Access and Flow

Measure - Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	5.20	4.00	Goal to reach OH Pay for Results target within three years, target to be set at 3.4 for 27/28	

Is this indicator related to:	
Emergency Department Return Visit Audits	Yes
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Implement a physician recruitment and retention strategy to ensure full schedule coverage, including expectations and accountability for shift coverage

Methods	Process measures	Target for process measure	Comments
Involve Chief of Staff for help with recruitment; optimize US recruitment; secure funding for ED mentorship program; implement retention strategies.	Percent of recruitment initiatives by Chief of Staff; Percent of US candidate applications received and reviewed; Percent of applications submitted for funding; Percent of retention strategies investigated; Number of shifts vacant each month	100% of recruitment initiated by Chief of Staff, 100% of US candidate applications reviewed; 100% applications submitted for funding; 100% of retention strategies implemented, zero vacant shifts each month.	

Change Idea #2 Launch an Emergency Department outpatient follow-up clinic to improve flow/reduce return visits

Methods	Process measures	Target for process measure	Comments
Recruitment of ED physicians; develop a process for clinic operations and patient inclusion/exclusion criteria; secure additional staff.	Percent of provider shifts filled; Percent of workflows developed for clinic operations including documented inclusion/exclusion criteria; Percent of staff shifts filled.	100% of provider shifts filled; 100% workflows developed for clinic operations including documented inclusion/exclusion criteria; 100%staff shifts filled.	

Change Idea #3 Pilot solutions with the vendors selected through the ED innovation challenge

Methods	Process measures	Target for process measure	Comments
Collaborate with selected vendors and ED clinical and operational teams through a phased co-design process to develop, pilot, and refine solutions that improve emergency department flow.	Percent of selected solutions that progress through co-design; Percent of solutions piloted within the ED environment; Completion of structured evaluation and feedback for each solution	100% of selected solutions progress through co-design; 100% of solutions piloted in the ED; 100% of pilots evaluated using defined success criteria related to ED flow	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Communication with physicians and nurses (%) composite metric	C	% / Survey respondents	Local data collection / Most recent consecutive 12 month period	66.20	68.00	Target not met in FY25/26, maintaining target of 68%	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Expand launch of standardized communication whiteboards to additional areas.

Methods	Process measures	Target for process measure	Comments
Implement communication whiteboards and associated workflows in areas identified to have the greatest impact based on patient experience results, and add "What Matters to You" to whiteboard templates.	Percent implementation in priority areas, percent of workflows updated.	100% of implementation in priority areas; 100% of workflows updated.	

Change Idea #2 Expand bedside patient surveying using QR codes and with volunteer resources support.

Methods	Process measures	Target for process measure	Comments
Evaluate results from bedside patient surveying pilot initiative and identify opportunities. Expand surveying to additional units with low survey completion rates. Include patient experience data on clinical dashboards.	Percent of priority areas identified; Percent of workflows implemented; Percent increase in survey completion on units with bedside surveying; Percent of dashboards including patient experience data.	100% of priority areas identified; 100% of workflows implemented; 30% increase in survey response rates; 80% of dashboards updated.	

Change Idea #3 Implement regular patient rounding by clinical leaders to proactively identify and address concerns that will improve patient reported communication with doctors and nurses.

Methods	Process measures	Target for process measure	Comments
Identify best practices in patient rounding and develop standardized script that will include a question related to communication with doctors and nurses across all inpatient units.	Percent of inpatient units conducting regular leader-led patient rounding.	80% of all inpatient units conducting leader led patient rounding by end of fiscal year.	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Using Blood Wisely Implementation	C	% / Other	Local data collection / Collecting Baseline	CB	100.00	Target based on achieving all criteria for benchmarks in order to be designated as a Using Blood Wisely hospital	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Ongoing physician education to promote awareness of Using Blood Wisely principles.

Methods	Process measures	Target for process measure	Comments
Incorporate Using Blood Wisely discussions into Grand Rounds and specific care groups.	Identification of opportunities for physician education, training provided.	Training provided to 80% of physicians across WRHN.	

Change Idea #2 Meet and sustain all Using Blood Wisely indicator requirements for all applicable patients.

Methods	Process measures	Target for process measure	Comments
Analyze cardiology patients separately, recognizing higher transfusion thresholds to accurately assess non-cardiac patient outcomes.	Using Blood Wisely indicator targets met, cardiology patients stratified in the data.	100% of indicator targets met, stratification of cardiology patients complete.	

Change Idea #3 Implement viscoelastic testing at Queen's Blvd site to enable more precise, evidence-based transfusion decisions.

Methods	Process measures	Target for process measure	Comments
Pilot implementation of viscoelastic testing and refine workflows and protocols through Plan Do Study Act (PDSA) cycles.	Workflows updated, identified improvements implemented.	100% of workflows updated, 100% of identified improvements implemented.	

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of delirium onset during hospitalization	O	% / Hospital admitted patients	CIHI DAD / April 1 to September 30, 2025 (Q1 and Q2), based on the discharge date (Discharge Date/Time)	0.88	0.98	Internal YTD performance Apr to Nov 2025 is 1.0, target set based on 2% improvement and anticipating an increase in rates due to coding enhancements	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Incorporate delirium risk identification, screening and prevention and management strategies in the Medicine program

Methods	Process measures	Target for process measure	Comments
Activate delirium prevention order set at admission; continue education on delirium prevention	Percent of patient files with delirium prevention order set activated at admission	80% patient files with delirium prevention order set activated at admission	Pharmacological Interventions as a part of the delirium prevention order set are in alignment with Choosing Wisely strategies.

Change Idea #2 Launch evidence based centralized delirium prevention team model across sites e.g. Hospital Elder Life Program (HELP)

Methods	Process measures	Target for process measure	Comments
Spread evidence based centralized delirium prevention team model across acute care in-patient Medicine.	Number of patient consults/engagements by delirium prevention teams	20 team members recruited; 200 consults by end of FY	Building and recruiting team in Q1/2 launching team in Q3/4