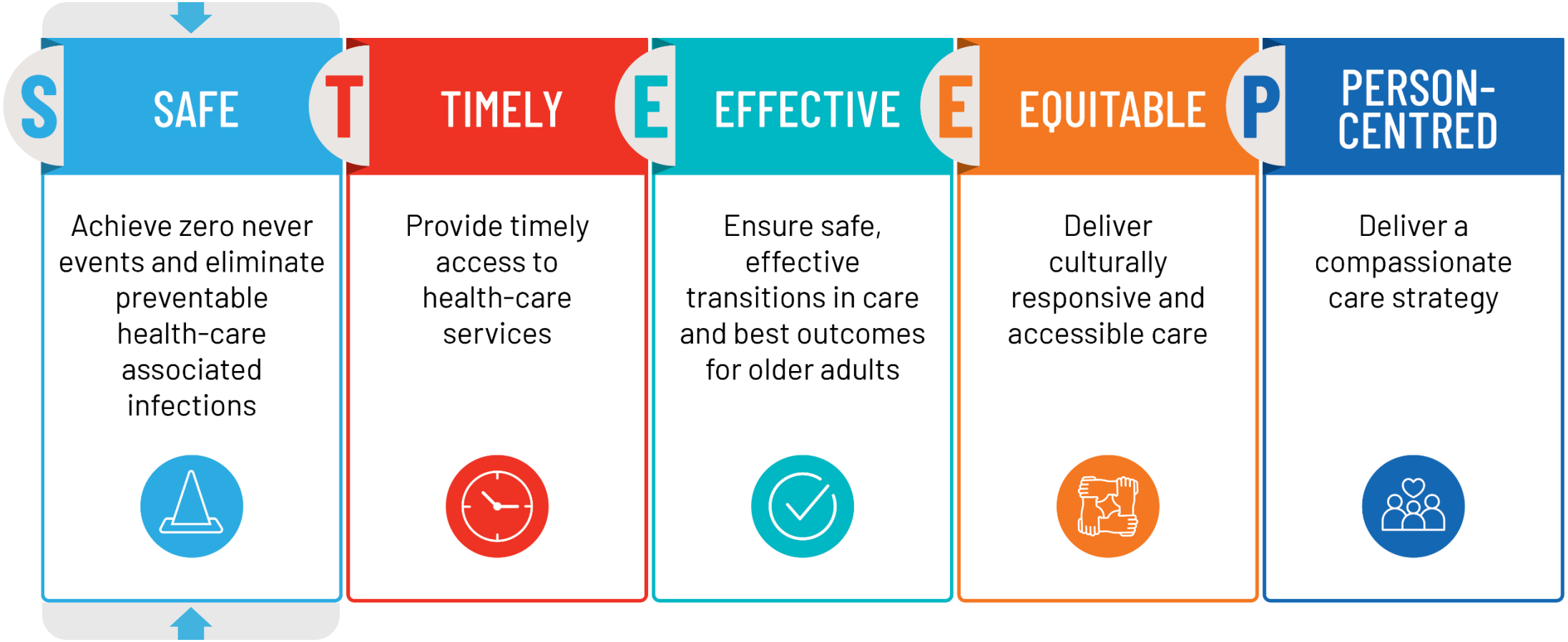
Quality Improvement Plan

(QIP) 25/26 Workplan

Quality Aims 2025-2028



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Quality Aim Domain – Workplan Page Navigation NEW

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Measurable variable that tracks progress towards achieving a specific QI goal Quantifiable data • Rate • Percent • Days In-between • Time • Experience score	Describes the patient population the indicator will focus on • Unit or program • Hospital or System • Specific patient population	The methodology of collecting the data • SAFER reports • Hospital Data • EPR report • Audits • Experience Survey	Current state metrics	Improvement target to meet or exceed **Aspirational 3 year stretch target**	Why and how the target was set • Meeting benchmark performance • Aligning with provincial performance • Evidence based practice

#	Change Idea	Methods	Process Measure	Target	Comments
1	• Specific, practical strategies that focus on improving aspects of a system, process or behavior • Can be tested and measured	Process and tools to use and monitor progress How and by whom Specific “actionable” and “measureable”	• How to measure and gauge the impact of the change idea • Quantifiable measure	Target set based on current data or best practices	These can include factors for success, partnerships, barriers, etc
2		**Foundational** work that is required to lay the groundwork for a successful project, initiative or change effort and will not impact year one target. Establishes a strong base to ensure the initiative is well-planned, evidence based and sustainable	Usually measured as “Project milestone” or “% completion”	100%	

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Aim Statement

Achieve zero never events and eliminate preventable health-care associated infections

#1 Sub Aim Statement:	Achieve ZERO Never Events

VP Lead	Medical Lead
Kate Wilkinson	Dr. Christine Soong

#2 Sub Aim Statement:	Reduce Self Harm Events

VP Lead	Medical Lead
Kate Wilkinson	Dr. Bob Maunder

#3 Sub Aim Statement:	Eliminate Preventable Healthcare Associated Infections (HAIs)

VP Lead	Medical Lead
Kate Wilkinson	Dr. Jennie Johnstone

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Achieve ZERO never events – Pressure Injury

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Days in-between Pressure Injury **HBH** Stage 3 and 4 (Never Event criteria)	ALL HBH	SAFER Reports	10 events Jan – Nov 2024 65.4 days in-between events	Days in-between events 10 % improve is 71.5 days **10% improvement year over year**	
Days in-between Pressure Injury **MSH** Stage 3 and 4 (Never Event criteria)	ALL MSH	SAFER Reports	1 event Jan – Nov 2024	Best achieved **ZERO ≥ 365 days**	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Develop 9th level (HBH) Work Plan to Prevent HAPI	**Foundational** Complete current state review of HAPIs with 9N and 9S	% Milestone	100%	Exclusion palliative pts
2		**Foundational** Identify and prioritize change ideas and implement ONE high impact change idea on 9th level	10% improvement of 9% HAPI Stage 2 +	8.1%	2 FY of data
3	SAFER	**Foundational** Optimizing reporting and escalation to clinical leads using SAFER system	% Milestone	100%	
4	SEM Scanner	Develop a SEM device standard protocol for targeted populations in the ICU and pilot	# at risk patients scanned /at risk patients	90%	Inclusion/exclusion criteria
5	PI Education	Targeted PI education embedded within annual Nursing Education Day at HBH (full time nursing)	% Competency Achievement	>75%	

