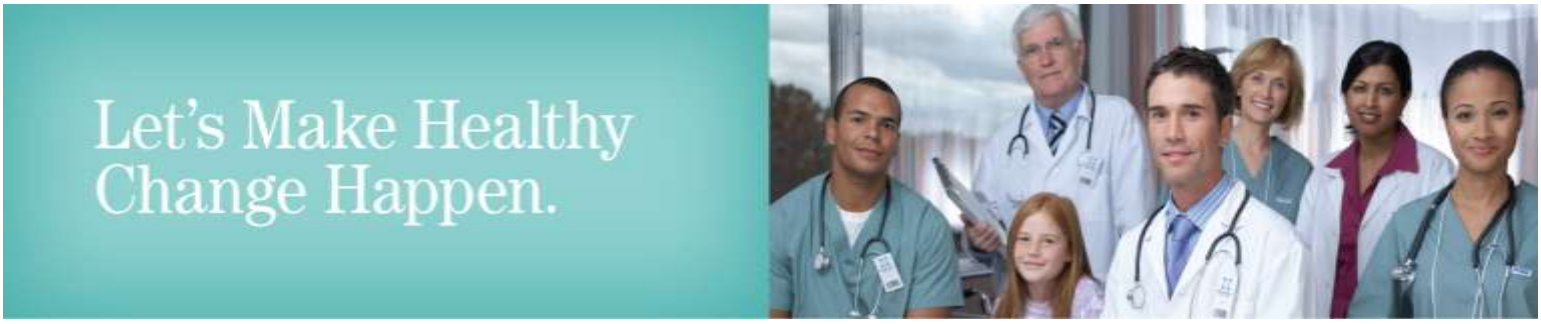
Quality Improvement Plan 2024/25 Narrative



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

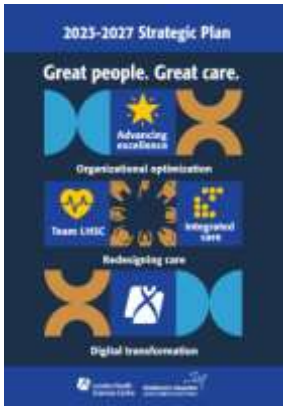
London Health Sciences Centre

1/18/2024

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.

Ontario

Overview



London Health Sciences Centre (LHSC) is one of Canada's largest research-intensive, academic acute care hospitals. We are committed to collaborating with patients, families, and system partners to deliver excellent care experiences and outcomes, educate the health-care providers of tomorrow, and advance new discoveries and innovations to optimize the health and wellbeing of those we serve.

The tagline 'Great people. Great care.' is our roadmap for how we will evolve alongside a changing health-care system as we advance excellence in care, teaching and innovation. LHSC will harness the power of teamwork, compassion, curiosity, and accountability to deliver exceptional care experiences that promote positive change in the health-care landscape.

Our Strategic Plan signifies LHSC's commitment to providing leading-edge health-care services that are responsive to the changing needs of our patients and community. With a shared vision, purpose and fundamental commitments to equity, inclusion and social accountability, we are dedicated to transforming health, together.

Our achievements for 2023 include:

- **Accreditation with Exemplary Standing**. Accreditation recognizes how well a hospital meets standardized levels of patient care and safety. In the past year, LHSC received three accreditation achievements, including Accreditation with Exemplary Standing from Accreditation Canada (the highest level of performance); Stroke Distinction for the Clinical Neurological Sciences department; and Accreditation for Canadian Surgical Technologies and Advanced Robotics (CSTAR).

LHSC Accredited with Exemplary Standing – March 2023

LHSC Stroke Distinction for Clinical Neurological Sciences – January 2023

Canadian Surgical Technologies and Advanced Robotics (CSTAR) Accreditation – February 2023

- **Health Standards Organization Leading Practices.** Leading practices are an award given to organizations by Health Standards Organization indicating the achievement of a unique practice, model of care or initiative that can be adopted by others nationally or internationally. Over this past year, LHSC was awarded 15 leading practices that have now been shared across the country by Health Standards Organization.

- **Recognition at the International level**. In October 2023, members of Team LHSC shared their knowledge and expertise on surgical best-practice, patient safety, employee wellness, epigenomics and artificial intelligence at the 46th Annual World Hospital Congress hosted by the International Hospital Federation. The conference presented an opportunity for physicians, researchers, and staff to learn alongside health-care colleagues from around the world, share knowledge and best practices, exchange innovative ideas, and collaborate as an international health-care community.

- **Maternal Fetal Centre for Excellence**. LHSC improved obstetrical patient care with the acquisition of 12 new innovative ultrasound machines this fall. This change in practice with modern technology resulted in LHSC being named a Maternal Fetal Medicine Centre of Excellence. This advanced technology will help to better treat patients with high-risk pregnancies by uncovering critical answers earlier, allowing for faster assessments and diagnosis, and research. The addition of these machines places LHSC as one of only four hospitals in the province with this type of advanced ultrasound capability and was made possible as result of a $1.3 million in donations through London Health Sciences Foundation.

Natasha Quin, Diagnostic Sonographer

- **Health and Homelessness.** Homelessness remains a challenge within the city of London and contributes to poor health outcomes. LHSC is partnering with the City of London and other organizations through the Health & Homelessness Whole Community System Response to help address rising homelessness. As part of this effort, LHSC and London Cares Homeless Response Services have established 25 supportive housing units to assist those with complex health needs, including discharged hospital patients at risk of readmission due to experiencing chronic homelessness. These safe and supportive housing units are fully furnished and facilitate 24/7 on-site access to health and social services such as mental health care, addiction treatment, educational resources, and food insecurity assistance, helping improve health outcomes for vulnerable residents and reduce demand for hospital resources.

LHSC and London Cares Supportive Housing Units Opening

- **Transitional Care Units**. In Ontario, hospital patients no longer requiring acute care are designated as "Alternate Level of Care." Over the past decade these numbers of patients have continued to rise and present challenges for many hospitals across the province. With shortages in long-term care facilities, even if patients are medically able to leave the acute care setting, there are challenges in placing them into appropriate care settings in the community. Additionally, over the past decade, the shortage of available beds versus the current demand has created additional pressures in maintaining patient flow in the hospital. In the past six months, LHSC has created 77 acute care bed spaces in partnership with four community retirement homes. These partnerships improve patient flow within the hospital and allow for safe transitions until the patient's destination of choice becomes available.

- **Continuous Improvement of Care (CIC).** LHSC is finalizing the full implementation of a quality improvement initiative that empowers all staff and care providers to identify opportunities for improvement and to problem solve, innovate, and develop long-lasting solutions. This initiative is

currently being implemented in all areas of our organization and is a key strategic plan priority for advancing excellence across LHSC.

