UNITY HEALTH TORONTO
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FY 2025-26 Quality Improvement Plan (QIP)

Workplan - Improvement Targets & Initiatives

AIM		Measure							Change				
OH Quality Issue	Quality dimension	Measure/ Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Experience	Patient-centred	**Top box response to "Did you feel you had enough information to manage your health after you left the hospital?**	% / Inpatients excluding pediatrics, mental health, palliative, intensive care and Providence Health Care (including HDP)	In house survey - Qualtrics / Q1-Q3 2024-25	**65.0%**	**66.3%**	A multi-year strategy is required to optimize the new After Visit Summary (AVS) tool in Epic which will directly support this initiative. A 2% increase represents a reasonable improvement over the next year. Year over year increases in performance will be a priority within the multi-year strategy.		1. Create organizational working group to facilitate multi-year AVS optimization strategy including Patient Family Partners. 2. Develop multi-year strategy to optimize AVS for inpatients with clear actions for completion in year 1 (2025-26). 3. Provide unit based data to clinical areas. Leverage our Quality Management System to review performance and problem solve as interdisciplinary teams. 4. Identify 1-2 clinical services to begin AVS optimization strategy in year 1 of multi-year strategy. 5. Collect baseline data at Providence (PHC) and complete analysis to inform further strategies as part of the multi-year AVS optimization strategy.	Progress measured by presence or absence of organizational working group. Progress measured by: 1. Development of a formal multi-year AVS strategy 2. Development of key actions for completion in FY 2025-26. Progress measured by the development of discharge experience dashboard in Qualtrics with easy to print function. Progress measured by the identification of 1-2 clinical services to focus optimization efforts on in FY 2025-26 based on volume of patients and discharge experience performance. Progress measured by capture of baseline data for discharge experience survey question at PHC completed.	By May 1, 2025 the Unity organizational AVS working group is in place. By June 1, 2025 a multi-year strategy to optimize the AVS is completed. By June 1, 2025 key actions for completion in FY 2025-26 developed. By April 1, 2025 discharge experience specific dashboard built in Qualtrics with easy to print function. By May 1, 2025 1-2 clinical services identified to focus optimization efforts on in FY 2025-26. By June 30, 2025 baseline data for discharge experience survey question at PHC completed.	In place by May 1, 2025. Both in place by June 1, 2025. In place by April 1, 2025. In place by May 1, 2025. In place by June 30, 2025.	
Safety	Safe	**Number of falls resulting in moderate harm, serious harm or death**	Number / All inpatients	Safety First / 2024	**60**	**57**	We are targeting a 5% reduction. With appropriate precautions in place, falls leading to harm are preventable.		1. Patient Safety to promote and track use of the Safety First incident reporting system as a standard tool to report falls. 2. Provide clinical programs and units access to data for all inpatient falls. Leverage our QMS to review program/unit performance. Promote local team ownership of data and opportunities to discuss to foster quality improvement initiatives. 3. Analysis of Contributing Factors in Safety First Fall Incident Reports to be completed to thematically map factors to selected Universal Falls Precautions. Summary data will be provided to Programs for identification of gaps in silo, to inform future safety improvement opportunities. 4. Support the uptake of the Falls Prevention Care Plan, its appropriate use and its integration into clinical care and as a foundation for discussion in team based QMS opportunities.	Falls Steering Committee to provide consultation on education material and resources to support dissemination of information to clinical operational teams on effective reporting of falls through Safety First. Data to be provided: 1. Number of inpatient falls with moderate or serious harm or death by unit (source: Safety First) 2. Percentage of inpatients with Universal Falls Precautions documented within outlined times according to discipline e.g. Nursing 2 hours, OT/PT as part of an initial assessment encounter with patients (source: Epic). Conduct thematic analysis of contributing factors, abstracted from Safety First Fall Incident Reports. Review draft themes identified with Steering Committee and key stakeholders to validate findings as they relate to implementation of Universal Fall Precautions. Obtain and user feedback on care plan utility and optimize design. Work with Clinical Informatics and Falls Steering Committee to confirm and implement an approach to monitoring the initiation of Falls Prevention Care Plans and associated documentation as clinically indicated.	Compare total number of falls reported in EPR against those reported in Safety First to confirm accurate Safety First usage. Development of standard reports/ dashboard on falls to be provided to all clinical programs across Unity. Percentage of Programs that have falls metrics on Program Quality Scorecard. Completion of contributing factors analysis, and related recommendations for future work Percentage of inpatients with Universal Falls Precautions documented by Nursing within 2 hours of admission (source: Epic). Percentage of inpatients with Universal Falls Precautions documented by OTs and PTs as part of initial assessment encounter (source: Epic).	Falls Steering Committee members to assist in the dissemination of education materials and other resources to support effective reporting of falls. Completed by Aug 31, 2025. Standard reports on falls across Unity developed and distributed by Q2. 100% of clinical programs should be monitoring Falls metric through Program Quality Scorecard. Completed by December 31, 2025. Identify current Falls Prevention Care Plan baseline data and set future targets for improvement by December 31, 2025. Determine optimization and related education plan based on end user feedback by December 31, 2025.	This work will be part of a multi-year improvement strategy
