform that allow patients to feel comfortable completing the TC-LHIN health equity survey		To understand identify and address patient inequity it is critical to collect diverse demographic data from the patient population. A critical element of surveying patients must be to ensure that patients voluntarily choose to respond to the 8 key questions asked on the TC-LHIN health equity survey. Communication strategies and process will be used to support this data collection. All participating patients who choose to provide a response to 6 or more survey questions as a proportion of all participating patients.		% of all participating patients who chose to provide a response to 6 or more of the survey questions as a proportion of all participating patients.		**80%** monthly target

Objective	Measure/Indicator	Unit/Population	Source/Period	Current Performance	Target Performance	Target Justification	Priority Level
 **Improve Quality of Care for Deteriorating Patients**	**Rescue Index** Number of in-patient ward decedents with full cardiac pulmonary resuscitation status per 1000 discharges	**Occurrences per thousand patients** Excludes in-patient decedents from special care units	**Source:** Coded data provided by Decision Support Department **Period:** Fiscal year, beginning April 2015	Baseline being developed	10 or less	This target was set through discussion among experienced care providers – internal baselines and external benchmarks were not available.	**IMPROVE**
	Planned Improvement Initiatives		**Methods**		**Process Measures**		**Goals for change ideas**
	Design and implement Key Performance Measures		Working groups will be established to define key performance measures (outcome, process, balancing) and design, build and implement data capture using electronic patient charts (will require training for all care providers). This data capture will be presented on a monthly basis.		% completion of monthly reporting system.		100 % achieved by July 30, 2015
	Ensure hospital-wide coordination and focus on Quality Management and Quality Assurance initiatives		A Rescue from Danger Steering Committee will be established with a mandate to monitor system performance and drive continuous improvement. The committee will include both administrative and Physician leadership.		Number (12) of Monthly meetings held in Fiscal Year 2015/16		10 meetings held over the course of the fiscal year
	Ensure Emergency Department patients are transferred to the appropriate ward at the right time		A program referred to as the ER – Stop program will be developed and implemented to ensure that each patient is transferred to the appropriate ward at the right time.		% of admitted ED patients with ER-STOP ticket on chart		100% achieved by July 30, 2015

Objective	Measure/Indicator	Unit/Population	Source/Period	Current Performance	Target Performance	Target Justification	Priority Level
Reduce unnecessary time spent in acute care	Percentage Alternative Level of Care (ALC) days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days.	% / All acute inpatients	DAD, CIHI / Q3 2014/15 – Q2 2015/16	15.5%	14%	TEGH in partnership with community partners aims to apply a proactive approach to the management of its ALC patient population and standardize patient care processes to continue to reduce ALC days and match the rate of improvement attained by other leading organizations.	**IMPROVE**
	Planned Improvement Initiatives		**Methods**		**Process Measures**		**Goals for change ideas**
	Identify patients at risk for complex discharges within the Emergency Department		Clear criteria and process will be established to identify and assign resources to patients at risk of becoming complex discharges.		Proportion of all geriatric Medical Short Stay patients and all patients referred to GEM nurses screened using Blaylock tool.		**85% compliance by June 2015**
	Providing escalating measures of leadership support to staff managing complex ALC discharges		A clear algorithm for determining when an ALC patient's discharge planning requires escalating support will be established and rolled out to ensure that complex ALC patients are identified and appropriately managed.		Proportion of identified 'complex ALC discharges' that have been effectively escalated.		**80% by Dec 2015**
	Empower staff and physicians by providing tools, workshops and ethical training on managing complex patient scenarios related to ALC discharges		A series of 6 workshops will be developed and offered to staff and physicians to provide training, ethics frameworks and support in managing difficult ALC discharges.		% of invited staff and physician that attend at minimum one session		**65% by January 2015**

Objective	Measure/Indicator	Unit/Population	Source/Period	Current Performance	Target Performance	Target Justification	Priority Level
Maintain rate of QBP hospital readmissions[3]	**TEGH QBP Readmission Rate (%)** Number of patients admitted for any non-elective cause to TEGH within 30 days of discharge from TEGH, for selected Quality based procedures (QBPs), divided by total patients discharged from same QBPs in prior 30 days.	**Percent of Patients** "Patients" defined as all patients discharged from one of the following QBPs: • COPD • Stroke • CHF • Pneumonia	TEGH Coded and Hospital Information System data for fiscal year 2015/16	14.8 %	**14.8% or less**	Target represents upper limit of a range, to account for highly variable monthly results.	**MAINTAIN**
	Planned Improvement Initiatives		**Methods**		**Process Measures**		**Goals**
	Ensure monthly results are visible to QBP teams		Ensure patient level data of all Readmitted cases are available to QBP leadership & establish monthly QBP reviews of key performance metrics, including Readmission Rate, in which improvement initiatives are identified, launched, and monitored		Number of monthly QBP Review meetings held as a proportion of all meetings which should be held. (100% = 4 QBPs x 12 months = 48)		90% achieved by March 2016
	Flag readmitted patients in patient chart		Design and implement system modification to electronic patient chart (eChart) to easily identify readmitted patients to care providers on wards		Percent of Readmitted patients with flag included in eChart, starting Q2 – F2015/16		100% achieved by March 2016
	Develop profile of Readmitted patients		Classify characteristics of all Readmitted QBP patients, and plot on charts & Explore existence of patterns or trends that may inform improvement initiatives		Percent of Readmitted patients classified and charted, starting Q2 – F2015/16		100% achieved by March 2016

[3] This is a balancing metric to ensure quality of care is at least maintained while we make improvements to QBP patient care pathways.