Reduce Self Harm Events

SAFE

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
# Self-harm events in "at acute risk" patients	**9S** (Mental Health) **ED** (Emergency Department) MSH	SAFER Events (using defined criteria)	FY 23/24 and 24/25 ED – 3 event 9S – 1 event	Theoretical Best "ZERO" **Theoretical Best "ZERO"**	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Appropriate screening and identification of suicide risk	**Foundational** Plan and build for a standardized suicide screening risk assessment tool and process for high risk patients (Accreditation ROP)	% project milestone	100%	EPR
2		Increase staff investment in C-SRSS screening for at risk ED patients at triage	C-SRSS completion rate	ED – increase to 50%	Current YTD 35%
3	Appropriate interventions to prevent harm in-hospital	**Foundational** Develop and implement a standardized safety checklist/assessment for high risk areas (ED and 9S) who are identified as high risk for self harm	% project milestone	100%	
4		**Foundational** Develop and implement the policy for effective patient searches (SH)	% project milestone	100%	
5	Patients Own Medication	Revise patients own medications standard process (policy) to include question on admission about own medications (pilot on GIM/Rehab)	% project milestone	100%	To build into EPR in future
6		Audit of appropriately stored patients' own medications across SH with medication room audits	Process adherence %	>80%	CB Quarter one
7	Environmental design	Update door management, CCTV and Wanderguard System (9S and GIM)	% Milestone	100%	**Capital**

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Eliminate Preventable Healthcare Associated Infections (HAIs) – CLABSI

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Rate of Central Line Associated Blood Stream Infections (CLABSI) in NICU	• Rate of CLABSI per 1,000 line days in the NICU	Hospital Collection Data	24/25 Q2 YTD is 6.5	5.8 (current target 24/25) 11% improvement Maintain current target **Achieve Canadian Neonatal Network top 75%**	Did not meet QIP target 24/25 – carry over

#	Change Idea	Methods	Process Measure	Target	Comments
1	Purposeful Central Line Audits and Mentorship	Dissemination of weekly audits for Central Lines (dressings, Alaris Pump settings, line configurations etc.)	% bundle achieved	>80%	
2		**Foundational** Develop process for PICC nurses and Clinical Coaches to support audits and point of care feedback	Project milestone	100%	
3	Protocols for Breast Milk Collection within 6 Hours of Birth	**Foundational** Develop breast milk Golden Hour protocol and checklist.	Project milestone	100%	
4		Develop breast milk Golden Hour education for all staff and physicians	Project milestone	100%	Roll out year 2 with compliance audits
5	Effective IPAC practices	Mandatory eLearning/ resource for all NICU staff and physicians (RN, MD, OT etc.)	% Competency Achievement	>80%	
6		**Foundational** Develop and implement IPAC education/ messaging for visiting staff and physicians	Project milestone	100%	Reference material or letter

Eliminate Preventable Healthcare Associated Infections (HAIs) – CAUTI

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Days in-between Catheter associated Urinary Tract Infection (CAUTI)	GIM and ICU	Hospital Collection Data	GIM average is 16.3 days in-between events from April 2023- Nov 2024 ICU average is 29.8 days in-between (same period as above)	10% improvement in GIM and ICU days in-between GIM target is 17.9 days ICU target is 32.8 days **10% improvement year over year (average days in-between)**	Since rate and count of CAUTI is relatively low and a rare event – target reset to "days since last" to highlight the extension of intervals between occurrences

#	Change Idea	Methods	Process Measure	Target	Comments
1	Prompt Discontinuation of Catheters	Increase uptake of external catheters in ICU	Catheter rate	10 % reduction in indwelling catheter rate	% improvement over last year
2		Increase uptake of physician indwelling catheters reminders in rounds in GIM	Completion rate in rounds (audit)	80% with patients who have catheters	
3	Best Practices for Catheter Maintenance & Care	Implement closed system urinary catheter kits in GIM & ICU	% usage in closed system urinary catheter	75% at MSH	
4		**Foundational** Develop evidence-based catheter care policy for ICU & GIM	Project Milestone	100%	CAUTI bundle

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Eliminate Preventable Healthcare Associated Infections (HAIs) – C.Diff

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Rate of nosocomial C.Difficile Infection (CDI) per 1,000 patient days Number of nosocomial CDI Cases	Inpatient units at MSH and HBH	IPAC Surveillance Data	FY 24/25 YTD Oct is 0.18 16 cases	Maintain or improve 0.18 per 1,000 patients days **Maintain top Provincial performer**	Most recent Provincial Range is 0.21 Q4 23/24 N/A Q1 24/25 0.18 Q2 2024/25

#	Change Idea	Methods	Process Measure	Target	Comments
1	Implement post-operative antimicrobial management guidance in General Surgery	Engage surgical stakeholders via education, audit and feedback to refine guidance and promote adoption	% adherence to guidance	80%	
2	Reduce use of antimicrobials with moderate- high risk of *C. difficile* in General Medicine	Work to establish validated baseline DOT and DDD data for antimicrobials with moderate/high-risk of CDI	% reduction in DDD / DOT per 100 pt day moderate/high risk agents	Collecting Baseline	DDD – defined daily dose DOT – days on therapy
3	Increase adherence to hand hygiene	**Foundational** Complete a comprehensive review of ABHR products for SH. implement new hand hygiene product validated for tolerability and acceptability by front line staff	% Milestones	100%	Engagement of front line staff in selection of product is linked to increased compliance

Continued →

Eliminate Preventable Healthcare Associated Infections (HAIs) – C.Diff (continued)

#	Change Idea	Methods	Process Measure	Target	Comments
4	Increase adherence to use of sporicidal agents for cleaning	Use daily environmental audit tool to monitor appropriate sporicidal wipe use at entrance of all C. difficile positive rooms across Sinai Health Provide feedback to support services via monthly report for targeted action where improvement is required	% of C. difficile positive rooms have sporicidal wipes present at entrance % of Previous C. difficile positive rooms that have sporicidal wipes removed % of Rooms requiring additional cleaning that have a green sheet posted and are signed off as per schedule	>90%	

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Eliminate Preventable Healthcare Associated Infections (HAIs) – VRE

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Vancomycin-Resistant Enterococcus (VRE) bacteremia rate	Inpatient units at MSH and HBH	IPAC Surveillance Data	0.453 VRE blood stream cases/10,000 patient days 6 cases	50% reduction based on cases **Theoretical Best ZERO Cases**	Better than provincial average