		***Percentage of admitted patients with universal falls precautions documented within 2 hours of admission**	% / Inpatients (exclud. ED non admitted, LTC)	Epic/ TBD	**TBD**	**TBD**							
		Number of hospital acquired Stage IV pressure injuries	Number / All inpatients	Safety First / 2024	**8**	**0**	Stage IV hospital acquired pressure injuries are a never event		1. Promote and track use of the Safety First incident reporting system as a standard tool to report all hospital acquired pressure injuries (HAPI) 2. Provide clinical programs and units access to data for all HAPIs. Leverage QMS to review program performance, problem-solve as interdisciplinary teams and implement targeted initiatives where required . 3. Improve access to therapeutic surface for patients that have been identified as at risk for pressure injuries. 4. Introduce a UHT-wide pressure injury prevention care plan and unique visual identifier for individuals at risk of developing pressure injuries in the new EPR	Provide education and resources to clinical operational teams on reporting HAPIs through Safety First Data to be provided: 1. Number of stage 4 HAPIs by site/ department (source: Safety First) 2. Percentage of inpatients with a completed Braden risk scale assessment and integumentary assessment within 24 hours of admission by unit (source: Epic) Monitor inventory of therapeutic surfaces to identify gaps and action plan to address gaps Reinforce and monitor enactment of standardized therapeutic surface algorithms with clinical teams Obtain and user feedback on care plan utility and optimize design	Compare total number of HAPIs reported in EPR against those reported in Safety First to confirm accurate Safety First usage. Development of standard reports on HAPIs to be provided to all clinical programs across Unity. Percentage of Programs that have HAPI metrics on Program Quality Scorecard Review root causes in Safety First cases where the correct therapeutic surface was not utilized. Work with clinical informatics team and Steering Committee to confirm and implement an approach to monitoring the initiation of pressure injury prevention care plans when clinically indicated. Review care plan completion rates for patient's identified as at risk for pressure injuries.	Dissemination of education materials and other resources on reporting of HAPIs completed by Aug 31, 2025. Standard reports on HAPIs across Unity developed and distributed by Q2 100% of Clinical Programs monitoring HAPI metric through Program Quality Scorecard Review inventory of therapeutic surfaces across Unity Health by March 31, 2026 and provide recommendations to Clinical Equipment department and operational teams for follow-up. Identify current care plan completion baseline and set future targets for improvement by December 31, 2025. Determine optimization plan based on end user feedback by December 31, 2025.	
		***Percentage of inpatients with a completed Braden risk scale assessment and integumentary assessment within 24 hours of admission**	% / Inpatients (exclud. Pediatrics, NICU, palliative, obstetrics, MH and ED non admitted)	Epic/ TBD	**TBD**	**TBD**							
		Number of newly acquired stage II,III,IV unstageable and deep tissue pressure injuries	Number / LTC home residents	In house data collection / Q1-Q3 2024/25	**30**	**25**	Our 2024-25 QIP target was not met, and so we will continue to prioritize this work this year to achieve this target.	RNAO Long Term Care Best Practices Program	1. Enhance the current process for high risk rounds. 2. Implement an application to improve registered staff's early identification, tracking and documentation related to pressure injuries. 3. Develop Best Practice Wound Care Champions on each floor to help disseminate knowledge to practice transfer.	Develop specific criteria for an interdisciplinary assessment of residents at high risk of developing pressure injuries. Engage relevant stakeholders in identifying criteria. Select application for skin and wound tracking by May 31, 2025. Implement skin and wound app. Raise awareness of Best Practice Guidelines related to wound care amongst registered staff. Ensure compliance with prevention strategies and updating of high risk wound rounds.	Percentage of units implementing the new process for interdisciplinary wound rounds each quarter. Number of staff who have received training on the skin and wound app. Percent of units implementing skin and wound app. Percent of FT and PT RNs on each shift who received Champions training. Percent of floors with RNs responsible for generating Weekly Pressure Injury Prevention High Risk rounds.	100% of units in the Houses of Providence to have initiated interdisciplinary high risk wound rounds by the end of September 30, 2025. 100% of units have implemented skin and wound app by September 30, 2025. 50% of FT and PT RN's received Champions training from RNAO by September 30, 2025. 100% of floors to have champion model in place by October 31, 2025.	Through collaboration with RNAO Long Term Care Best Practices Implementation Coach.