2024/25 Quality Improvement Plan Measures and Targets:

Indicator	Target
1. Board and Executive Training on Equity, Diversity and Inclusion	100%
2. Discharge Summaries within 48 Hours	80%
3. Length of Emergency Department Wait for Bed at 90th Percentile	23 Hours
4. Patient Experience Survey 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?*	65%
5. Patient Safety Culture Survey 'Overall Rating Score'	64%

Engagement in the Quality Improvement Plan development:

Our commitment to quality improvement across LHSC starts with gathering the perspectives from those we serve and members of Team LHSC to learn what matters most to them. We understand that effective engagement improves efficiency of work, creates legitimacy amongst our community and providers, and builds a culture of shared transparency. To create the Quality Improvement Plan, a variety of engagement methods, driven by the International Association for Public Participation (IAP2) Framework, were used. The framework for engagement ensures that health care organizations implementing service-based decisions reflect and incorporate the perspectives of those who work at and are served by LHSC.

Our engagement process was extensive, conducted over a three-month period, at varying times of the day, across all sites and using multiple techniques (e.g., surveys, community discussions, huddle boards, and walkabouts). Our goal was to gather as many different perspectives as possible from our staff, physicians, learners, community, and patients (both adult and paediatric). These are the diverse ways we gathered information to guide the development of our Quality Improvement Plan:

Inform	Consult	Involve	Collaborate	Empower
				
Engagement Booths Nighttime Unit Rounding Staff Town Halls All Staff Emails	**3** Community Conversations	**100**+ Survey Responses	**3** Patient Partner Meetings **1** Child & Youth Advisory Meeting **5** LHSC Committees	**1** Indicator Chosen by Patient Partners

Novel this year was empowering our Patient Partners to determine which client experience question was most relevant to them. While Ontario Health suggested the client experience metric, our Patient Partners were vocal in sharing this was not what mattered to them, requesting a different question. With full support of our Quality & Culture Committee, the decision was left to our Patient Partners for inclusion in the 24/25 Quality Improvement Plan. Also, new this year was engaging our child and youth partners to explore what mattered to them. The engagement similarly revealed that the experience question reflecting their challenges was important and needed to be explored more fully. While not included in this year's Quality Improvement Plan, based on this feedback we will be working towards a question for the 2025/26 Quality Improvement Plan.



Engagement Methods Across London Health Sciences Centre including meeting our Child and Youth Advisory Council, Individual Patient Partners and Gathering Input from Staff, Physicians, Patients, Caregivers, Learners, and Volunteers.

Access and Flow

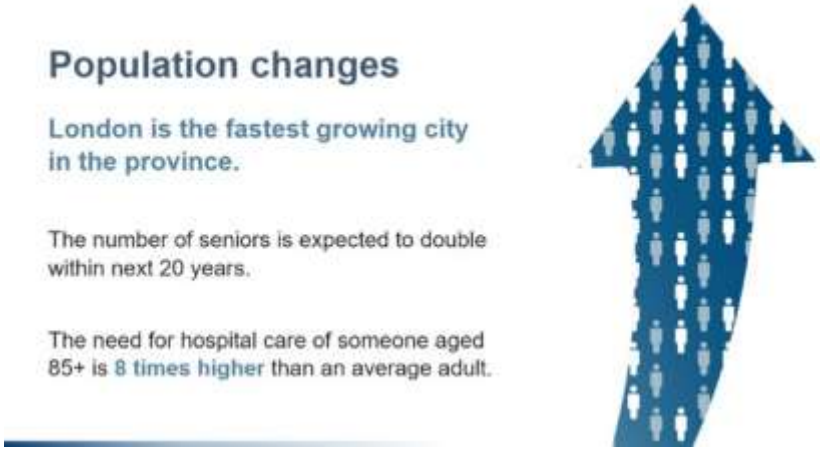
Access to care continues to be a challenge provincially. It is not solely the initial service that defines access, but rather the ability to flow along the continuum of care, reflecting how well an organization is able to flow patients from service to service. For our community, waiting in unconventional spaces for a bed or a waiting area not only contributes to anxiety but contributes to dissatisfaction of patients and families. At LHSC we continue to focus on improving the efficiency in delivering services and ensuring that care is received in appropriate settings. Over the last year, LHSC has experienced success within the area of access and flow including:

- The creation of a Capacity Management team within the organization to support the centralization of bed assignment and management to optimize patient flow.
- The implementation of an emergency department 'push-pull' strategy to move patients quickly from the Emergency Department into inpatient settings. We have improved emergency management services offloads (within one hour) by over 60 percent in November and December of 2023 when compared to the same months in 2022.

The creation of over 100 care spaces for alternative level care and vulnerable patients has helped create flow within LHSC's clinical programs. By increasing the number of Alternate Level of Care (ALC) beds and cohorting patients together, clinical teams can care for patients in the right place at the right time.

Equity and Indigenous Health

Communities in southwestern Ontario are rapidly expanding and changing. London is the fastest growing city in the province and one of the fastest growing cities in the country.



LHSC's Office of Inclusion and Social Accountability's mandate is to improve health outcomes and care experiences for patients of equity-denied communities by identifying and addressing systemic barriers within the health care system. The Office's education and consultation services are instrumental in supporting hospital leaders, physicians, and staff to build their capacity in providing care that is responsive to the needs of the many, diverse communities we serve.

TEAM LHSC showing local love at the 2023 London Ontario Pride

Advancing health equity across LHSC starts with our fundamental commitments:

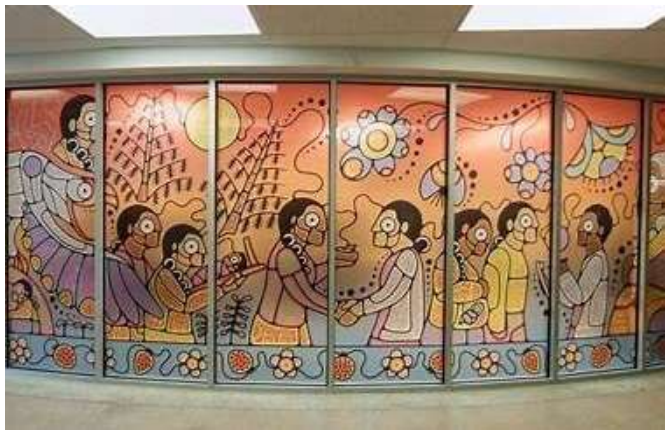
- We commit to creating an inclusive and safe environment for patients, caregivers, community, and staff by dismantling systems of oppression, discrimination, racism, and bias.
- We commit to seeking out, listening to, and working with individuals and system partners to create equitable access and experiences of care that address the social determinants of health.
- We commit to truth and reconciliation and the cocreation of health solutions that include Indigenous ways of knowing and healing.
- We commit to truth and reconciliation and the cocreation of health solutions that include Indigenous ways of knowing and healing. This will include community and patient led initiatives to advance Indigenous health strategies and improve outcomes in alignment with First Nation, Inuit, Metis and Urban Indigenous communities (FNIMU) systems of health and healing.