#	Change Idea	Methods	Process Measure	Target	Comments
1	Reduce use of antimicrobial agents that promote VRE colonization on General Medicine	Work to establish validated baseline DOT and DDD data for anti-anaerobic antimicrobials	% reduction in DDD / DOT per 100 pt day of VRE-promoting agents	Establish Baseline	DDD – defined daily dose DOT – days on therapy
2	Increase adherence to hand hygiene	**Foundational** Implement new hand hygiene product validated for tolerability and acceptability by front line staff	% Milestones	100%	Change idea also captured in CDI
3	Increase adherence to daily double cleaning of VRE rooms	Provide feedback to support services via monthly report for targets action where improvement is required	% of Rooms requiring additional cleaning that have a green sheet posted and are signed off as per schedule	>10% Percent improvement is 99%	

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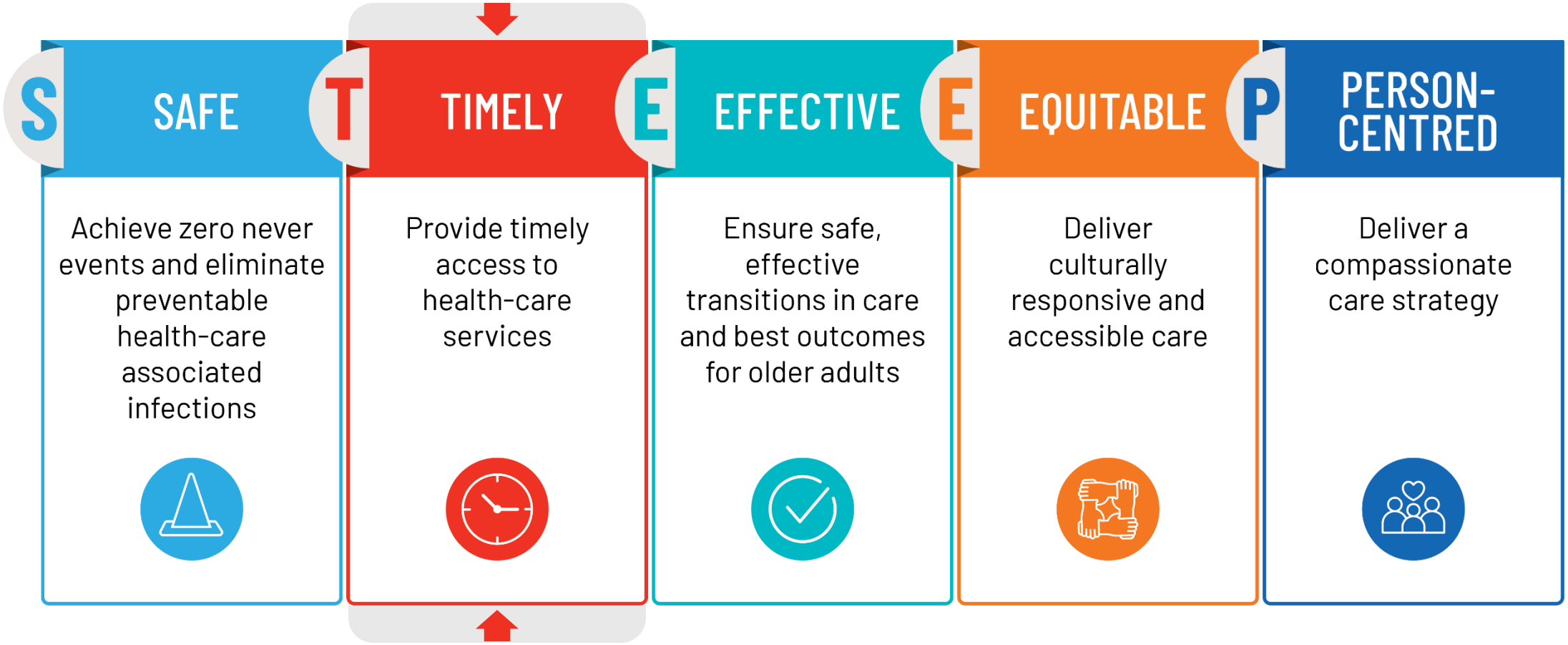
Quality Aims 2025-2028



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Aim Statement

Ensure timely access to care in acute, complex continuing and rehabilitative care by reducing waits and harmful delays in care

#1 Sub Aim Statement:	Achieve Top Performance (90th percentile – P4R Rank, OH Regional) amongst academic organization focused on:

- Ambulance off-load time (Ontario Health Priority)
- ED wait time to physician initial assessment (Ontario Health Priority)
- ED Time to inpatient bed (Ontario Health Priority)
- ED length of stay for non-admitted patients with low/high acuity
- ALC rate and throughput

VP Leads
Kate Wilkinson and Sandra Dietrich Kara Ronald (ALC)
Medical Leads
Dr. Dave Dushenski (ED) Dr. Jordan Pelc (HBH) TBD (MSH)

#2 Sub Aim Statement:	Achieve incremental year over year improvement in surgical capacity and efficiency to achieve wait time target by:

- Increasing surgical volumes
- Increasing Cancer surgical volumes
- Improving % wait list priority targets for all surgeries (Long waiters)

VP Leads
Kate Wilkinson and Sandra Dietrich
Medical Lead
Dr. Ian Witterick

Achieve Top Performance – ED Ambulance Offload Time (OH) BOARD PRIORITY

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Ambulance off-load time	EMS ED Patients	OH ED P4R Ranking Report	FY 24/25 YTD Nov is 49 min	10% reduction 44 min **Meet or exceed P4R** **30 min**	Provincial target is 30 min

#	Change Idea	Methods	Process Measure	Target	Comments
1	Efficient Triage and Registration Processes	**Foundational** Introduce expedited registration for EMS	Time from check-in to full registration	Establish baseline	
2	RN Skillset matches Operational and Patient Care Needs	Expand skillset for triage trained nurses to support offload role (education and training)	% of ED RNs with triage training	Increase to 50%	Currently 43%
3		Expand skillset for cardiac monitor trained RNs (education and training)	% of ED RNs with cardiac monitor training	Increase to 80%	Currently 70%

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Achieve Top Performance – ED Time to Inpatient Bed BOARD PRIORITY

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
ED Time to Inpatient Bed (90th Percentile)	ED Decision to admit to time left unit	Hospital Data	FY 24/25 Q3 YTD 28.8 hours Current FY 24/25 target is 35.2	Maintain 28.8 hours (90th percentile) **10% improvement year over year**	Final state bed map/ increase capacity for Medicine/Surg beds Respiratory Season Flux