		Percentage of reported workplace violence incidents that resulted in health care and lost time	% / Worker	In house data collection / 2024	**7.8%**	**7.0%**	We are targeting a percent improvement of 10%		1. Perform a detailed review into workplace violence health care and lost time data to understand contributing factors and root causes to inform the development and implementation of QI initiatives. 2. Perform a detailed review to develop improvement strategies to address non-compliance with non-violent crisis intervention education and training in high risk areas. 3. Leverage EPIC to understand ABC policy compliance and implement strategies to increase compliance with the Violence Assessment tool (VAT) and Safety Plan.	We will pull data from our Parklane database to be able to review lost time and healthcare incidents from the last fiscal year. We will maintain an Excel tracking spreadsheet of all incidents and the findings including common themes of contributing factors, who we followed up with and outcomes of the incident. Maintain a database/spreadsheet of all high-risk departments to track enrollments, attendance and completion of the Non-Violent Crisis Intervention (SMG) training. Review performance and report on training completion rates and any observed correlations with workplace violence incidents. Engage relevant stakeholders in a review of findings (e.g., department heads, safety committee). We will work with the data analytics team from EPIC to build the policy compliance reports. Performance to be trended and shared with teams. Teams can chose to include leveraging the QMS for engagement and policy sustainment. When reviewing individual incidents, data will be reviewed in the patient's chart in EPIC and findings will be kept in an Excel tracking document in a secure file location. Reports from EPIC and policy compliance will be shared with the Corporate Prevention of Workplace Violence and Harassment Steering Committee on a quarterly basis.	Percentage of lost time incidents reviewed for FY24/25 Percentage of healthcare incidents reviewed for FY24/25 Number of root causes analysis reviewed and/conducted Number of themes and recommendations for prevention of lost time and healthcare incidents Percentage of staff in high-risk departments (ED, Mental Health (inpatient and outpatient), Withdrawal Management, Security) enrolled in training. Percentage of staff in high-risk departments who complete training annually. Percentage of staff in high-risk departments who complete training annually. Percentage of healthcare incidents for WHSW to audit in EPIC to check if VAT and Safety plan were completed. If not, WHSW to follow up with clinical team to understand barriers to completing. Number of units WHSW will attend huddles/meetings and provide education on VAT/Safety plan compliance	100% of lost time incidents reviewed by end of Q3 80% of lost time incidents reviewed by end of Q3 Review 10 previous root causes analysis and participate in 10 different root cause analysis for current incidents by Q3 Develop a report that includes a list of common contributing factors and 5+ recommendations to implement for incident prevention Achieve a target enrollment/attendance of 80% of staff in high-risk departments into the training program by end of Q4. Increase the percentage of staff in identified high-risk departments who complete training to 80% by the end of the FY 25/26.	Work in collaboration Parklane Claims Analyst, WHSW Safety Team and clinical leaders who conduct Root Cause Analysis after incidents. Factors for Success: The database/spreadsheet helps identify high-risk departments, which allows for strategic targeting and resource allocation. Collaboration with Elevate (our learning management system) is essential in order to ensure attendance records are accurate. Partnership and linkages with high-risk department managers and educators will be important to improve enrollment/attendance at training sessions.
