2024/25 Quality Improvement Plan
Improvement Targets and Initiatives

AIM		Measure						Change				
Priority Issue	**Quality Dimension**	**Measure / Indicator**	**Unit / Population**	**Current Performance**	**Target**	**Target Justification**	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Access and Flow	**Timely**	% Referrals Acknowledged within 14 Days: referrals acknowledged within 14 days / total # of referrals for onboarded clinics (excludes incomplete referrals)	# of referrals received in eligible clinics	Q3FYTD 93%	85%	**Maintain Previous Gains.** Target is based on the 14-day threshold established by the CPSO. Reliable referral intake and management remains an important and ongoing goal for 2024.25, with a focus on organizational spread. To date, implementation is complete for 19 clinics with 29 remaining. As the new referral management process is implemented in each clinic, it is captured in hospital-wide measurement. We anticipate workflow challenges in several large volume clinics scheduled for implementation this upcoming year and have set this year's target with this in mind.	Referral partners including UHN, Sinai Health System	1) **Process Redesign**. WCH will continue to spread its new referral management model that involves digitization, de-centralized management, and standardization. Additional clinics, many of which were not part of the centralized model, are slotted for the upcoming year	As clinics are onboarded, % referral acknowledgement is tracked via referral dashboard (in EPR) and organization-wide on the Quality Scorecard	# of clinics onboarded to the new referral management system	At least 10 additional clinics by March 31, 2025	
								2) **Electronic Monitoring**. A referral dashboard has been developed to allow clinical managers greater oversight and to drive local and system-wide improvement. This tool will enable managers to better understand their referral patterns in real time, as well as ensure that referral management practices are consistent.		# of onboarded clinics tracking performance via referral dashboard	At least 10 additional clinics tracking referral management by March 31, 2025	
	Effective	% Virtual Care Adoption: # of video or phone appointments / total appointments not requiring in-person intervention	# appointments not requiring in-person intervention	Q3FYTD 37%	40%	**Maintain Previous Gains.** The past year has focused on establishing a new baseline in light of recent funding changes for virtual care as well as learning about the unique impacts of virtual care in each area. Efforts moving forward will focus on optimizing the patient experience and establishing appropriate targets relative to each area, based on appropriateness and effectiveness. A target of 40% represents a modest improvement of 8% from current performance with an aim to maintain the gains previously achieved.	Epic	1) **Process Improvement.** The WCH Virtual team, in collaboration with clinical teams and patients, will work to optimize the patient experience of virtual care, including a focus on patient choice, expanding EPR functionality, and streamlining workflow. Decision support tools will be developed or refined to assist with identifying patient encounters suitable for virtual care and flagging patients who require in-person care.	Virtual Care Adoption rates are tracked at multiple venues including Senior Leadership Council, Digital Quality Committee and on the quarterly Quality Scorecard.	# improvements made to video visit workflow	At least 2 improvements/ refinements to hospital-wide video visit processes will be implemented by March 2025	
								2) **Electronic Monitoring.** We will continue to expand and refine our Virtual Visit Dashboard to allow for close monitoring at the hospital-wide and program levels, taking into account that the "right" amount of virtual care varies by patient population. Timely monitoring also allows for timely support in areas with virtual adoption rates lower than anticipated. Integrating virtual care adoption rates within regular program leadership conversations will be a key factor in determining the ultimate desired target for this indicator.		% area leaders using Virtual Visit Dashboard	75% of area leaders will use Virtual Visit Dashboard to drive performance monitoring and improvement activities in their areas by March 2025	