#	Change Idea	Methods	Process Measure	Target	Comments
1	Prioritization of Highest Yield Change Ideas	**Foundational** Conduct a root cause analysis on prolonged LOS for ED admitted patients and prioritize flow initiatives accordingly	Project milestone	100%	
2	Standardize Bed Assignment Process	**Foundational** Refine standard operating procedure for bed assignment for patient registration and admitting department	Project milestone	100%	
3	Implementing EDD process and interventions	**Foundational** Establish Rehab, Reconditioning and GIM LOS targets for defined populations and identify improvements	% Milestone	100%	
4		**Foundational** Pilot EDD process across targeted Rehab units and GIM admitted patients at MSH	Number of Units	MSH 4/4 units HBH 4/4 units	

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Alternate Level of Care (ALC) BOARD PRIORITY

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
ALC Rate % patients designated ALC – Long Term Care (open cases)	All ALC patients at MSH and HBH	Hospital data	**FY 24/25 YTD Nov** ALC Rate = days/bed days HBH median – 17.6 MSH median – 18.6 72% patient designated ALC – LTC (open cases)	Current FY 24/25 Rate target SH 15 ALC – LTC 5% improvement = 68.6 % **Rate**: Maintain 15% **ALC – LTC:** 10% improvement to 64.8%	Keep current targets

#	Change Idea	Methods	Process Measure	Target	Comments
1	Identification of patients at risk of becoming ALC and who are ALC	Implement CFS (Clinical Frailty Score) in ED and Med/Surg units at MSH and targeted HBH units for older adults (ALC rate)	# patients screened/number of eligible patients screened.	>75%	Med/Surg 6/8 ED 1/1 HBH –3/14
2		Develop and test SH evidence informed intervention bundle for patients deemed 'at risk' for ALC for patients identified as at risk on defined units at HBH	% of at risk patients who receive the relevant intervention bundle	>75% HBH	Goal is to avoid ALC designation
3		Implement ALC – LTC approval process at MSH (incl RCC) and HBH.	% approved ALC – LTC designations (number of ALC – LTC designations approved over all ALC-LTC designations)	>90%	Goal to avoid ALC designation for LTC
4	Expand Sinai Health to Home (SHtoH)	Spread SHtoHome to MSH	Volume of patients admitted to SHtoHome program	200 patients Year End	8/8 MSH, 1/1 RCC.

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Achieve Surgical Volumes and Surgical Bed Capacity BOARD PRIORITY

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Surgical Hours Surgical Volumes (Elective) Cancer Surgical Volumes	All surgeries (Cancer and non-cancer)	Hospital measure Perioperative Clinical Information System (PCIS)	Surgical Hours: 22,422 (forecast YE) Surgical Volumes 24/25 target is ≥7500 Cancer Surgery Volume target is ≥2000	Surgical Hours: 15% increase to 25,785 Surgical Volumes: Maintain or increase 24/25 volumes **Volumes; Year over year improvement**	Both a capacity and efficiency metric to optimize surgical access. Surgical time is determined by demand, surgical specialty, case complexity and long waiters

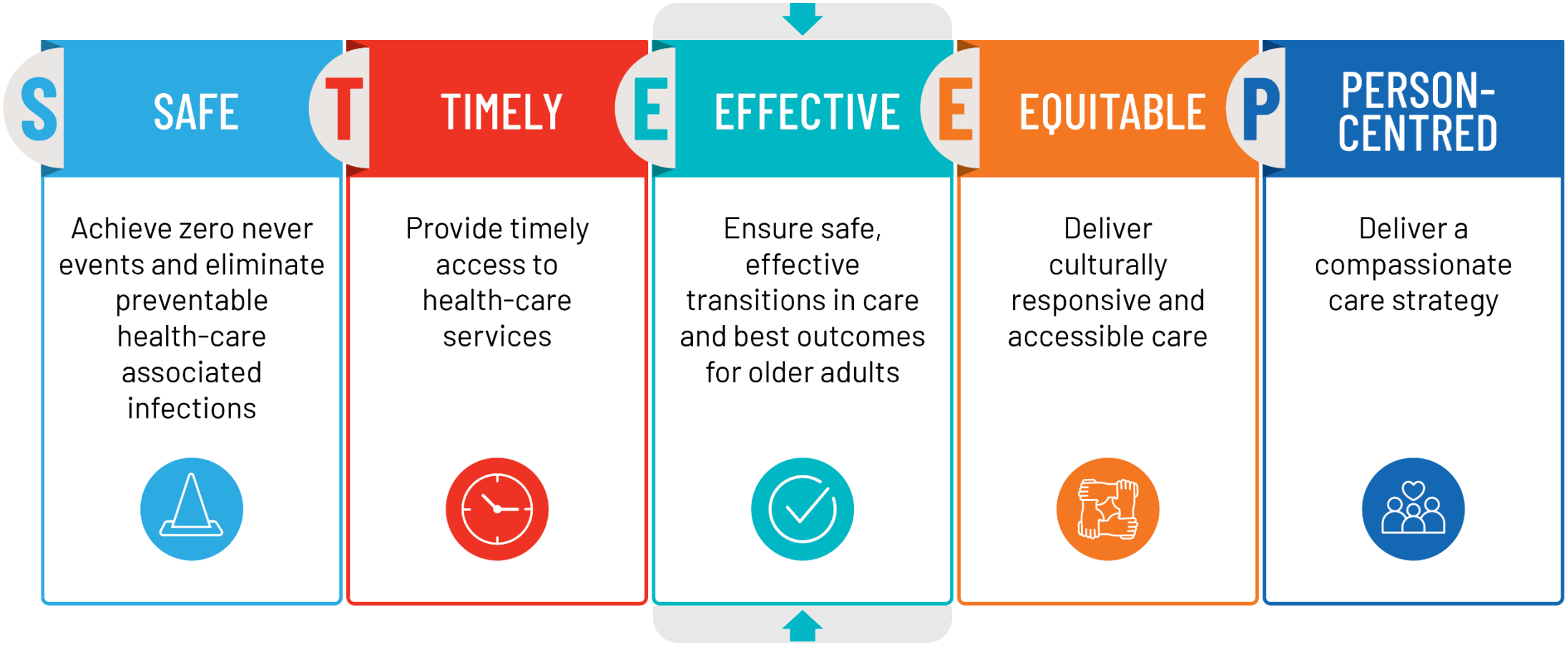
#	Change Idea	Methods	Process Measure	Target	Comments
1	Increase OR and Surgical Bed Capacity to match Post Construction Operating Plan (PCOP)	Expand current OR capacity to address backlog for surgical patients through continued workforce stabilization.	# of Operating rooms in operation	17/17	
2		Optimization of OR efficiency through workflow improvements for; • Turn around time • First patient start time	Turn Around Time Operating Room Utilization % first case on start time	10% improvement to 36 min Utilization Target: 95-100% 90th percentile	Current 40 min Utilization 98%
4		**Foundational** Through strategic planning sessions, create a new OR schedule to maximize opportunities to achieve strategic growth	% Project Milestone	100%	
5		Expand inpatient surgical and ICU bed capacity within the system.	# of new surgical bed in operation	Surgical 18/18 ICU 3/3	Repatriate 12 GIM beds 2 beds on 11S 4 beds on 14S