Objective	Measure/Indicator	Unit/Population	Source/Period	Current Performance	Target Performance	Target Justification	Priority Level
Reduce wait times in the Emergency Department	**Physician Initial Assessment:** 90th percentile Time to Physician Initial Assessment	Hours / All Emergency Department Patients	Hospital collected data / Q1 15/16 – Q4 15/16	4.4H	4H	TEGH aims to meet or exceed the average performance of high-volume emergency departments in Ontario.	**IMPROVE**
	Planned Improvement Initiatives		**Methods**		**Process Measures**		**Goals for change ideas**
	Continuous Improvement Education		Education Series developed to build a foundational knowledge base for ED Staff and Physicians, to assist them in understanding the importance of both Process Improvement / Lean strategies, as well as the impact of wait times within the ED as both a quality and satisfaction marker.		% of Staff / MDs that attended at least 1 session from the Education Series		**90%**
	Regular Distribution of Real-time Patient Wait time Data		Enhance the utilization of real-time patient flow data within the Emergency department to provide staff timely, relevant information that can influence action.		% of staff with access to enhanced patient wait time data		**100% of staff have access to enhanced patient flow data by June 2015**
	Targeted Process Improvement Projects		Three key priorities have been identified as drivers for reducing PIA: eliminating sources of delays related to chart processing, Improved patient way finding, better match staffing to department demand. Monthly the ED Working group will assess and develop appropriate projects focused on these key challenges.		Number of process improvement projects launched monthly		**1 Project launched monthly**

Objective	Measure/Indicator	Unit/Population	Source/Period	Current Performance	Target Performance	Target Justification	Priority Level
 **Improve hourly rounding to improve quality of care**	Patient experience with hourly rounding ('care rounds'), measured through post-discharge phone calls. Patients will rate their experience on a 5-point scale. The indicator will be percent of responses with positive score (4 out of 5 and above).	Patients discharged from Medical & Surgical Units	**Source:** Post-discharge phone call logs : Internal data **Period** Q1 – Q4 2015/16	75%*	80%	Patient experience with care rounds is currently low due to unclear expectations regarding how care that should be delivered, both for patients and staff. Tactics were chosen to directly address these issues and should result in marked improvement.	**IMPROVE**
	Planned Improvement Initiatives		**Methods**		**Process Measures**		**Goals for change ideas**
	Based on the output of the Late Career Nurse Initiative, the care rounds model will be redesigned and rolled out to all medical & surgical units		Unit leadership and formal councils (e.g., UBCs) will be engaged to educate staff on the new care rounds model. Opportunity to adapt/customize will be given, where appropriate..		% staff satisfaction with care rounds (pre/post survey included in roll-out)		% Staff satisfaction with rounding improved by 15%, measured 3 months after roll-out
	Patients will be educated regarding the care rounds model in an effort to manage expectations and create a pull-mechanism for high quality rounding		Patient/community advisors and CPC will co-develop educational materials and provide input on methods to educate patients on what to expect from their care at TEGH.		%-positive response to question regarding education on post-discharge phone call survey		75%
	The quality of care rounds will be assessed by hospital leadership through rounding on patients		Patient experience with care rounds will be assessed in real-time using the same question asked for the lag indicator. Eventually staff will assess patient experience directly through a phased-in approach beginning with leaders and staff doing assessments together.		%-positive response on patient experience question(s) asked in-person		80%

*Based on baseline measured by asking patients who are in hospital at the time.

Objective	Measure/Indicator	Unit/Population	Source/Period	Current Performance	Target Performance	Target Justification	Priority Level
Improve patient satisfaction	**Patient Satisfaction:** Percentage positive score with overall satisfaction with inpatient care received (NRC-Picker).	% / All inpatients	NRC Picker / October 2013 – September 2014	90.5%	92%	Patient centered care is a critical element of TEGH's strategic plan. Strongly aligned with provincial priorities and organizational priorities, TEGH aims of matching the performance level of the GTA peer average	**IMPROVE**
	Planned Improvement Initiatives		**Methods**		**Process Measures**		**Goals for change ideas**
	Standardize the capture of the TEGH Patient Experience		Develop a standard method to compare, contrast and aggregate the patient perspectives captured through diverse modalities at TEGH, including Post Discharge Phone Calls, NRC Picker Surveys, Patient Stories, Patient Videos etc		Proportion of targeted patient experiences captured using standardized structure.		**100% of targeted patient experience capture structures adopt standard system by April 2016**
	Coordinate and align organizational efforts to improve the patient experience		Establish a diverse governance body consisting of leadership, management, patients and frontline staff aimed at coordinating and aligning organizational efforts to improve the patient experience to 1) discuss trends collected from our patient experience and 2) Monitor and maintain the alignment of our patient experience with patient centred initiatives		Number of gaps in the TEGH patient experience identified.		**Identify and prioritize one in the TEGH patient experience quarterly**
	Improve the patient experience in the emergency department		The ED Patient Experience Impacts the overall IP Patient Satisfaction. ED Patient satisfaction is no longer a lag indicator on the QIP. However, maintaining a focus on it is critical. The ED department will review its monthly satisfaction scores and aim to trial a test of change quarterly to improve the overall patient experience in the ED		Patient Satisfaction: Percentage positive score with overall satisfaction with ED care received (NRC-Picker).		**85% Overall Satisfaction achieved by March 2016**