Access and Flow

Measure - Dimension: Timely

Indicator #7	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	5.30	3.40	Target established by Ontario Health.	

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

Change Ideas

Change Idea #1 Explore and optimize Emergency Department (ED) patient flow with implementation of Rapid Assessment Zone (RAZ)

Methods	Process measures	Target for process measure	Comments
Oversight by the Emergency Department to implement criteria for patients assessed in RAZ. Performance and Analytics to support data reporting for % of patients assessed through the RAZ.	% of patients assessed through the RAZ.	Collecting Baseline (CB).	Evaluate the average Physician Initial Assessment (PIA) time (# hours) during RAZ hours. Data collection in collaboration with Performance and Analytics.

Change Idea #2 Co-develop plan to improve ED patient workflow with Physicians and Nurse Practitioners (NPs)			
Methods	Process measures	Target for process measure	Comments
ED oversight to support NP expanded scope within the RAZ.	ED length of stay (#hours) combined high and low acuity.	Less than 6.0 hours.	Working with Performance and Analytics to collect data relating to PIA times when a provider (Physician or NP) is assigned to the RAZ.

Change Idea #3 Physician recruitment strategy a) STEP Program: Physicians assigned to RAZ between 11 am to 7 pm b) Family medicine recruitment for 5pm to 9pm (peak patient volume times)			
Methods	Process measures	Target for process measure	Comments
ED oversight to strategies for Physician recruitment.	ED length of stay (# hours) for high and low acuity.	Less than 6 hours.	Working with Performance and Analytics to collect data relating to average PIA times when a physician is assigned to RAZ.

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Community Mental Health: Percentage of in-person and virtual visits in the counselling and treatment program (%).	C	% / Mental health patients	In house data collection / April 2026-Mar2027	CB	CB	The first year of a multi-year indicator for the Community Mental Health team.	

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

Change Ideas

Change Idea #1 Optimize internal and external referral pathway workflows to support and prioritize in-person and virtual visits.			
Methods	Process measures	Target for process measure	Comments
Community Mental Health oversight to continued monitoring of the Community Mental Health Counselling Waitlist (avg # days).	% of in-person and virtual counselling sessions provided in comparison to in-person and telephone sessions.	Collecting Baseline (CB).	The Community Mental Health Counselling and Treatment Program reports increased effectiveness when sessions are conducted both in-person and virtually.
Change Idea #2 Increase number of clinicians on site for walk-in clinic days.			
Methods	Process measures	Target for process measure	Comments
Walk-in clinic hours have been extended. Community Mental Health oversight to monitor the number on-site visits in the counselling and treatment program during these times.	% of in-person visits during walk-in clinic times and % virtual visits with clinicians on site.	Collecting Baseline (CB)	The Community Mental Health Counselling and Treatment Program reports increased effectiveness when sessions are conducted both in-person and virtually.
Change Idea #3 Optimize virtual visits through teams in EPIC.			
Methods	Process measures	Target for process measure	Comments
Community Mental Health oversight, supported by Performance and Analytics to track the % of virtual visits per clinician per week.	% of in-person and virtual visits per clinician per week (to track adoption).	Collecting Baseline (CB).	The Community Mental Health Counselling and Treatment Program reports increased effectiveness when sessions are conducted both in person and virtually.

Equity

Measure - Dimension: Equitable

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (mandatory); Percentage of physicians (voluntary) who have completed the EDI training (%).	C	% / Staff	In house data collection / April 2026-Mar 2027	CB	80.00	To improve engagement of staff and credentialed staff in EDI initiatives and activities within the organization.	

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 Increase awareness and education for 2026/27.

Methods	Process measures	Target for process measure	Comments
Equity, Diversity, and Inclusion Advisory Committee (EDIAC) oversight to track and trend completion rates through LMS platform. Data collection supported by Professional Practice Digital Learning Specialist and reported to QPSR and area leaders.	% of staff completed and % of credentialed staff completed.	80% Staff and 70% Credentialed Staff.	To support successful engagement in EDI initiatives, Physician Chiefs and Physician Leads are encouraged to participate in EDI activities to model behaviours for their teams.

Change Idea #2 Implement planned engagement activities to increase completion rate of EDI initiatives.

Methods	Process measures	Target for process measure	Comments
Equity, Diversity, and Inclusion Advisory Committee (EDIAC) oversight to track # of engagement activities facilitated by Organizational Development.	Evaluation of engagement activities completed (% responses).	100% of planned engagement activities implemented.	Engaging staff and credentialed staff in EDI activities to reinforce content delivered through training; facilitate training completion.

Experience

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of positive responses to, "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?"	C	% / Survey respondents	Hospital collected data / April 2026-Mar 2027	82.00	100.00	Working towards 100% positive responses to the patient experience survey (Qualtrics).	

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 Track, trend, and analyze responses to this survey question quarterly.

Methods	Process measures	Target for process measure	Comments
With Senior Leadership Team (SLT) and Patient Experience oversight, Qualtrics Experience survey responses, collects both quantitative and qualitative data that is shared with department teams to track, trend and analyze responses.	% surveys completed.	100% completion of surveys distributed.	Survey responses are collected from patient's via email or QR code affixed to their after visit summary (AVS).

Change Idea #2 Develop action plans to address result trend.