In the past year, LHSC introduced and started working towards these commitments through the Office of Inclusion and Social Accountability. Under the Office, the Indigenous Health stream has enabled the organization to apply a strategic focus on identifying and removing barriers to equitable and inclusive healthcare, while establishing relationships with the Indigenous communities we serve built on trust, commitment and accountability. Below are some of the key initiatives that have been implemented to date:

- **Indigenous Voices Matter**. At the Indigenous Voices Matter event, held in July 2023, LHSC staff members, including several executives, were on hand to facilitate break-out discussions and listen as attendees often shared emotional stories. Approximately 140 First Nations, Inuit, and Métis community members from across Southwestern Ontario were present to share their experiences and express their thoughts on how LHSC can make services more welcoming to and respectful of Indigenous Peoples. Attendees included patients, families, care partners, health staff from local and regional health centers, First Nation Chiefs, leadership from Indigenous health and social organizations, Elders, youth, Métis leaders, and residential school survivors. The event was the first of its kind in the region and has built the momentum for future engagements and continued relationship building which informed our five-year strategy for LHSC. Team LHSC, leaders, and executives have been working on recommendations from this engagement session and will report back to the First Nations, Inuit, and Métis communities in 2024.

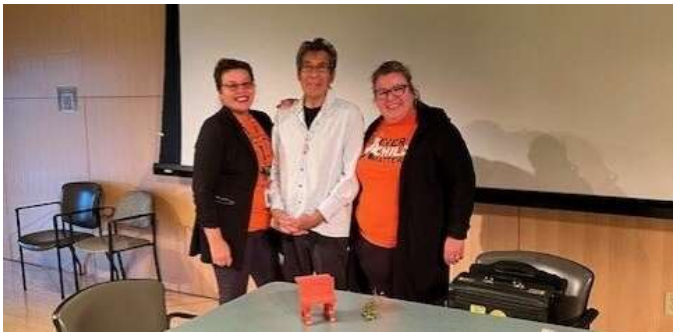
Indigenous Voices Matter event – July 2023

- **Elder Services within the Healing Space**. The Elder program was created to incorporate Indigenous ways of knowing and healing into the westernized model of care. This service supports staff, providers, patients, and families with mental, emotional, spiritual, and physical support and is a direct response to the Truth and Reconciliation Call to Action #22: “We call upon those who can effect change within the Canadian healthcare system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders.” Over 200 LHSC patients, families and staff have utilized this program since October 2022.



LHSC Healing Space

- **Indian Residential School Survivor Talk** with Geronimo Henry. An all-staff education event was made available to all staff in recognition of the National Day for Truth and Reconciliation, honoring those who survived the Indian Residential School system. Approximately 150 staff attended this educational event, where Geronimo shared his experience at the Mohawk Indian Residential School in Brantford, Ontario.



Geronimo Henry and team members from LHSC's Office of Inclusion and Social Accountability

- **Partnering to prevent amputation**. LHSC is collaborating with Atlohsa Family Healing Services, Middlesex London Ontario Health Team (MLOHT), and St. Joseph's Health Care London to address the concerning rates of diabetes-related lower limb complications among Canada's Indigenous populations and a notably higher frequency of lower extremity amputations. Based at Atlohsa's Wiigiwaaminaan Shelter at St. Joseph's Health Care London's Parkwood Institute and operating in multiple locations across Ontario, the program offers a culturally safe environment for Indigenous Peoples.

Addition of the Black Health stream to the Office of Inclusion and Social Accountability. As the first hospital in Ontario to create a health stream dedicated to Black Health, LHSC is in the unique position to collaboratively improve care experiences and health outcomes for Black individuals. Established in May 2023, this initiative aligns with Ontario Health's Equity Diversity Inclusion and Anti-Racism Framework as well as The Black Health Plan for Ontario. This focused stream underscores LHSC's fundamental commitment to addressing the disparities and inequities that persist among Black communities, impacting their health outcomes. To date our Black Health stream has engaged many health and social service system partners and initiated a Black Health Navigator pilot initiative to support patients and families with access and transitions of care that are culturally sensitive and responsive.

The addition of a Black Health stream to the Office of Inclusion and Social Accountability occurred in May 2023

Partnering to reduce harm. LHSC has partnered with London Intercommunity Health Centre on a project focused on harm reduction, trauma and violence informed care and cultural safety. This project, funded through the Public Health Agency of Canada, focuses on improving access to health care services for individuals experiencing homelessness, substance use and/or poverty. The project will inform the development of an organizational Harm Reduction Strategy.

Patient/client/resident experience

London Health Sciences Centre believes in and encourages a partnership between patients and their health care providers. We are all responsible for adopting a people-centred care approach and acting to ensure patients and care partners are active participants in their healthcare. To that end, gathering the perspectives of patients, youth, families, and caregivers in a partnered way is crucial in ensuring LHSC's Quality Improvement Plan represents what matters most. Over the past year, we have continued our journey in partnership and

focused on strengthening our commitments to patients, families, and caregivers through the implementation of the following:

- Successful re-launch of the Patient Experience Surveys for adult and pediatric inpatient, outpatient, emergency, day surgery, and neo-natal intensive care unit on September 18, 2023. Since implementation, we have increased our response rate upwards of 42%, with over 21,000 surveys completed;
- Launching of the People-Centred Care Video which was co-designed with patient and family partners;
- Creating a role of the Patient Experience Quality Consultant to address internal quality assurance and quality improvement from patient concerns, and;
- Collaboration with Patients and Caregivers on the development of the Quality Improvement Plan through the Patient Partner meetings, and Child and Youth Advisory meetings.

Patient Feedback and Engagement. LHSC is committed to hearing from patients, families, caregivers, youth and children to ensure care experiences are positive and focused on the needs of the individual and their circle of care. There are many ways to capture feedback from very formal methods like surveys, committees, focus groups, to informal ways including one-on-one conversations with providers. At LHSC we leverage both formal and informal to obtain valuable feedback from patients and families.

Patient Partners participated in Accreditation Readiness by evaluating the processes seen in clinical units against the standards

How feedback is actioned. Patient and care partner feedback is instrumental in guiding the work we do. Valuable feedback is highlighted within our balanced scorecard, reports to the Board of Directors and various committees across LHSC. There is an expectation of meeting targets, following up on key concerns through facilitated resolution and involving patients and families where possible and desired.

Ongoing education across LHSC to ensure patients and providers are aware of the Patient's Rights and Responsibilities

As we move into the next fiscal year, we are excited to leverage our new survey tool to gather the perspectives of patients, families, and caregivers in real-time. This new chapter will allow for leaders and Patient Partners to better inform quality improvement work across the organization and help incorporate true integration of best practices into all LHSC activities from the bedside to the boardroom.

Provider experience

LHSC continues to place staff wellness and provider experience as a focal point for our organizational priorities. Our new strategic plan is overt in capturing 'Team LHSC' as a priority to guide us through the next three years, creating a resilient, engaged, and joyful workforce. As we plan our activities over the next five years, we will build upon our successful historical endeavors, such as the multi-year **LHSC Wellness and Mental Health Action Plan**, which focused on providing leadership support, peer support, and self-management strategies to all staff.

A workplace of choice. As part of the Strategic Priority, ensuring wellness among staff is of paramount importance. One of the ways we have demonstrated our commitment to staff wellness is through the provision of enhanced mental health benefits coverage to all staff. As of January 2024, all full-time union and non-union staff, spouses and dependents can receive unlimited mental health benefit coverage. This expansion of coverage is an opportunity for the organization to recognize the work and home challenges facing many staff members and provide support for staff mental health wellness. LHSC is a leader among health care organizations by offering employees unlimited mental health benefits.