		Rate of Vancomycin Resistant Enterococcus (VRE) – Nosocomial colonization or infection	Cases per 1,000 inpatient days (days hospital beds were occupied by patients) during the reporting period / All inpatients	IPAC VRE surveillance data (internal) and patient days (Decision Support and EPIC) / April 1, 2024 – Feb 28, 2025	**SMH: 0.46 SHC: 1.11 PHC: 0.01**	**SMH: 0.40 SHC: 0.80 PHC: 0.01**	Targets were set by benchmarking against our own past performance and what was determined to be realistic and achievable improvement goals for next year. The target for PHC is set as maintaining the current low rate.		1. Develop standard work for Environmental Services and clinical teams with respect to equipment and supplies cleaning and storage. 2. Conduct a Macrobor assessment and establish a process for managing down time in collaboration with clinical units, engineering, EVS. 3. Outbreak prevention plan for high-risk units. Determine measures that high-risk units may need to implement to prevent VRE above routine IPAC practices (e.g. Chlorhexidine bathing, environmental cleaning based on bioburden, etc.). 4. Consider targeted antimicrobial stewardship interventions in critical areas. 5. Equipment integrity assessment and processes for improvement. 6. Targeted education and training on cleaning and disinfection of shared equipment and body fluid management (including correct macerator use).	Development and/or update of policies outlining roles and responsibilities. Update and tracking of IPAC training for staff. Implement auditing program to ensure compliance. Regular meetings with EVS and clinical teams. Collaborative assessment of current state of macerators across all sites by IPAC and engineering. Formalize down-time procedure with IPAC, engineering, EVS and clinical teams. Implement a preventive maintenance schedule and downtime management process. Creation of outbreak prevention plan/guide by interprofessional working group (IPAC to lead but requires input from all relevant stakeholders). Identify high risk areas for VRE acquisition and outbreaks, and assess for utility of antimicrobial use assessment. Implement guidelines for appropriate antimicrobial use. Equipment assessment completed by clinical equipment team, clinical units and IPAC. Develop a process for regular inspection, maintenance and replacement of damaged equipment. Train staff on proper process. Formal and informal education and training for EVS, nursing, other relevant staff. Development and/or update of policies outlining roles and responsibilities.	1. Completion and dispersal of policies. 2. Percent of new staff who have completed relevant IPAC training. 3. Compliance rate (measured through audits). 1. Macerator assessment completion rate. 2. Completion of formalized downtime procedure. 3. Number of macerator downtime incidents. 4. Average downtime duration. 1. Compliance rate of Chlorhexidine bathing. 2. Environmental cleaning audit scores and audit numbers. 3. Set Hand hygiene compliance target. 4. Hand hygiene compliance. Adherence rate to antimicrobial stewardship guidelines. Reduction in inappropriate antimicrobial use. 1. Baseline assessment of equipment assessments done on high risk units 2. Reassessment of equipment on high risk units quarterly.	1. 75% of unit managers aware of new policy within 3 months 2. 25% of staff with documented completion of training in first 3 months 3. Audits to be completed monthly. 1. 100% of macerators assessed within 6 months 2. Completion of formalization downtime procedure for current macerators within 3 months 3. Reduce macerator downtime incidents by 25% within six months 4. Reduce macerator downtime by 25% within 6 months. 1. Achieve 75% compliance with CHG bathing 2. Maintain environmental audit scores above 95% 3. Set up unit based hand hygiene target at all high risk units within 1 month 4. Meet and maintain hand hygiene compliance target within 6 months. Baseline to be captured and targets to be set pending review 1. A baseline assessment of 100% of equipment on high risk units will be completed within 3 months 2. Quarterly reassessments of equipment in high risk units will achieve 75% compliance with schedule audits. 80% staff completed training within 3 months.	This requires significant collaboration between IPAC, EVS and nursing both at leadership level and at a unit level.