Surgical Long Waiters BOARD PRIORITY

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
% wait list priority targets for all surgeries (long waiters)	% of open cases who exceed recommended wait times	Hospital measure NOVARI WTIS	QIP 24/25 target (all surgeries) is <41% Open Non-Oncology FY 24/25 Q3 YTD is 46% Open Oncology FY 24/25 Q3 YTD is 33%	All Surgeries <37% (10% Improvement of 24/25 target) **Year over year improvement 10%** **To achieve <30% for all surgeries at end of 3 years**	Oncology open Long Waiter target set by CCO is ≤10% Non-Oncology open long waiters are a higher proportion of activity for all surgeries (94%/6%)

#	Change Idea	Methods	Process Measure	Target	Comments
1	Optimize OR Capacity	**Foundational** Define and stabilize process to review and validate patients waiting routinely	% milestone	100%	
2		**Foundational** Prioritize new OR capacity to address strategic growth and achieve wait time targets	% Project Milestone	100%	
3		Dedicating additional OR time based focused solely on longest waiters	% OR blocks dedicated to LW that are utilized by LW cases	Long waiter rooms will be utilized 75% for LW surgeries	Variable based on available case types, OR length, etc
4		Maintain surgical throughput of ratio of added to completed case	# of completed cases compared to the number of new cases added (Throughput)	>1.0	Supports planning and OR black allocation

Quality Aims 2025-2028



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Aim Statement

Ensure safe and effective transitions in care

#1 Sub Aim Statement:	Ensure safe and effective **transitions in care** by reliably delivering targeted HQO Transition Between Hospital and Home standards including optimizing a Mental Health and Addictions care pathway.

#2 Sub Aim Statement:	Achieve the highest quality of life and health outcomes for older adults by meeting their fundamental care needs and optimizing transitions in care by focusing on the 4M's in alignment with IHI Age Friendly Health Systems and other leading practices.

VP Lead	**Medical Leads**
Kara Ronald	Dr. Christine Soong – Transitions in Care
	Dr. Robert Maunder - Mental Health and Addictions Pathway
	Dr. Nathan Stall – Best Outcomes for Older Adults

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Transitions in Care: Mental Health and Addictions Pathway – Access

EFFECTIVE

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Visits (access) to emergency psychiatric care and addictions services • Emergency after-care # visits • HBH/ACS Volumes # visits	All patients across SH (MSH and HBH)	Hospital Data collection	**ED After Care** = 128 YTD Q3 (42 pts per quarter) **HBH ACS** Baseline = 0	**ED:** 47 patients per quarter (10% increase) **HBH ACS:** Collecting Baseline **10% year over year (depending on need)**	Year over year will depend on reaching saturation of need

#	Change Idea	Methods	Process Measure	Target	Comments
1	Adequate HHR Resources	**Foundational** Initiate plan for new learners (residents) into PES service coverage	% project milestone	100%	Pending UofT approval
2		Operationalize mental health clinician at HBH (addictions service)	New hire	1/1	Position posted – pending hire
3	Optimized PES & Addictions Services	Operationalize new 3 bed capacity on 9S (MSH)	# new beds	3/3	
4	Novel PES & Addictions Services to Meet Patient Needs	**Foundational** Define inclusion/exclusion criteria, develop proactive pathway, and set targets for new pro-active PES interventions for high-risk ED patients	% project milestone	100%	Targets to be used next FY
5		NEW! Operationalize new weekly addictions service at HBH	Initial assessment within 7 days of referral	80%	

Transitions in Care: Patient Experience – Access to Information PODS

EFFECTIVE

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Patient Experience Access to information prior to and at discharge POD (Patient Orientated Discharge) summaries	• **HBH** – Rehab • **MSH** – Cardiology (10S) and Ortho (11th floor)	OHA Patient Experience Survey Jan 1- Dec 31, 2024 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?	**HBH – all Rehab** Completely 47% Quite a bit 30% **MSH - 10S, 11N/S** Completely 62% Quite a bit 23%	**HBH** – 5% improvement Completely (Top Box) Target 49% **MSH** – 5% improvement Completely (Top Box) Target 65% **SH 10% Improvement Top Box as more units adopt PODs**	5 % improvement top box year over year Top Box hardest to move Because it reflects perfection or exceptional performance

#	Change Idea	Methods	Process Measure	Target	Comments
1	**HBH:** Optimize ePOD implementation	**Foundational** Understand current state re: ePODS compliance e.g. barriers, challenges – Implement Audit Process	Compliance Audit	CB	
2		**Foundational** Review ePODS standard of care protocols and processes	% Milestone	100%	
3	**MSH:** Develop POD for target population	**Foundational** Understand current state re: PODS compliance e.g. barriers, challenges – Implement Audit Process	Compliance Audit	CB	
4		Pilot PODS for targeted population Primary Hip and Knee (11N/S) Cardiology Heart Failure (10S)	Unit Pilot	3/3	