Redesigning our workforce: Health Disciplines Transformation. Further supporting the provider's experience, we are evaluating perceptions of health discipline providers with respect to their priorities to identify key opportunities for improvement including compensation, staffing levels and workload, role scope, and research and education. This work will be pivotal in ensuring the successful corporate initiative underway '**redesigning**

care' that will build on interprofessional teams and integrate best practices to allow staff to work to their full scope.

A **research and student placement enhancement plan** are also in development. The goal of this work is collectively to move to a learning model that meets the needs of our team members and allows for a 70/15/15 model of development. This model focuses 70 per cent on regular work, 15 per cent on formal education, and 15 per cent on research for learning and development of team members.

LHSC Teaching Award recipient for driving LHSC's education mandate forward and creating exceptional learning experiences – September 2023

Safety

As part of LHSC's Strategic Priority to Advance Excellence, we are making commitments to ensure learning is embedded throughout all points in the patient's journey. To achieve this priority, LHSC has adopted a continuous improvement of care model to help empower staff and physicians to solve problems. This model allows for the sharing of learnings and enables the organization to build on successes.

Patient Safety Plan. We continue with the implementation of our 2022-2026 Patient Safety Plan, which is founded on the idea that a shift from being reactive to being proactive is imperative to improving patient safety culture. Most important to building a proactive culture of patient safety is the idea that by learning from patient safety incidents the organization can build a safer future for patients.

Recognizing Champions in Patient Safety. LHSC recognized members of Team LHSC who have demonstrated a passion for and commitment to improving patient safety at the annual Patient Safety Champion awards. The awards in 2023 spanned across the themes of perioperative care, falls, remote monitoring of patients, access, and patient partner involvement.

LHSC Award Recipients for the 2023 Patient Safety Champions Awards – November 2023

Creating a culture of patient safety including a psychologically safe workplace. LHSC strives towards empowering our people utilizing the Just Culture framework. In a Just Culture organization, staff and providers are treated with respect and feel supported when things go wrong or almost go wrong. Since 2019, more than 500 leaders and staff at LHSC completed Just Culture training. This helps us to respond to safety incidents and improve psychological safety in the workplace consistently and fairly. Additionally, LHSC is working with Healthcare Excellence Canada to formally introduce the National Standard for Psychological Health and Safety in the Workplace across the organization that will continue create safe spaces to discuss safety concerns amongst staff.

Population Health Approach

LHSC is transforming the health-care system to better coordinate care for the populations we serve. Our current projects leverage collaboration to engage staff, physicians, patients, and care partners in redesigning care pathways to better meet their needs. In the past year, LHSC has been an active partner with the Middlesex London Ontario Health Team to develop integrated care pathways, fully co-designed with patients and care partners, in congestive heart failure and lower limb preservation to improve the way that LHSC staff work with partners across the health-care system.

Community partnerships. Through the Health and Homelessness Whole of Community System Response, LHSC has developed internal and external partnerships to operate as a single system to support the entire population, with particular focus on marginalized communities. Within this initiative, we have taken the lead to ensure that barriers are strategically addressed to serve the community in areas that need support.

Digital Population Strategy. LHSC has been working on a project funded through Ontario Health to create digital population registry and care records that can be used by multiple provincial health partners. Within this project, we have developed the Ontario Health Team Coalition for Population Health Management, which brings together key health leaders from across the province to help develop parameters for a Population Health Management Information System.

Executive Compensation

The Excellent Care for All Act (ECFAA) requires that the compensation of the CEO and executives reporting to the CEO be linked to the achievement of performance improvement targets laid out in your Quality Improvement Plan. The purpose of performance-based compensation related to The Excellent Care for All Act is to drive leadership alignment, accountability, and transparency in the delivery of Quality Improvement Plan objectives. The Excellent Care for All Act mandates that hospital Quality Improvement Plan's include information about how executive compensation is linked to achievement of Quality Improvement Plan targets. The proposed compensation plan for the 2024-2025 Quality Improvement Plan is for all five indicators selected to be part of the performance compensation and equally weighted.

The proposed compensation plan for the Quality Improvement Plan is for 5% of the President and CEO's annual salary to be directly based on the organization's ability to meet or exceed the target as outlined for the five compensation-based indicators. Each indicator will be weighted equally, with 'pay-out' only occurring if the target is achieved. There is no performance corridor of achievement or scaled approach to compensation. If the target is not met, the percentage allocated to the indicator as part of 'pay at risk' payment will not be paid. For the remaining executive staff, 3% of their annual salary will be at risk with the same method applied for 'pay at risk'. Outlined below are the indicators linked to executive compensation, the target that must be achieved and the percentage of 'pay at risk' allocated to each indicator. Compensation, as it relates to the 5 listed indicators will be awarded as follows:

Board and Executive Training on Equity, Diversity and Inclusion

- Less than 100% of executives complete the training = No award (CEO 0%, Executive Staff 0%)
- 100% of executives complete training = Full award (CEO 1%, Executive Staff 0.6%)

Discharge Summaries within 48 Hours

- Greater than or equal to 80% = Full award (CEO 1%, Executive Staff 0.6%)
- Less than 80% = No award (CEO 0%, Executive Staff 0%)

Length of Emergency Department Wait for Bed at 90th Percentile

- Greater than 23 hours = No award (CEO 0%, Executive Staff 0%)
- Less than or equal to 23 hours = Full award (CEO 1%, Executive Staff 0.6%)

Patient Experience Survey 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?

- Greater than or equal to 65% = Full award (CEO 1%, Executive Staff 0.6%)
- Less than 65% = No award (CEO 0%, Executive Staff 0.6%

Patient Safety Culture Survey 'Overall Rating Score'

- Greater than or equal to 64% = Full award (CEO 1%, Executive Staff 0.6%)
- Less than 64% = No award (CEO 0%, Executive Staff 0.6%

Contact Information/Designated Lead

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Sign-off

I have reviewed and approved our organization's Quality Improvement Plan

Matthew Wilson, Board Chair _____ (signature)
Stephen Smith, Board Quality Committee Chair _____ (signature)
Dr. Kevin Chan, Acting President & Chief Executive Officer _____ (signature)

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

Appendix C - Quality Improvement Plan 2023/24 Progress Report

Excellent Care for All Act

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Ontario Health (OH) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