Methods	Process measures	Target for process measure	Comments
With oversight from Senior Leadership Team (SLT) and Patient Experience, quantitative and qualitative data collected from Qualtrics Experience survey responses will be used to highlight result trends among departments and teams. The development of action plans will address any identifiable trends in the data.	Action plans developed to address results trend for at least one hospital program.	100% action plans completed.	Action plans implemented to address identifiable trends in the data, with a goal of 100% completion of action plans to improve the result trends.

Measure - Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Completed wellness initiatives per department (#).	C	Number / Staff	In house data collection / April 2026-Mar 2027	CB	CB	This is the first year of a multi-year indicator for staff wellness, as identified as a gap on the Accreditation Canada Global Workforce Survey.	

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

Change Ideas

Change Idea #1 Implement, monitor, and evaluate wellness action plans.

Methods	Process measures	Target for process measure	Comments
Facilitated by Organizational Development and the C4Cs team, with feedback from staff, completion of wellness initiatives at the unit level will be evaluated.	% of completed wellness initiatives per department per quarter.	Collecting Baseline (CB).	Ongoing monitoring and evaluation of wellness initiatives with completion rates and staff feedback.

Change Idea #2 Track completion of initiatives (date of initiative, and initiative theme).

Methods	Process measures	Target for process measure	Comments
Facilitated by Organizational Development and the C4C team, with feedback from staff, completion of wellness initiatives at the unit-level will be evaluated.	% of completed wellness initiatives per department per quarter.	Collecting Baseline (CB).	Ongoing monitoring and evaluation of wellness initiatives with completions rates and staff feedback.

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of mobilization for in-patients on Acute Care (%)	C	% / In-patients on Acute Care	In house data collection / April 2026-Mar 2027	CB	CB	This is the first year of a multi-year indicator, as a delirium prevention strategy.	

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

Change Ideas

Change Idea #1 Develop and implement nurse-led mobility interventions.

Methods	Process measures	Target for process measure	Comments
Access and Flow oversight with staff education and training related to mobilization strategies, documentation and patient assessment.	% of staff engaged in education and training activities.	100% staff on In-patient Acute unit.	Focus staff education and training related to mobilization strategies, documentation and patient assessment to enhance reporting, data collection and reduce the incidence of delirium.

Change Idea #2 EPIC optimization for mobility documentation in the Clinical Information System (CIS).

Methods	Process measures	Target for process measure	Comments
Access and Flow oversight, supported by Performance and Analytics, daily mobility data will be collected from the CIS with monthly reporting of the rate of mobilization of patients on the In-patient Acute unit.	% of staff trained on mobility intervention documentation.	100% staff trained on mobility intervention documentation.	Focus staff education and training related to mobilization strategies, documentation and patient assessment to enhance reporting, data collection, and reduce incidence of delirium.

Measure - Dimension: Effective

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Compliance of Hand Hygiene after patient/patient environment contact (%)	C	% / Staff	In house data collection / Apr 2026-Mar2027	86.00	96.00	To align with the target reported on the Corporate Balance Scorecard (CBS)	

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 Increase number Hand Hygiene auditors to ensure audits for moments 2 and 3.			
Methods	Process measures	Target for process measure	Comments
Infection Prevention and Control (IPAC) oversight to increase number of auditors and audits for moments 2 and 3, that will support progress to the target for moments 1 and 4 as well.	% increase of hand hygiene audits completed per quarter.	10% increase of hand hygiene audits completed per quarter.	Increased IPAC capacity with hand hygiene audits by championing unit-level staff to support reinforcing hand hygiene compliance and audits.

Change Idea #2 Leadership engagement in Hand Hygiene compliance messaging and monitoring.			
Methods	Process measures	Target for process measure	Comments
With Infection, Prevention and Control (IPAC) oversight with engagement of unit-level leadership to support Hand Hygiene messaging and compliance monitoring through visibility of rates on unit quality boards and safety discussion huddles.	% department compliance.	100% department compliance.	Consistent Hand Hygiene compliance messaging and monitoring to support teams with improving hand hygiene rates, ensuring safer care.

Measure - Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
In-patient falls with injury rate (%)	C	% / All inpatients	In house data collection / Apr 2026-Mar2027	2.70	2.50	To align with the target reported on the Corporate Balance Scorecard (CBS)	

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

Change Ideas

Change Idea #1 Monitor and evaluate falls assessment and prevention strategies.			
Methods	Process measures	Target for process measure	Comments
Falls Quality Aim Committee oversight, supported by Performance and Analytic for data collection of MORSE fall risk screening documentation in the Clinical Information System (CIS).	% of patients with MORSE fall risk screening completed in triage or within 24h of admission.	Collecting Baseline (CB).	The Falls Quality Aim committee launched improved visibility of patients with moderate and high fall risk through the use of yellow "Call don't fall" wristbands. Manual audits are completed by falls champions assigned to specific units.

Change Idea #2 Develop and implement patient and family engagement and education resources.			
Methods	Process measures	Target for process measure	Comments
Falls Quality Aim Committee oversight to track the number of staff engaged in falls prevention education and training through the LMS/E-learning portal. Patient and family/care-partner engagement in falls prevention education is monitored through access to resources (eg. number of times a web page was accessed).	% of staff; % of patients and family who engaged in education activities.	Collecting Baseline (CB).	Patient and family/care-partner education resources have been updated and released in different forms of media. The Falls Quality Aim Committee will monitor the distribution of, and access to, these resources and develop strategies for improved tracking.