AIM		Measure						Change				
Priority Issue	**Quality Dimension**	**Measure / Indicator**	**Unit / Population**	**Current Performance**	**Target**	**Target Justification**	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Experience	**Patient-centred**	Patient Experience – Overall Care: # of top box responses (ratings of 9-10) for overall care / total # respondents	patients receiving patient experience survey	NA	CB	**Collecting Baseline.** New patient experience survey distribution process via email will be launched in 2024 using standardized instruments: Ontario Day Survey Experience and Ontario Outpatient Experience surveys. We will be collecting baseline (CB) data this year with an aim to establish a target for the next QIP cycle.	OHA	1) **Process Improvement.** The primary objective for 2024.25 is to successfully implement a new process for electronic patient experience surveys across the organization. In the spirit of PDSA, refinements and modifications to our approach will be made as we learn from our implementation efforts. This work is dependent on the implementation of a systematic process for the collection of email addresses and relevant consents in collaboration with the Virtual Care and clinical teams.	Hospital-wide results will be tracked quarterly via the Quality Scorecard. Area managers and directors will have access to their results in real-time via Qualtrics, which includes alert functionality.	# of clinical areas with patient experience surveys implemented	At least 3 areas will have implemented patient experience surveys via Qualtrics by March 2025	
										# of area leadership teams using the Qualtrics dashboard to drive improvement in their areas	At least 3 teams will be using the Qualtrics dashboard by March 2025	
Equity	**Equitable**	Patient Health Equity Survey Completion Rate*: % active patient completion of the "We Ask Because We Care" survey (includes partial and no consent responses)	active patients	Q3 2023.24 48%	60%	**Relative Improvement.** Collection of equity data is essential to address healthcare equity gaps and aligns with the Ontario Health mandate. WCH has a multi-year plan to achieve OH target of 75% completion rate. For 2024.25, a target of 60% has been established representing a 15% improvement over Q3 performance (which excludes Family Practice).	OH	1) **Process Improvement.** The associated processes for this new survey will be closely monitored to identify optimization opportunities. One area of focus related to patient interface is ensuring patients are presented with multiple ways to complete the survey without contributing to undue survey burden. We are also asking patients to anonymously share their reasons for electing not to complete the survey so that can analyze the results and apply the learnings to our approach on an iterative basis. Finally, all aspects of workflow will be monitored, including the sharing compliance rates with various teams so that they can address local concerns or issues.	Tracked quarterly on the hospital's Equity and Quality Scorecards which are reviewed by Senior Leadership Council, WCH Equity Committee, and by WCH Board of Directors.	Compliance rates at the team/ department level # actions taken based on feedback	This data will be shared regularly with teams by January 2025 A minimum of 2 improvements will be made based on patient and staff feedback by March 2025	
								2) **Education & Awareness.** In partnership with patients, clinical teams, and Strategic Communications, we have developed a comprehensive plan to promote the survey. Strategies include providing information relating to its purpose and importance via several communication channels. In addition, we have committed to multiple check-ins with various groups to address questions and concerns as they arise.		# Hospital-wide and patient facing communications about the survey	A minimum of 3 communications by March 2025	

AIM		Measure						Change				
Priority Issue	**Quality Dimension**	**Measure / Indicator**	**Unit / Population**	**Current Performance**	**Target**	**Target Justification**	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Safety	**Safe**	Medication Reconciliation: % of eligible patients who have had medication reconciliation completed	% / total # of patients eligible for MedRec	Q3FYTD 78%	80%	**Maintain Previous Gains.** The focus for 2024.25 is to maintain gains made in Surgery, make improvements in AACU and continue to spread to new clinical areas while developing a new organizational MedRec strategy. As MedRec is implemented in new areas, they will be captured in hospital wide measurement. A target of 80% was established due to the unpredictability associated with added to new clinical areas and represents a 2.6% relative increase from our Q3 performance.	NA	1) **Process Improvement.** Improving workflow in areas where areas MedRec is implemented will be the focus of our improvement efforts in 2024.25. Staff will be supported to complete several complimentary projects related to MedRec. We will also continue to leverage our EPR in order to streamline data collection in order to free up team members so they can devote more time to patient care activities.	Progress will be monitored by both the Pharmacy leadership team and clinical areas where MedRec is implemented. Senior Leadership Council is provided with regular updates including performance tracking on the quarterly Quality Scorecard.	% patients meeting criteria who have MedRec completed including the receipt of a medications list	80% in all areas with MedRec by March 2025	
								2) **Spread.** As we develop a refreshed MedRec spread plan, we will focus on clinical areas and patient populations where medication management is a major component of the encounter. Moving forward, we will leverage an interprofessional leadership model and strive to spread to at least two additional patient populations or clinical areas.		# areas where MedRec fully implemented	Implementation completed in one additional clinical area and implementation initiated in another clinical area by March 2025	
	Safe	Number of workplace incidents of incivility: # reported by hospital workers within a 12 month period	Count / Worker	(cumulative) Q3FYTD 44 Jan-Dec 2023 50	56	**Relative Improvement.** Workplace violence continues to be an important safety focus as well as a contributor to workforce experience. WCH has few incidents that meet the OHSA definition for workplace violence; incidents of incivility are more common. The focus for 2024.25 is to increase awareness and promote greater reporting, with a target of 56 which represents a 40% increase from last year's target, leveraging gains made in 2023.24.	TAHSN	1) **Education, Training & Awareness.** It is acknowledged that education and awareness are continuous activities and thus Occupational Health, Safety and Wellness (OHSW) engages in a number of activities such as Code White drills, in-service sessions, attendance at staff meetings, and team huddles, incident investigations, etc. As a result of tracking, expanded examples of what is acceptable/unacceptable behaviour, targeted training/drills for certain groups, and additional physical controls.	The number of workplace incivility incidents is tracked and discussed via multiple venues including on the Quality Scorecard and at Senior Leadership Council. Code White drills are summarized at the Emergency Preparedness and Joint Health and Safety Committees.	# of Code White drills and/or education sessions completed	6 Code White drills and/or education sessions to be completed by March 2025	
								2) **Process Improvement.** Incident debriefs and root cause analysis have led to several hospital-wide and local process changes including enhancements to our Code White alarm system, regular Code White drills, optimization/ reorganization of clinical and patient facing space, improved communication, and greater situational awareness. Annual risk of violence assessments have also contributed to greater awareness at the frontline leader level. We anticipate further improvements to emerge this year as a result of this process.		% of annual risk of violence assessments completed	100% of scheduled annual risk of violence assessments will be completed by March 2025	