Appendix B - Quality Improvement Plan 2024/25 Workplan

Measure: Percentage of Board and executives who have completed relevant equity, diversity, inclusion, and anti-racism education

Quality Dimension: Equitable

Unit/Population	Source/Period	Current Performance	Target
%/Leaders	Local data collection / Most recent consecutive 12-month period	Not Available	100% of Board Members and Executives to complete training on racism and oppression
Target Justification	Of the 13 hospitals with an equity training metric, there was 1 teaching hospital, Hamilton Health Sciences, with a target of "100% of the executive leader team members receive cultural competency training." This work needs the understanding, support and commitment from leadership in order to drive systemic and organizational change, therefore we are initially focusing on the board and executive leaders		
External Collaborators	University of Western's Digital Learning Equity Diversity and Inclusion modules		

Change Ideas

Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
Source online e-learning modules on broad range of topics related to equity, inclusion and anti-racism including **Black Health**	In collaboration with the Learning and Development team we are exploring potential learning partners such as University of Western's Digital Equity Diversity and Inclusion Learning modules	Modules are available on iLearn	Sourced and available modules by June 2024

Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
Source online e-learning modules on broad range of topics related to equity, inclusion and **anti-racism including Indigenous Health**	In collaboration with the Learning and Development team we are exploring potential learning partners such as University of Western's Digital Equity Diversity and Inclusion Learning modules	Modules are available on iLearn	Sourced and available modules by June 2024
Develop a learning and development strategy for equity and inclusion that understands the needs of the organization and creates a pathway to determine who needs what training when	Hire a learning and development specialist to develop a corporate wide strategy and conduct an organizational needs assessment Determine role specific learning requirements Determine an organizational learning pathway that includes required training and timing for each role	Organizational needs assessment completed Role specific learning plan developed Organizational learning pathway with mandatory requirements developed (or implemented?)	Strategy to be completed by December 2024

Measure: Discharge summary sent from hospital to primary care provider within 48 hours of discharge

Quality Dimension: Timely & Efficient

Unit/Population	Source/Period	Current Performance	Target
%/Discharged Patients	Hospital collected data CERNER/most recent 3-month period	68.9% Q3 fiscal year 2023/24	80%
Target Justification	The target rationale is based on both peer targets and performance. Of the 13 large hospitals who have this indicator on their public Quality Improvement Plan, the average performance at the end of Fiscal Year 2021/22 was 78.6% and average target was over 80%.		
External Collaborators	None		

Change Ideas

Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
Quality improvement education College of Physicians and Surgeons of Ontario hospital focus	Physicians can sign on and work with LHSC's Centre for Quality Innovation and Safety to learn quality improvement root cause analysis methodology	Number of Root Cause Analyses and collaborative sessions and number of change ideas generated from root case analyses	April 2024 start
OneChart functionality improvements	OneChart to automatically pull data fields into a note to assist with efficient completion	Data fields identified Review and testing that the appropriate information is being automatically pulled Functionality is validated and used to assist in Discharge Summaries	Data fields identified April/May 2024 Review and testing July/Aug 2024 Validation Oct – Dec 2024
Identify high volume/quantity users for high impact priority	Target improvement strategies and spread to those high-volume areas in greatest need	Champion list of those leaders or areas lessons	To be completed July 2024

Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
areas and explore discharge summary quality	of improvement Explore measuring quality of discharge summaries and balancing measures	learned have been shared with/spread to	
Establish a Resident Quality Council	Continue to increase visibility and understandability of the data (better graphs and trending), expand use of storytelling and using the data to inform change	Number of edits, editing patterns, to the discharge summary	To be completed fall 2024

Measure: Patient Safety Culture Survey - 'Overall Rating Score'

Quality Dimension: Safe

Unit/Population	Source/Period	Current Performance	Target
All Staff, Pulse Sample Survey	Year to date	'Overall Rating Score' 61% Year to date	64%
Target Justification	This is a new indicator and LHSC does not historical data or peer comparison data. The target has been set as a 3% improvement on the current performance.		
External Collaborators	Accreditation Canada		

Change Ideas

Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
Learning from Incident Management Systems Improvement Commitment	Implementation of a new incident management system, with multiple modules that allow for data analytic sharing and patient experiencing from Incident Management Systems	Project Plan developed Stakeholder engagement New software implemented Data and analytics framework developed	Implementation of a new incident management system by December 1, 2024
Implementation of Continuous Improvement of Care	Rollout of the continuous improvement of care model to drive quality and safety at all levels of the organization, through leader and staff education by empowering our people to solve problems and improve outcomes, and by advancing a culture of evidence-informed decisions.	Number of board members and executives trained on the executive management system. Sustainability plan developed. Status exchanges and huddle quarterly compliance audits.	Training provided to Executives, Board of Directors and Patient Partners by June 30, 2024. Continuous Improvement of Care Sustainability Plan approved and initiated in April 2024. 90% of status exchanges and huddles occurring each quarter

Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
	Develop Continuous Improvement of Care Sustainability Plan.		
Improved Serious Safety Event Process	Closing the loop of incidents for Serious Safety Events back to staff, patients and families.	Number of times findings from the series safety event review is shared with staff. Number of times recommendations are shared from Series Safety Events with staff. Number of times recommendations are shared from Series Safety Events reviews shared back to patients and families.	90% of Serious Safety Event findings communicated to clinical team 90% of Serious Safety Event recommendations communicated to clinical team 90% of Serious Safety Event recommendations communicated with Patient or Patient's family.
Patient Safety Plan Implementation	Implement Psychological Safety training for all formal leaders Continuation of Just Culture training for all formal leaders	Number of formal leaders trained in Psychological Safety and Just Culture	85% of formal leaders trained in Psychological Safety and Just Culture** ** part of Healthcare Excellence Canada strategy Patient Safety Culture Bundle.