Ontario Health provided the following guidance on the development of the progress report: Realizing that the Quality Improvement Plan is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Some Questions to Consider for the "Lessons Learned" column are: What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Discharge summary sent within 48 hours of discharge	63.8% Q3 FY 2022/23	80%	68.9% Q3 FY 2023/24	Target Not Met to Date
Change Ideas from the 2023/24 Quality Improvement Plan	**Was this change idea implemented as intended? (Y/N)** **Lessons Learned:**			
Utilization of technology to improve consistency of discharge summary quality (completeness and accuracy) **Method:**	**YES ~ This change idea was implemented and there is continued progress.** 1. Email reminders for completion were sent ahead of the 48-hour mark 2. One Chart enhancements in Cerner continue			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
• Enable use with various departments via Plan-Do-Study-Act (PDSA) cycles – example high volume programs/divisions • Facilitate integration of technology (only if made available) into discharge summary process of care **Process Measure and Target:** • New tool development (Yes/No) and number – Completed	3. Health Information Management advanced their audit and correction process to identify prolonged in-progress discharge summaries that are not correctly forwarding to consultants for signature by trainees			
Integration into competency-based education **Method:** Build quality-based criteria for discharge summary and incorporate into core trainee competency of physicians to reduce time to review discharge notes prior to signing **Process Measure and Target:** • Criteria development – Completed • Champion list of those leaders or areas lessons learned have been shared with/spread to - Completed	**NO ~ This change idea was not implemented** Medicine worked with two residents to brainstorm how to adjust the criteria to improve discharge summary documentation quality and resident's education, and had a few meetings with the Competency Based Medical Education (CBME) and Medicine senior leadership. However, it does not seem feasible to adjust the Entrustable Professional Activities (EPA) criteria and there is no consensus among Medicine consultants. Therefore, we did not pursue further with this change idea. **Lessons Learned:** Getting the details of the summary right is challenging due to patient complexity. Conversations with residents need to ensure accuracy on key tests, treatment, and plans for follow-up.			
Coordinate distribution or systems challenges **Method:**	**YES ~ This change idea was implemented and there is continued progress.** Three system changes occurred to make timely discharge summary authentication easier:			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Standardize methods of discharge summary creation and distribution to reduce variation in process and data capture **Process Measure and Target:** Development/creation of summary document Variation rates - Completed				1. Transcription service release notes with blanks to consultants on the same day 2. Email reminders for completion were sent ahead of the 48-hour mark 3. Health Information Management advanced their audit and correction process to identify prolonged in-progress discharge summaries that are not correctly forwarding to consultants for signature by trainees.
Identify high volume/quantity users and low performers **Method:** Target improvement strategies and spread to those high-volume areas in greatest need of improvement **Process Measure and Target:** Champion list of those leaders or areas lessons learned have been shared with/spread to – Completed				**YES ~ This change idea was implemented and there is continued progress.** The Orthopaedic Surgery Quality Committee has successfully met LHSC's corporate target, with the department completing discharge summaries within 48 hours (about two days), for a high of 83 per cent of the time in FY 2023/24 Q1 and most recently 77.7% in FY 2023/24 Q3. Orthopaedic Surgery adopted previously developed solutions by peer departments, Medicine and Otolaryngology, and tailored them to their practice patterns and workflow. Orthopedic surgery is a very high-volume service and had a real opportunity for improvement. Medicine started the improvement initiative with Medicine Clinical Teaching Units (CTU) in July 2022. Following interviews with some low performers, two change ideas were implemented: 1. Weekly performance metrics to Department Heads so that they can track and address the issue with low performers when they were on call. There are three Plan Do Study Act (PDSA) cycles as we revised the data metrics based on consultants' feedback, and in the last Plan Do Study Act (PDSA) cycle an enhanced audit and feedback approach were used for persistent outlier consultants 2. Share strategies from high performers

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
	By the end of June 2023, 76% of discharge summaries from all six Clinical Teaching Unit (CTU) teams met the 48-hour target (improved from 62% in FY2021/2022) and the average hours from patient discharge to discharge summary sign-off was reduced from 53 to 38 hours.			
Enhancing data availability and information sharing. Use the data to provide information that will assist in improved outcomes **Method:** Continue to increase visibility and understandability of the data (better graphs and trending), expand use of storytelling, using the data to inform change **Process Measure and target:** LHSC Intranet stories, presentations at department or quality council meetings, or published journal articles – Baseline collection year	**YES ~ This change idea was implemented and there is continued progress.** Lessons learnt from Medicine Clinical Teaching Unit: remain flexible to revise reporting metrics to address stakeholders (consultants) feedback. We expanded reporting metrics from a dichotomous value to median and average signing speed, proportion of editing notes, and raised the reduction in variation in teams and in individual consultant's performance. Research was conducted and presented at the Centre for Quality Improvement and Patient Safety (cquips.ca) 2023 Symposium. The title of the poster was: Improving discharge summary timeliness in medicine clinical teaching units in an academic tertiary care medical center. The aim was to improve discharge summary distribution from Medicine Clinical Teaching Unit (CTU) within 48 hours from 62% to 75% in one year by June 2023. This was achieved. The following Plan Do Study Act (PDSA) cycles occurred: 1. Physician accountability through audit & feedback 2. Hospital system change for reporting 3. Trainee education Keys for success: 1. Iterative data analysis informs actionable insight 2. Cross team collaboration including hospital leadership facilitates changes Orthopaedic Surgery adopted previously developed solutions by peer departments, Medicine and Otolaryngology, and tailored them to their practice patterns and workflow. Key enabling factor was the timely data from			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
	Decision Support and buy-in from the Orthopaedic Department's leadership and consultant physicians. The primary changes included achieving uptake of the auto-authenticate feature in Cerner, education to team members of the importance of timely discharge summary completion, stakeholder engagement including involving residents in the process, and an audit and feedback system to highlight strong and weak performances. By combining mentorship, data analysis, and engagement of physicians and residents, the Orthopaedic Department was able to significantly increase their percent of discharge summaries shared timely.			
Implement Sustainability Plan **Method:** Continue to increase visibility and understandability of the data (better graphs and trending), expand use of storytelling, using the data to inform change **Process Measure and target:** LHSC Intranet stories, presentations at department or quality council meetings, or published journal articles – Baseline collection year	**YES ~ This change idea was implemented and there is continued progress**. For Medicine Clinical Teaching Units, during the sustainability phase, we only provided a short summary of teams' performance through emails to Department Heads. Given the high patient volume, approximately 900 patients will benefit from this improvement annually.			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Number of workplace violence incidents reported by hospital workers (as defined by Occupational Health and Safety Act) within a 12-month period. (Count; Worker; January - December 2021; Local data collection)	731 Q3 FY 2022/23	1024 Annual Cumulative	619 Q3 FY 2023/24	Meeting Target 
Change Ideas from the 2023/24 Quality Improvement Plan	**Was this change idea implemented as intended? (Y/N)** **Lessons Learned:**			
Re-establish violence prevention sub-committee of Joint Health and Safety Committee **Method:** Form committee with representation from areas with high incidents of violence. Set clear terms of reference to examine trends, perform root cause analysis, make recommendations for mitigating strategies. Focus of committee should be on incidents that meet the definition of violence under the Ontario Health and Safety Act. Consider extending membership to include key	**YES ~ This change idea was implemented and there is continued progress.** Reporting has been challenging due to possible underreporting from some areas. It is believed that incidents of violence in the Emergency Department may be under-reported. In other areas reporting has been complicated by frequent reporting of minor incidents that may be an unavoidable consequence of care related to some diagnoses. Current practice is to consider any incident in which a patient touches a staff member with resistance as a level 2 incident of violence. Frequent reporting of these incidents may distract from more serious events.			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
stakeholders who may not be members of Joint Health and Safety Committee (security leadership, mental health leadership, Emergency Department leadership) **Process measure and Target:** Quarterly reports from committee summarizing observations and recommendations - Completed	The violence prevention subcommittee was formed with representation from Safety, Professional Practice, Security and from the Emergency department in addition to representation from throughout the hospital. To date the formation of this subcommittee has not produced any tangible outcomes that have impacted the Quality Improvement Plan metric. The formation of the subcommittee has allowed for more in-depth conversation regarding incidents of violence however the committee has not found a focus for discussion that relates specifically to prevention. Sub committee discussions thus far have been productive in reviewing incidents that have occurred but there have not been recommendations for change. No reporting has emerged from the subcommittee meetings.			
Increase involvement of primary clinical department stakeholders in violence prevention **Method:** Utilize existing reporting which reflects the incidents of violence at a departmental level. Increase reporting frequency to monthly basis in order to increase the timeliness of interventions. **Process measures and Target:** Completion of steps: • Establish monthly report	**YES ~ This change idea was implemented and there is continued progress.** Work has been done at a pilot level with one mental health department within the hospital. There have been efforts to analyze the root cause of incidents and strategies have been put in place to reduce the impact and the frequency of violent incidents. Regular reporting and wider implementation of this change idea have not been established. Moving forward efforts need to be data driven.			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
• Identify top 3 departments based on previous year data • Implement minimum one initiative by end of the first quarter of fiscal year 23/24 • Monitor incidents monthly to audit effectiveness of intervention *All completed	**Lessons Learned:** Evaluation within the safety department has found that this change idea is valuable and should be pursued to a greater extent. Future efforts should be established to ensure data driven efforts and wider communication.			
Establish multidisciplinary teams to review care plans with respect to violence **Method:** Partner with clinical leadership in high incidence areas to establish method to quickly identify individual inpatients with high likelihood of escalated behavior and violent reactions. Build on existing patient flagging tools to identify inpatients who require care plan review beyond flagging. **Process measures and Target:** Completion of steps: • Establish minimum one multidisciplinary team by end of the second quarter of fiscal year 2023/24 • Baseline data collection on care plans developed	**YES ~ This change idea was implemented and there is continued progress.** This has been established on some units. Effectiveness has not been evaluated. Although there have been multidisciplinary efforts to evaluate care plans the outcome of this work has not been linked to data or reporting for Quality Improvement Plan purposes. **Lessons Learned:** More rigorous implementation and evaluation of efforts related to this change idea would require greater coordination with clinical leaders.			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Engage professional practice as key stakeholder in violence prevention **Method:** Partner with professional practice and subject matter experts to assist with literature review and perform gap analysis between current best practice and existing models of care with respect to violence prevention. Review aspects of existing care plans that could be enhanced or modified to reduce violence. **Process measure and Target:** Gap analysis complete by end of the third quarter of fiscal year 2023/24 – Complete	**No ~ this change idea was not implemented.** Although work may have been done which would support this change idea it was not linked directly to the Quality Improvement Plan. Further conversation is required with professional practice in order to determine the value of this change idea.			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
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	28.1 hours Q3 FY 2022/23	24 hours	25.5 hours Q3 FY 2023/23	Approaching Target 