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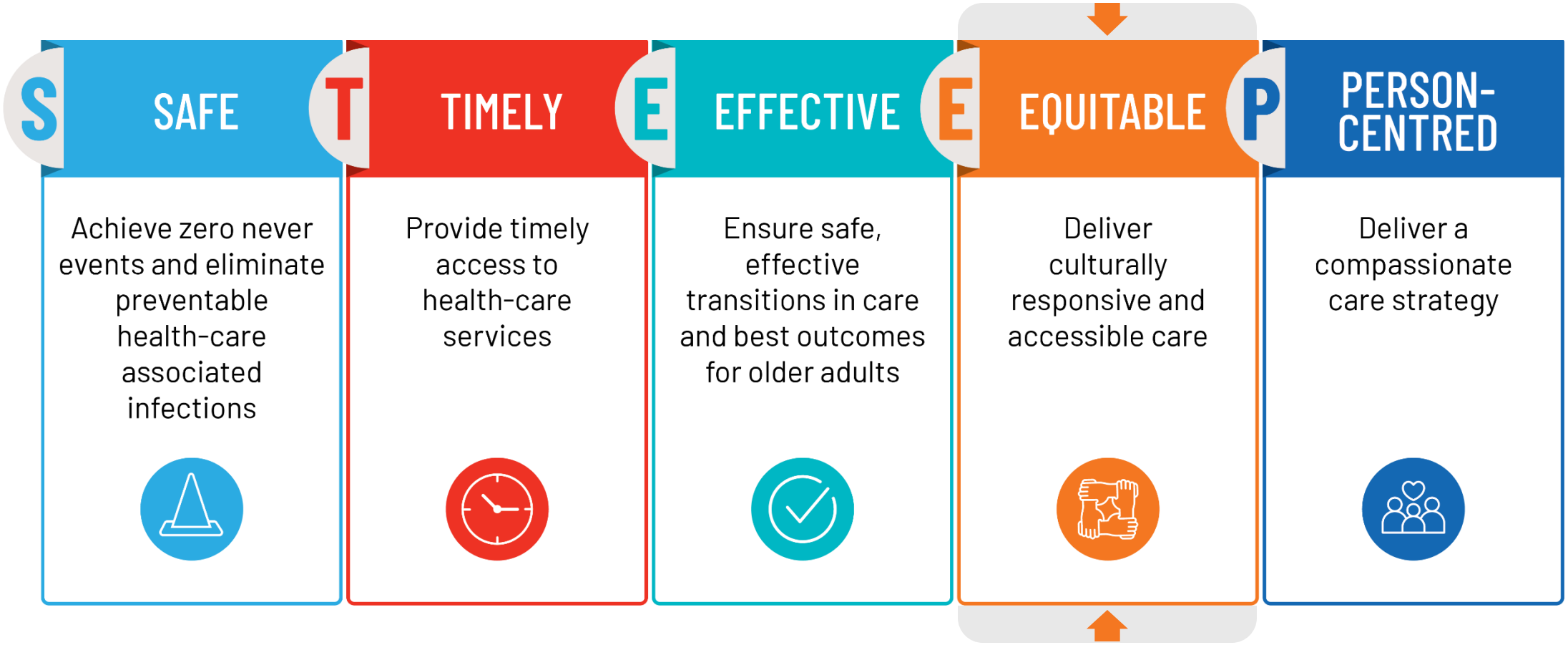
Quality Aims 2025-2028 Equitable



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Aim Statement

Deliver Culturally Responsive and Accessible Care

E EQUITABLE

#1 Sub Aim Statement:	Advance the maturity of Sinai Health's Equity program to ensure culturally responsive and accessible patient care

#2 Sub Aim Statement:	Reduce disparities in a**ccess** to care**, patient experience** and **clinical outcomes** for equity deserving populations in targeted program areas.

VP Lead	**Medical Lead**
Nely Amaral (Michael Palomo)	Dr. Mark Lachman

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Health Equity (Page 1/3) – Universal Accessibility

E EQUITABLE

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Progression on organizational Maturity Scale from Exploring to Transforming	Across SH	Hospital Measurement using AHA Health Equity Road Map (see next slide for details)	**Exploring**	Committing **Affirming/Transforming**	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Universally Accessible & Inclusive Care	**Foundational** Support the inclusion of persons with disabilities in Patient Family Advisory Committees (PFACs).	PFAC	2/2 (additional)	The hospital will actively recruit individuals with disabilities and lived experiences to participate in PFACs and other community advisory committees
2		**Foundational** Develop roadmap to implement prioritized accessibility enhancements identified by the RHF at HBH to achieve GOLD Certification by 2027/2028.	% Project Milestone	100%	
4		Revise and provide accessibility training for healthcare providers to include best practices that enhance knowledge, skills, and attitudes	% Competency Achievement (new hires)	>80%	The hospital will make this updated training mandatory for all current staff
5	Governance and Capacity	SH Equity and Accessibility committee to develop annual Health Equity and Accessibility awareness campaign/event (MSH and HBH)	Event completion	1/1	

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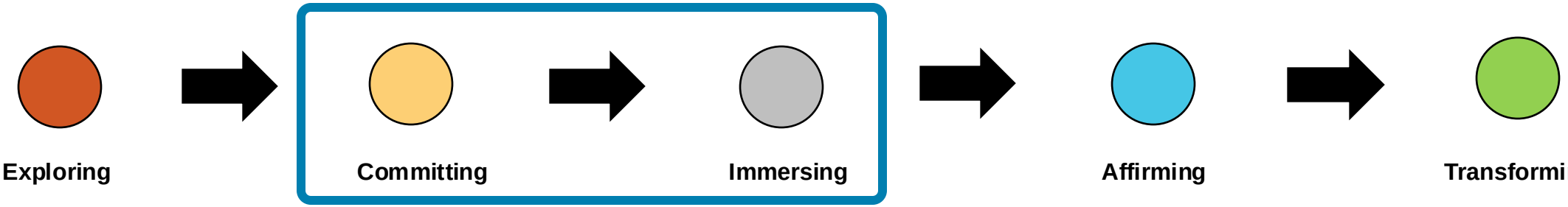
Health Equity Organizational Maturity Continuum

DELIVER CULTURALLY RESPONSIVE and ACCESSIBLE CARE



Exploring

Hospital **is exploring strategies** to **provide culturally responsive and accessible care** for all patients

Committing

Hospital **implements plan** to **tailor services for unique needs of diverse patients** throughout the organization to provide culturally responsive and accessible services

Immersing

The hospital **strengthens staff capacity to support diverse patients' unique needs** in accessing health information, services and integrates stakeholders' voices

Affirming

Hospital routinely **assesses and explores new ways to expand culturally responsive and accessible services**

Transforming

The hospital includes **cultural competency in staff evaluations.**
Patients can easily **access information, tools, and services** for equitable quality care.
The hospital **partners with patient-centered community groups** to address social determinants of health beyond the reach of healthcare

Adapted by the AHA Health Equity Road Map

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Health Equity (Page 2/3) – Culturally Safer Care

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Progression on organizational Maturity Scale from Exploring to Transforming	Across SH	Hospital Measurement using AHA Health Equity Road Map (see next slide for details)	**Exploring**	Committing **Affirming/Transforming**	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Cultural Safety and Humility	Ontario Health Indigenous Relationships and Cultural Awareness Courses (4 modules in a phased rollout). Start with modules 1 and 2 to NEW clinical operations and support function Mangers	% Competency Achievement	>70%	Spread to all staff
2		Mandate Anti-Black Racism Training (Developed by WCH) for all Leaders (Clinical Operations and Support Functions Forum)	% Competency Achievement	>70%	Mandatory on all new hires Q3 24/25 Spread to all staff
3		Establishing an Indigenous Patient and Family Advisory Committee to guide decision-making and inform Indigenous initiatives (or partner with other organizations)	PFAC x1	1/1	**First Nations, Inuit, Métis and Urban Indigenous Priorities and Initiatives:** Co-ordinate regional and provincial programs and services • Measure, monitor and evaluate • Build and sustain productive relationships • Equitable access to culturally-safe care • Build and enhance capacity and education