Measure: Percentage of patient respondents who responded “completely” "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?"

Quality Dimension: Patient Centered

Unit/Population	Source/Period	Current Performance	Target
% / Survey respondents	Ontario Hospital Association (OHA) Ontario Adult Inpatient Short-form Patient Experience Survey (OAIP) plus maternity module.	Survey results from September 18 – November 26 for this question are 58.8% percent of patients responded ‘completely’ of total survey responses.	65%
Target Justification	There is no peer data available at this time. The Ontario Hospital Association is working with Qualtrics in the development of a benchmark tool for hospitals in Ontario using Qualtrics to have access to peer data. The target has been set as a 6.2% improvement on the current performance.		
External Collaborators	The Middlesex London Ontario Health Team Coordinating Council are building a patient, client, caregiver network for the region and LHSC’s Patient Experience Advisory Council and Cancer Care Patient and Family Advisory Council have both met with and will continue to meet with this network		

Change Ideas

Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
Patient Experience Survey Results Collection and Dissemination Process Development and Continuous Improvement	Scorecard and dashboard data dissemination and utilization to drive quality improvement. Expand access to this question by including it on all surveys. Areas who are performing below peer programs, will be engaged to identify opportunities to improve and partner with Patient Engagement to involve patient and family partners in developing and implementing improvements. Tools can include focus groups, tracers, and process mapping. A Patient Experience Survey Working Group will be established to monitor and evaluate	Inclusion of this survey question on all 9 surveys to increase access Percent of engagement requests Develop the workplan for the upcoming year	Question is included on 100% of surveys 100% of programs not meeting target are working with Patient Engagement

Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
	the patient experience survey process and identify opportunities to reach patients and care partners who do not have email.		Implement new workplan
Patient and Family Partner teamwork	This fiscal year, a formal process will be put in place to ensure all Patient Experience Advisory Council and Patient and Family Advisory Councils receive the summary data of patient experience surveys.	Patient Experience surveys results reported to Patient Experience Advisory Council and Patient and Family Advisory Councils	Two times a year survey data is reported to Patient Experience Advisory Council and Patient and Family Advisory Councils

Measure: Time to Inpatient Bed: Time interval between the Disposition date/time and the date/time patient Left the Emergency Department (ED) for admission to an inpatient bed or operating room at the 90th percentile

Quality Dimension: Timely & Efficient

Unit/Population	Source/Period	Current Performance	Target
Hours/ All emergency visits	Canadian Institute for Healthcare Information National Ambulatory Care Reporting System (NACRS)/most recent 3-month period	25.5 hours Q3 fiscal year 2023/24	23 Hours
Target Justification	Results trending and peer benchmarks. In fiscal year 2022/23 Q2, the provincial 90th percentile Emergency Department wait time for an inpatient bed was 34.5 hours and Ontario teaching hospitals 31.5 hours. Our performance currently is better than our peers, however this target is anchored in data from the last several quarters and realistic with current system issues.		
External Collaborators	'Private-Public partnerships for transitional care units in collaboration with Home and Community Care and local retirement homes, City of London Homeless Hub Strategy and partners and continued coalition with Emergency Medical Services (EMS).		

Change Ideas

Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
Continue to create capacity and build on accountability mechanisms to improve patient pull	Spread and scale Transitional Care Units (TCU) Iterate Emergency Department Push/Pull Strategy Anticipated Date of Discharge entered within 24hrs of inpatient admission and proactive discharge planning accountability within 48 hours Transparency in Emergency Medical Services and LHSC	Alternate Level of Care Rate Anticipated Date of Discharge Recorded	Alternate Level of Care Rate 5.9%

Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
	data to support load leveling conversations between LHSC and Emergency Medical Services		
Create reporting mechanism for bed status changes to enhance visibility of time from bed available to bed assigned	Create reporting structure Implement with Capacity Managers and Patient Access and Flow team Implement with LHSC Clinical Managers and Directors	Time to Inpatient Bed Time from bed available to bed assignment	Improvement in 90th Percentile Time to Inpatient Bed ~ Target 23 hours Baseline data collection for reporting
Development and implementation of the 2024/25 Pay-for-Results (P4R) Action Plan.	Development and implementation of the 2024/25 Pay-for-Results (P4R) Action Plan will be data driven utilizing driver diagrams	Completion of the 2024/25 Pay-for-Results (P4R) Action Plan.	Pay-for-Results (P4R) Action Plan to be completed by April and implemented by March 2025