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Change Ideas from the 2023/24 Quality Improvement Plan	**Was this change idea implemented as intended? (Y/N)** **Lessons Learned:**			

Capacity creation and accountability mechanisms for patient pull and centralizing core bed functions
Methods:
• Creating Alternate Level of Care (ALC) cohort units
• Establishing Partnerships with community housing
• Updating repatriation agreements with hospital partners
• Building Emergency Department decant units
• Implementing the new LHSC Access and Flow Toolkit
  ○ The Toolkit includes Standard Operations Procedures (SOPs) for patient transfers - Internal Admissions and Discharge Procedure, which outlines the responsibilities, patient transfer guidelines, and bed assignment guidelines for internal patient admissions and transfers.
	YES ~ This change idea was partially implemented and there is continued progress.
	
	Progress to date (April – November):
	• Creation of 77 Alternate Level of Care spaces (ALC) in Transitional Care Units in partnership with 4 local retirement homes
	• Creation of 25 units in partnership with London Cares to house vulnerable members of the community facing chronic homelessness
	• Creation of an Admission Support Team (AST) to support the pull of admitted patients from the Emergency Department up to their inpatient bed by supporting the floors with discharges of assigned beds or with the admission of the patient from Emergency Department.
	• Implementation of an Emergency Department Push/Pull strategy to support Emergency Medical Services offload and movement of admitted patients up to their inpatient bed
	  ○ Patients admitted in the Emergency Department are moved to an inpatient unit within 30 mins of their bed assignment
	  ○ This strategy is driving our access to inpatient care metrics in a positive direction: November 2023 90th Percentile, time to inpatient bed is 22.1hrs, representing a 30% improvement from August 2023 values
	• The LHSC Access and Flow Toolkit was a F22/23 initiative that is now complete. Work around Anticipated Date of Discharge (ADD) and Discharge Smoothing has continued with the goal of having Anticipated Date of Discharge entered within 24hrs of admission to an inpatient unit to support proactive patient discharge readiness
	
	Lessons Learned:			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
○ The toolkit was developed using a working group comprised of clinical leaders from a variety of clinical areas. ○ This will see standardization of access and flow practices to improve patient transfer times e.g. Emergency Department Time to Inpatient Bed. ○ Weekly Working group sessions with programs in the early stages of implementation. Each clinical area has identified physician(s) and clinical staff to: support their clinical teams roll-out and implementation; provide assistance and expertise to develop a team-specific implementation plan with their clinical area; and attend meetings to discuss and plan roll out activities for their area.				• The creation of our Capacity Manager team coupled with the launch of Standardized Views and Permissions in our Capacity Management (bed board) application has enabled the centralization of bed assignment and data-driven accountabilities for bed planning • Working together with Home and Community Care Support Services (HCCSS) a total of 92 patients have been supported in our Transitional Care Units (August to November 2023). By keeping open communication and dialogue with our Home and Community Care Support Services partners we have improved processes to ease the transition of these patients from LHSC to their Transitional Care Units destination and then onto their final Long-Term Care home of choice. ○ Completion of Long-Term care application in Transitional Care Units where required ○ Referrals to Home and Community Care a minimum of 24hrs in advance of discharge ○ Earlier assessment for mobility aids • Continued bi-weekly touchpoints between LHSC Access and Flow and Home and Community Care • High Ambulance Offload delays impact patient care and result in Code Zero events in the city of London ○ Since the beginning of November, the percentage of ambulances that were able to offload in one hour or less has increased from 75% to 95-100%. ○ Time to Inpatient Bed has been trending in a positive direction since the beginning of November, decreasing from 22 hours on November 1st to 6 hours on November 20th. ○ We are currently reviewing hallway “MOCK” bed locations and criteria for transfer • Our Admission Support Team was originally one team per site, 1000 to 1800. A second 2000 to 0400 shift has been added at each site to continue to support movement of patients to inpatient units