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Health Equity (Page 3/3) – Linguistically Accessible

E EQUITABLE

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Inpatient Experience (Linguistic Accessibility)	WIH population including L&D, NICU, Mother and Baby Program (MBP)	Magnet Patient Survey: During your hospital stay, how often did nurses explain things in a way you could understand?	FY 2024/25 data Nov YTD on 15/16 MUR (L&D, NICU and Mother and Baby Program) Top Box (Always) 73%	5% increase Target is 77% **Top performer on Magnet survey**	In future – use demographic data of non-English as the **denominator**

#	Change Idea	Methods	Process Measure	Target	Comments
1	Linguistically Accessible	Implement Phase One of Spread of On-Demand Interpreter Services in High Priority Areas. Areas include: **MSH**: 9 South, NICU, L&D, MBP **HBH**: Rehab (3rd Floor, 4th Floor)	Utilization rate Collecting Baseline	–	Units selected based on current interpreter usage (in person or line) Devices are of no cost if min amount of min are used (no capital)
2		Identify priority patient education/information materials for translation of materials in WIH and translate top 2	Materials translated	2/2	Top 5 languages

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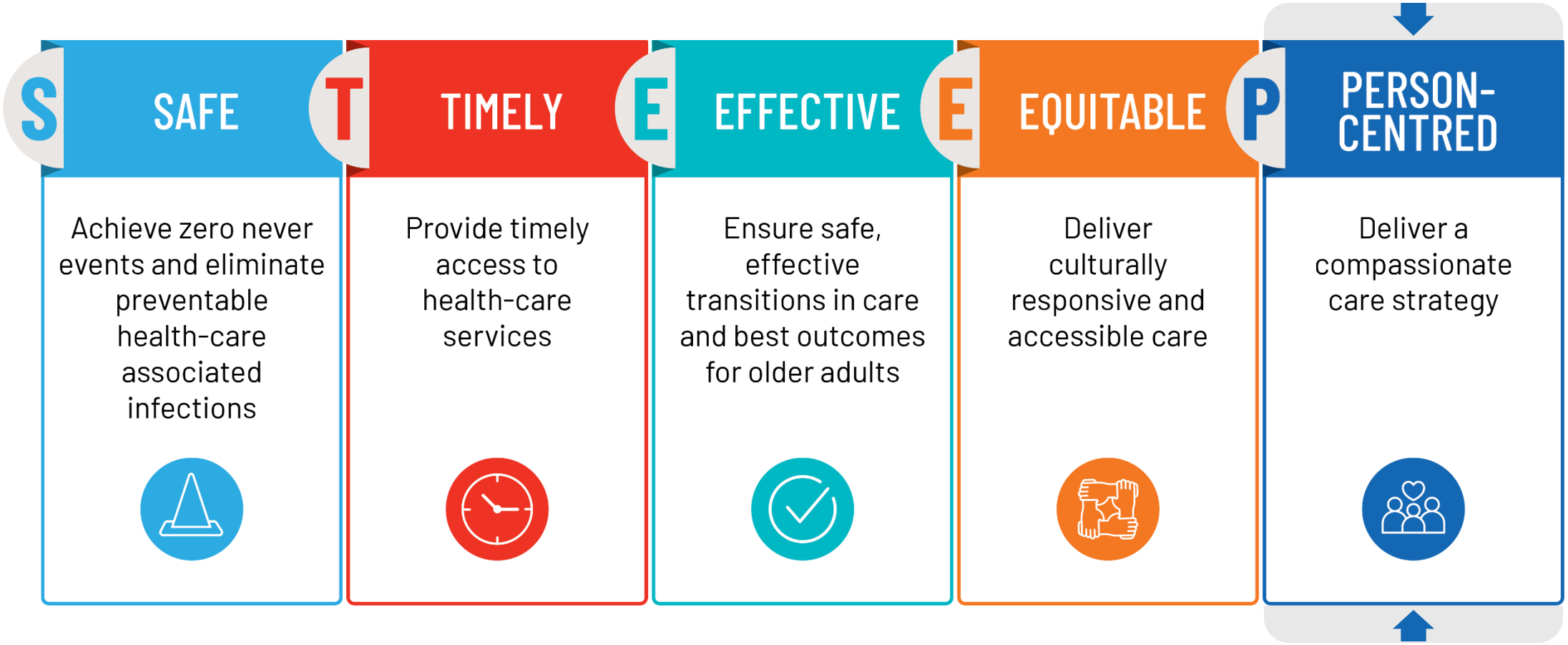
Quality Aims 2025-2028



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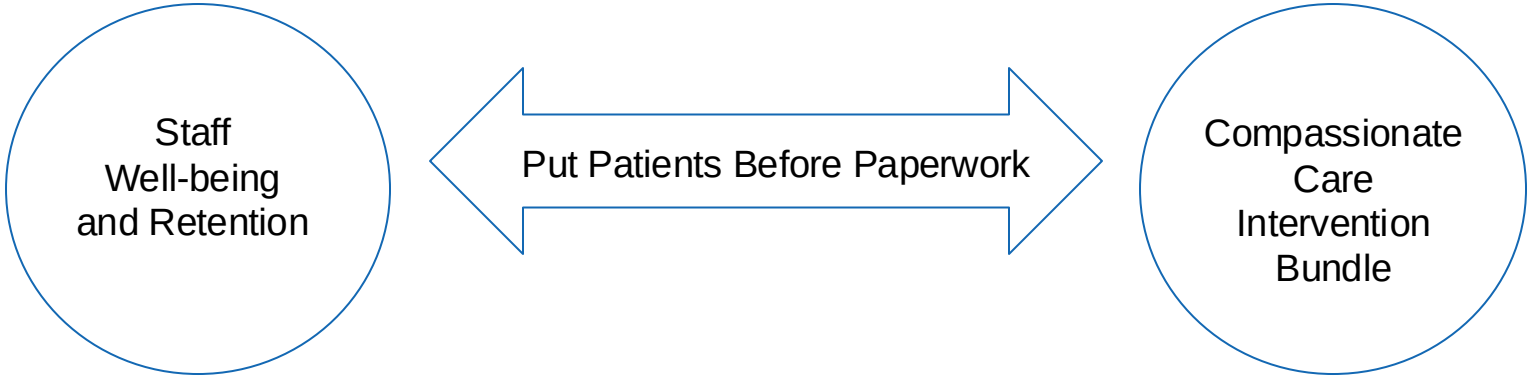
Aim Statement **Deliver a Compassionate Care strategy by implementing an evidence-based compassionate care intervention bundle, supporting staff well-being and prioritizing patient needs over paperwork**