Efficient	Efficient	**Number of potentially avoidable Emergency Department visits for long-term care residents**	Number / LTC home residents	In house data collection / 2024	**HOP: 173**	**HOP: 156**	The Houses of Providence current rate of ED transfers is below the provincial average. However, there has been an increasing trend in the number of residents transferred to ED since 2021. The Houses of Providence is aiming for a meaningful change of a 10% reduction to address this increase.	Palliative Clinical Nurse Specialist, Palliative Integrated Long Term Care (iLTC)	1. Increase utilization of external resources 2. Increase awareness of palliative philosophy with families and Resident Assistants 3. Identify residents who would benefit from a palliative approach to care earlier in the care trajectory	Develop guidelines for registered staff and Physicians when referring to NP from Unity Health NLOT or contacting LTC + program. Engage relevant stakeholders in planning (NLOT, registered staff, Physicians).	Percentage of Floors that have implemented the new process Percentage of registered staff and physicians who have received education on new guideline Completion of education sessions delivered to families and resident assistants Percentage of residents who had an ED visit in the last 30 days who underwent an initial interdisciplinary palliative care assessment upon their return to the home. Numerator = total number of residents who had an ED visit in the previous 30 days who underwent an initial interdisciplinary palliative care assessment. Denominator = total number of residents with ED visits (who have not been previously reviewed in palliative rounds).	Draft guidelines developed by June 30, 2025. Trial new process on one floor in July 2025 with goal to have the new process rolled out on 100% of floors by September 1, 2025. 85% of registered staff and Physicians have received education on the guidelines by August 2025. Delivery of three education sessions (two for Families and one for Resident Assistants) completed by October 31, 2025. 60% of residents who had an ED visit in the last 30 days have been reviewed in interdisciplinary palliative rounds with implementation starting in April 30, 2025. Target of 60% to be maintained each quarter.	Leverage Unity Health Toronto's NLOT and LTC + programs. Education to be provided by Palliative Clinical Nurse Specialist (Palliative Integrated Long Term Care iLTC).
Access and Flow	Timely	**90th percentile ED LOS for Admitted Patients performance ranking compared to peer group**	90th percentile PAR ranking / All acute patients admitted via ED	OH PAR Performance Reporting, CIHI, NACRS / Dec 2024 – Nov 2025	**SHC: 7 out of 11 SMH: 2 out of 9**	**SHC: Top 1/3 SMH: Top 1/3**	EDLOS tends to increase and decrease across the system. Therefore we have set a relative target to be in the top 1/3 performance rank compared to our respective peer groups in the GTHA: SMH: Teaching Hospitals SHC: Very-high-volume Hospitals		1. Review and revision of Over Capacity Protocol (OCP): determine organizational surge capacity and implementation of levers to support flow during periods of capacity escalation. 2. Development of monthly and quarterly reports indicating daily average number of admitted patients who, at 8:00 am, had been waiting at least 2 hours since their disposition decision was made and who left the ED after 8:00 am. Report will be reviewed quarterly at the Access, Flow and Transitions Taskforce. 3. Develop and implement an IPAC review process for patients admitted in ED who have isolation orders to facilitate timely discontinuation where appropriate.	Confirm current surge capacity opportunities and response to periods of capacity escalation. Engage various stakeholder groups to evaluate use of existing OCP levers and recommendations for additional levers to support flow during periods of capacity escalation. Implement quarterly review of level 3 escalations at Access, Flow and Transitions (AFT) taskforce with a focus on: total ED NBA's; Flex bed usage; Bed Closures; number of surgeries; unconventional space use; ICU occupancy; number of discharges (by time of day and destination). Review data analytics opportunities for predictive flow with Project Connect COGITO team. Review data analytics opportunities to monitor daily average of admitted patients who remained in the ED at 0800 with no identified bed on an inpatient unit; Determine KPI's impacting the ability to transition patients who have been waiting at least 2 hours since disposition decision was made out of ED to inpatient beds ; Review current state process for use of unconventional spaces to support early transitions out of ED. Review of daily volumes of admitted patients in ED with isolation orders; Review time from order to discontinuation of isolation and variables facilitating discontinuation; Perform current state analysis of process for daily review of patients requiring isolation who remain in the ED; Collaborate with Project Connect COGITO team to identify data analytics options within EPIC.	