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Process Measures and Targets: • Alternate Level of Care Rate – 5.9% • Anticipated Date of Discharge Recorded – Baseline data collection				
Real time Occupancy Dashboard in Capacity Management to enable real time interventions **Method:** • Implement with clinical Directors • Implement with Managers **Process Measures:** • 90th percentile Emergency Department Length of Stay for Non-admitted High Acuity patients – 7.7 hours • 90th percentile Emergency Department Length of Stay for Non-admitted Low Acuity patients – 5.8hours	**YES ~ This change idea was implemented and there is continued progress.** **Progress to date:** • Roll out of real time occupancy dashboard corporate wide complete (Fall, 2022) and ongoing iterations completed in Q2 (bed status updated for additional access and flow details) • Implementation of Capacity Management Standardized Permissions and Views is underway and expected to be completed by Dec 18, 2023 • A full review and reclassification of all beds build in our system is complete • A second Gemba Walk to confirm all physical and unconventional bed spaces will be completed in early 2024 **Lessons Learned:** • Informational Technology Services (ITS) work to support this initiative has also enabled validation of LHSC's closed beds 'status' to improve line of sight and clarity around how our bed map is presented in the Capacity Management Application			
Development and implementation of the 2023/24 Pay-for-Results (P4R) Action Plan **Method:** Development and implementation of the 2023/24 Pay-for-Results (P4R)	**YES ~ This change idea was implemented and there is continued progress.** **Progress:** • 19 Pay for Results (P4R) initiatives are underway and are on track to be completed by March 31, 2024			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Action Plan will be data driven utilizing driver diagrams **Process Measure and Target:** • Completion of the 2023/24 Pay-for-Results (P4R) Action Plan – Completed	• Team was able to pivot on a few Pay for Results initiatives to implement two key Access and Flow initiatives to support time to inpatient bed: ○ Admission Support team: team of Registered Practical Nurse (RPN) and Personal Support Worker (PSW) at each site and additional Portering and housekeeping staff to support expedited movements of admitted patients on inpatient units ○ Emergency Department Push/pull strategy: defining methodology, thresholds and accountability for bed assignments and movement of admitted patients **Lessons Learned:** • The data driven approach coupled with a formal action plan and project oversight has enabled 18 net-new initiatives to be supported with Pay for Results (P4R) funding this year. LHSC team members have looked for innovative ways to support emergency department flow			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Surgical Wait 2 – Priority 3 and 4 closed cases within target	61.5% Q3 FY 2022/23	71.0%	71.0% Q3 FY 2023/24	Meeting Target 
Change Ideas from the 2023/24 Quality Improvement Plan	**Was this change idea implemented as intended? (Y/N)**			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
	Lessons Learned:			
Block Allocation and Operating Room Grid Optimization **Method:** • Develop framework for ensuring patient wait times and grid allocation are appropriate by service • Review same day admission booking practices to ensure surgical capacity • Optimize operating room booking process LHSC wide as well as operating room grids • Review, revise LHSC wide booking policies and accountability framework • Work with surgical teams to ensure 2-week bookings for scheduled cases (to best of ability) • Development and testing of Occupancy tool with Ivey Business to support surgical booking process **Process Measure and Target:** • Complete current state analysis to support Grid Optimization – Completed	**YES ~ This change idea was implemented and there is continued progress.** Rigorous monitoring of Operating Room (OR) utilization prompted the realignment of service grid hours to facilitate the creation of additional incremental Operating Room blocks that were reallocated to prioritized regional services line. This resulted in a notable reduction in the number of over-target oncology cases at LHSC. Specific guidelines were established for incremental blocks, ensuring that only the longest-waiting and over-target oncology patients were considered for booking. Executive engagement and oversight of this initiative led to increased compliance with waitlist targets. An analysis of historic occupancy as well as the probability that surgeries will result in a same-day admit vs a one-day care was also completed. Based on these results, surgical services were provided with 'caps' on same-day admit surgeries to ensure that LHSC could continue to complete surgeries as well as ensuring occupancy available for patients incoming from other means (via the Emergency Department, regional transfers, etc.). Policies were also introduced to ensure that surgeons were scheduling patients for surgery at least two weeks in advance so that internal teams could do occupancy reviews to ensure that surgical services were staying within their assigned same-day admit caps. This data, paired with the occupancy tool developed in collaboration with the Ivey Business School, allows us to calculate our rolling forecasted occupancy so we can identify were we might need to make more of a concerted push to discharge or repatriate patients or defer non-urgent regional transfers to avoid the cancellations of surgeries.			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
				Onboarding as one of 7 “early adopter” hospitals within the provincial Surgical Efficiency Target Program (SETP) initiative expected to result in more streamlined booking process as well as efficiency gains within LHSC Operating Rooms. Developing an up-to-date, relevant, and comprehensive LHSC-wide policy presents challenges due to operational variations across three distinct sites. Engaging a large group of stakeholders is essential to ensure policies accurately reflect the procedural needs at each site. **Lessons Learned:** It is important to include language that aligns with provincial Surgical Efficiency Target Program key performance indicators and Wait Time Information System (WTIS) guidelines. Given the intricate nature of the process, an annual review is necessary to ensure the policy aligns with hospital priorities. Consolidating all Operating Room policies into a single document enhances efficiency, accessibility and alignment with provincial Operating Room measures/metrics.
Bed Map Optimization **Method:** • Develop current state bed map to support surgical volumes • Determine bed map optimization strategies • Draft, validate, reconcile funding for surgical beds				**YES ~ This change idea was implemented and there is continued progress.** A current state bed map was developed to ensure line of sight to all beds and bed types within both LHSC hospital sites. An analysis was completed to ensure we have optimized the allocation of the beds we have available to the appropriate services most in need of beds. A future state bed map has been identified and implementation of the future state is

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
• Initiation of bed flow analysis/simulation with Ivey Business **Process Measure and Target:** Completion of the current state grid optimization – Completed	underway. Lead times on equipment to operationalize new beds continue to be a challenge. Bed funding reconciliation exercises have been completed for the past six fiscal years as well as forecasted bed funding reconciliation status once the future state bed map is implemented.			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Time to Physician Initial Assessment 90th Percentile* Adult only	6.5 hours Q3 FY 2022/23	6.0 hours	7.4 hours Q3 FY 2023/24	Target Not Met to Date 
Change Ideas from the 2023/24 Quality Improvement Plan	**Was this change idea implemented as intended? (Y/N)** **Lessons Learned:**			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Development and implementation of the 2023/24 Pay-for-Results (P4R) Action Plan **Method:** • Length of Emergency Department Wait for Bed at 90th percentile strategies as detailed above • Development of a data driven action plan for 2023/24 Pay-for-Results (P4R) **Process Measure and Target:** • *Metrics that will be on the Emergency Department Dashboard such as Emergency Department census, average new visits per hour, and Emergency Department return visits • Balancing Measure – Number of Patients	**YES ~ This change idea was implemented and there is continued progress.** Pay-4-Results Action Plan implemented and monitored by Office of Capacity Management (OCM). Q2 data remains above target. Interventions implemented end of Q2 beginning of Q3 have shown positive trends. 1. Corporate bed placement strategy 2. Reassessment nurse 3. Intermediate Zone/Ambulatory Care Unit (ACU) optimization 4. Direct to Consult conversations for appropriate Emergency Department diversion 5. Addition of Hallway stretchers in Emergency Department 6. Change to internal flow within the Emergency Department 7. Adjusting to a 1-tiered triage system A dashboard sharing results for the outcome measure and balancing measure, Left Without Being Seen, with leaders was successfully developed.			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Who Leave without Being Seen – Baseline collection year				
Secure staffing resources/health human resources **Method:** • We have and continue to hire to meet demand • New staff training **Process Measure and Target:** • Staff ratios – Resourced to meet demand/no vacancies • Staff vacancies – Resourced to meet demand/no vacancies	**YES ~ This change idea was implemented and there is continued progress.** Continue to hire and recruit. We meet with our recruitment team on a regular basis to strategize hiring practices, streamline onboarding and support staff at the elbow. Action staff feedback regarding education to maintain retention. A dashboard sharing both vacancy and turnover data results consistently with leaders was developed.			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
Were you involved as much as you wanted to be in decisions about your care and treatment? ***Patient Experience question**	64.4% Q4 FY 2021/22 (n-size 139/219)	65.0%	80.0% Q3 FY 2023/24 (percent of patients who responded "always" or top box to this survey question)	Meeting Target 