P PERSON-CENTRED

VP Leads	Sub-Aim	Medical Lead
Nely Amaral and Lianne Jeffs	Compassionate Care Intervention Bundle	Lesley Wiesenfeld (delegate)
Barb Griffin Ian McDermott	Staff Well-being and Retention	Mark Lachman (Physician wellness)
Lily Yang	Put Patients Before Paperwork	(CMIO)



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Compassionate Care Strategy – Compassionate Care Strategy BOARD PRIORITY

PERSON-CENTRED

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Compassionate Care (patient)	9S (Neuro/Medical Complex Care) HBH pilot MSH 14N (General Surgery)	Compassionate Care Survey “Involve you in decisions about your treatment”	2024 Experience Survey: Strongly Agree **HBH 9S**: 30% **MSH 14N:** 43%	10% improvement Top Box (Strongly Agree) **HBH 9S: 33%** **MSH 14N: 47%** **Top Performer Compassionate Care survey for provider and patient**	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Compassionate care bundle	**Foundational** Develop governance structure/advisory group (SH)	% Project Milestone	100%	
2		**Foundational** Develop and conduct an asset mapping (inventory) of internal compassionate care work in place and pilot on 9S at HBH	% Project Milestone	100%	
3		Launch a pilot on 9S (HBH) and 14N (MSH) with the CC Intervention bundle/ (Patient) Family Integrated Care	2/2 units	100%	
4		**Foundational** Analyze and synthesize data points/sources to inform development of 3 year compassionate care strategy including bundled intervention, implementation/ operationalization plan, and evaluation framework including data visualization strategy	% Project Milestone	100%	
5		Co-design a CC Strategy	% Project Milestone	100%	

Compassionate Care Strategy – Well Being: Workplace Violence

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Time in-between Serious Workplace Violence incidents resulting in harm	All staff and physicians across SH	SAFER	2023/24 2 events Sept and June Days in-between is 267 days	5% improvement Time in-between events is 280 days **Theoretical Best to ZERO**	See OHS Serious Safety Reporting Classification of Harm (next slide)

#	Change Idea	Methods	Process Measure	Target	Comments
1	Enhanced Management of High Risk Behaviors	**Foundational** Plan for expansion of VAT for WIH and 6N/6S at HBH areas	% Milestone	100%	EPR
2		Complete employee training (Safe Management Group) to high risk areas of HBH (6N/6S)	% Competency Achievement	75%	Nursing and HD
3		Develop and launch an aggression visual indicator and process across SH and pilot	% Milestone	100%	
4	Support for Staff involved in incidence of violence	Develop Code White Hot Debriefing Tool and pilot **on one unit at each site**	Units to pilot	2/2	
5		Expand Personal Duress System (**MSH**: GIM) **(HBH**: 6N/6S)	Duress System Implemented	MSH 4/4 units HBH 6N/6S	Carried over from 24/25 QP CAPITAL

Compassionate Care Strategy – Well Being: Voluntary Departure < 2years

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
% improvement in nursing turnover and achieve a ZERO Never Event related to the premature departure (voluntary) within two years of hire	Nursing at MSH and HBH	OHA Benchmark 12.26 (all staff) MSH approx. 7% (all staff)	Nursing (SH) FY 24-25 Q3 19.8%	10% Improvement to 18% **Year over year improvement to Theoretical Best ZERO**	

#	Change Idea	Methods	Process Measure	Target	Comments
1	Exit Interview	Develop exit interview process for nursing and pilot on 10 nursing staff who voluntarily resign in first 2 years of hire	Completion	10/10	
2		Provide unit level data on Nursing Turnover in first 2 years of hire	% Milestone	100%	
3		Develop Action Plan based on Exit interview and Nursing Retention Toolkit – pilot on highest turnover unit	% Milestone	100%	
4	Reconciliation, Equity, Diversity and Inclusion (REDI) Strategy Implementation	Enhance REDI trainings offering for leaders	% Milestone	100%	
5		Establish a REDI Advisory Committee	% Milestone	100%	
6		Global Workforce Survey (Accreditation Canada) to establish REDI baseline	% Completion	60%	

Compassionate Care Strategy – Digital Strategy

PERSON-CENTRED

Indicator	Unit Measure or Patient Population	Data Source	Baseline	Target for 25/26 3 Year Stretch Target	Target Justification
Board Resource and Planning Project Approved Milestones	% Milestone Completion	Minutes Board Resource and Planning	**NA**	90% milestones	**Project based initiative**
EPR Renewal Priority Indicators • HIMSS Level/Digital Maturity • Patient Experience - Patient Portal • Clinician Burnout (mini-Z) • Clinician Burden • Adoption of Evidence Based Practices	TBD	EPR Renewal Evaluation	**Available for Q1 2025/26**	Collecting Baseline Targets to be Set with Benefits Realization framework	**EPIC is not anticipated to be live until 2026/27**

#	Change Idea	Methods	Target	Comments
1	Renew EPR EPIC **Foundational**	Getting Ready: • Board and RAP Go-No-Go Approval (total cost of ownership; governance structure) & Signed Governance agreement. • Implement Governance Structures, Recruit Resources • Finalize Scope: Integrations, Third Party Contracts • Orientation Sinai Health Leadership Team, Technical Readiness, Detailed Project Plan	90% Milestone Completion	Q1
2		Phase 0 Pre-work and Project Team Training • Project Team Training and Certification • Finalize KPIs and Benefits Realization Plan • Provisioning Sinai Health with Environment Access, Complete Data Collection Documents	90% Milestone Completion	Q2
3		Phase 1 Workflow Walkthrough and Configuration • Review and Determine Future State Workflows • Testing Preparation, Readiness and Training to Configure Workflows	90% Milestone Completion	Q3
4		Phase 2 User and System Readiness • System Testing: Application, Interface, Conversion, Mapped Record, Results Routing, Technical, End to End • User Acceptance Testing, Org. Readiness, Training Preparation	90% Milestone Completion	Q4 to Q1 2026/27