Change Ideas from the 2023/24 Quality Improvement Plan	Was this change idea implemented as intended? (Y/N) Lessons Learned:
Improved survey collection and dissemination process commencing **Method:** The Canadian Patient Experience of Care survey process at LHSC London Health Sciences Centre is undergoing innovative improvement which will: • Increase survey result data to be reflective of more programs and patient areas at the organization as survey distribution is planned to expand to more areas than the National Research Council (NRC) Ontario Hospital Association method from fiscal year 2017-2022 • Increase survey response rates, survey administration per the Ontario Hospital Association is to be via email and we are encouraged that this change will increase	**YES ~ This change idea was implemented and there is continued progress.** Surveys launched September 2023 and include adult and pediatric inpatient, outpatient, emergency, Neonatal Intensive Care Unit (NICU) and Day Surgery. Overall response rate is 41%. The patient experience strategic priority is "involved as much as you wanted to be in your care and treatment". The target performance is 65% with an overall response rate of 80%. Performance ranges from 55% to 87%. Patient and Family Partners were involved in the selection of this metric including Patient and Family Advisory Council members. As this was a baseline performance year, the tracer process was not implemented and is scheduled to be utilized in 2024/25. LHSC participated in the Canadian Institute for Healthcare Information (CIHI) Modernization pilot for the Canadian Patient Experience Survey and was the only Ontario hospital who participated. Surveys were distributed to patients discharged between April to June of 2023.

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
response rates and thus increase patient and family perspective sharing at LHSC, we will look into options for populations who do not have access to email • Increase timeliness to survey results on LHSC leader scorecards, more real time, relative to the National Research Council (NRC) Ontario Hospital Association method from fiscal year 2017-2022 that had a three month or more survey response delay • Innovate on survey questions/survey forms posed - LHSC has signed on to the Canadian Institute for Healthcare Information (CIHI) pilot to trial the short form survey question set and the new long form survey set. **Process Measures and Target:** • Survey Response rates – Baseline collection year • Number of programs surveying that ask this survey questions – Baseline collection year	Responses have been submitted to the Canadian Institute for Healthcare Information (CIHI) for analysis.			

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Patient and Family Partner teamwork **Method:** • Patient partner rounding with patients and families to dive deeper/root cause how we can help patients and families feel more involved. • Team with LHSC Patient and Family Partners on the LHSC Quality Improvement Plan to co-develop change ideas. Team sessions will be developed and a calendar set. **Process Measure and Target:** Number and frequency of patient partner discussions on this survey question - Baseline collection year	**YES ~ This change idea was implemented and there is continued progress.** Patient and Family Partners, in partnership with the Accreditation and Patient Engagement Team developed the Tracer program which included the strategic priority question: “involved as much as you wanted to be in your care and treatment". Six Patient and Family Partners were recruited and trained to lead the tracer events. The tracer events were conducted between June 28 and December 14, 2023. There were 57 patients interviewed: 44 from inpatient units and 13 from outpatient units. Responses were shared with the specific units through the Accreditation dashboard to help inform quality improvement initiatives. The tracer program will continue to be used as a tool to gather qualitative data from patients to understand barriers to being involved in their care as well as what contributes to feeling involved. Patient and Family Partners were involved in the development of the patient experience strategic priority metric. Additionally, members of Patient and Family Advisory Councils were consulted on the metric and supported the use of this metric with the caveat that each patient’s experience will be unique and what feels like being involved by one will not be the same for another.			
Children’s Hospital Shared Decision Making **Method:** • Provide education/training that builds the skills needed for shared decision making and fostering a culture that embeds patient and parent values and engagement in the decision process this will help to	**YES ~ This change idea was implemented and there is continued progress.** Through the lens of equity, diversity and inclusion we provided education and training that built the skills needed for Shared Decision Making and fostered a culture that imbedded patient and parent values, engagement in the decision process and helped to improve the parent’s knowledge about their children’s care options as well as increase participation in treatment decisions.			

Measure/Indicator from 2023/24	Performance as stated on Quality Improvement Plan 2022/23	Target as stated on Quality Improvement Plan 2022/23	Current Performance 2023	Comments
improve parent's knowledge about their children's care options as well as increase participation in treatment decisions • Promote informed decision-making among parents and caregivers, through various interventions/tools that have been developed, such as patient (parental) decision aids, and family-centered educational programs to increase parents' capacity to make informed decision • Provide a series of patient/caregiver focused education sessions to high risk groups on a regular basis, including post-session follow up support and communication to patients as needed **Process Measures and Target:** • Shared decision making among parents, children and health professionals – Completed • Patient (parental) decision aids – Completed • Education and information provision to parents - Completed/education provided	To promote informed decision-making among parents and caregivers, various interventions/tools have been developed. Factors that affected parent participation in decision-making included professional attitudes, culture about the involvement of parents, organizational attributes (e.g., availability of treatment options), specific features of the child's condition, and parental characteristics such as their personality, values, beliefs and prior knowledge and experience. Providing Shared Decision-Making education sessions proactively for patients/families who were at a high likelihood of having multiple and challenging health care decisions was anticipated to be a valuable intervention. Such sessions encouraged patients/families to explore, research and use all the Shared Decision-Making tools available to them along their health care journey. Rather than just involving decision aids or coaching at the time of a decision, providing proactive education takes a different approach to gaining the skills of how to come to a preferred decision with challenging health decisions and strengthen the family's problem - solving skills. The objective of the education sessions was to a) unpack the concept of Shared Decision Making, b) demonstrate the anatomy of Shared Decision-Making guided choices, c) introduce decision coaching and d) show examples of how Shared Decision Making helps in challenging decisions and decisions that are challenging. **Outcomes/learnings for Clinical Practice:** Greater attention to health literacy and socially-disadvantaged populations,			

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	Engage the families and caretakers in decision-making, Stop Information overload, Be proactive, Invest in unhurried and undistracted conversation (refer to Poster) **Education and Chat Session - Patient/Family Testimonials:** "I feel much more knowledgeable about what shared decision-making is and the role of a decision-making coach following this workshop." "I learned more about decision making for my son in 41 min than I have over the past 6 yrs." "The example with the tool was well done and I can see how that would be very useful to families." "Seeing how the decision tools work is the most beneficial way of learning the material"			