Develop standard work for operationalizing OCP. Develop escalation report accessible in EPIC analytics dashboards for monitoring of key metrics influencing capacity escalation. Develop process for quarterly review and feedback of escalation reports. Develop EPIC analytics dashboard for monitoring of daily number of admitted patients remaining in ED who, at 0800, had been waiting at lease 2 hours since their disposition decision was made Develop standard operating procedures for use of unconventional spaces to support early transitions out of ED Develop process for quarterly review of reporting on daily average number of admitted patients who, at 8:00 am, had been waiting at least 2 hours since their disposition decision was made. Develop standard work for daily review process of patient requiring isolation who remain in ED in collaboration with Infection, Prevention and Control (IPAC), ED and internal Medicine teams Develop analytics dashboard in EPIC for monitoring of performance indicators impacting discontinuation of isolation.	Revised Over Capacity Protocol completed and implemented by July 31, 2025. Capacity Escalation report built and accessible in EPIC system by August 31, 2025. Capacity Escalation report to be reviewed quarterly at AFT Taskforce meetings by December 31, 2025. 0800 NBA Dashboard developed in EPIC by July 31, 2025 Standard Operating Procedures for management of unconventional space use to support access and flow to be completed by September 30, 2025 Quarterly review of 0800 NBA report and KPI's impacting transitions before 0800 at AFT Taskforce implemented by December 31, 2025. Standard operating procedures for review of admitted patients requiring isolation in ED developed by November 30, 2025. ED Isolation analytics dashboard developed in EPIC by October 31, 2025	
		Monthly average open Alternate Level of Care (ALC) cases	Number / ALC patients	WTIS; EPR (Epic) / Q1 - Q3 2024/25	**SHC: 84 SMH: 56 PHC: 36**	**SHC: 76 SMH: 50 PHC: 32**	We are targetting a 10% improvement aligned with OH reduction targets	Ontario Health, GTA Rehab Network, WTOHT ALC Working Group	1. Review of discharge delay reasons, Estimated Date of Discharge (EDD) and ALC barriers to discharge. 2. Develop and implement standardized escalation practices to support reduction and timely discharge of ALC cases. 3. Reestablish acute to rehab "Purple Pathway" and identify additional patient populations to support transitions to UHT post-acute sites.	Complete current state and root cause analysis; Identify KPI's for monitoring and control; Review of data and discharge delay reasons; identify system barriers to discharge and potential mitigation strategies; Collaborate with Project Connect team to leverage EPIC functionality and dashboard development to support access to data and timely review; Identify pilot units to trial process improvement change initiatives. Review current state and root cause analysis of ALC discharge delay reasons; Engage with stakeholder groups involved in discharge planning process; Identify KPI's to inform data review, monitoring and control; Collaborate with Project Connect COGITO team to review functionality to support escalation triggers. Current state analysis of referral volumes by program to UHT post-acute sites; Review of GTA Rehab Network Process Map and Admission criteria for Direct Access ED to inpatient Rehab; Identify KPI's for monitoring and control; Collaborate with Project Connect COGITO team to identify data analytics options within EPIC.	Develop and implement EDD protocol/process Develop discharge delay documentation and escalation processes Develop KPI report for monitoring and trending of discharge delay barriers Implement new protocols/process on pilot units Establish accountability structure for discharge escalation and response. Develop standard work for escalation processes Develop UHT Care Transitions letters and escalation processes documentation to support clinicians in their daily work Establish accountability structure for ALC escalation & response Create and disseminate communications and education materials. Create and disseminate communications and education materials Initiate pilot with PHC site of UHT for Direct Access from ED to inpatient rehab Develop standard operating processes for rehab referral direct from ED; Develop analytics dashboard in EPIC for monitoring of performance indicators impacting transitions to UHT post-acute sites.	Completion of current state and root cause analysis by April 30, 2025 Discharge delay documentation and escalation processes developed by June 30, 2025 Discharge Delay dashboard and report developed by July 31, 2025 Education and communication materials for dissemination to support implementation developed by August 31, 2025 Implementation of new protocols/process on pilot units by September 30, 2025. Standard work for escalation processes completed by May 31, 2025 Implementation of standard work for escalation processes by July 31, 2025 EPIC ALC dashboard with KPI's developed by August 31, 2025 Education and communications materials developed by June 30, 2025. SOP for rehab referral direct from ED developed by May 31, 2025 Pilot for Direct Access from ED to inpatient rehab initiated by June 30, 2025 KPI's and EPIC capability for monitoring identified by May 31, 2025.	
Equity	Equitable	**Percentage of clinical areas that have at least one patient-focused equity-oriented improvement initiative**	% / All inpatient and select outpatient units	In house data collection / n/a	**N/A**	**100%**	This target allows for realistic growth opportunities across the organization. Areas with equity oriented improvement efforts in place can look to expand implementation beyond education, evaluate impact, integrate more community partners, or launch new initiatives.		1. Cascading of organizational equity quality priority onto unit quality teams to highlight priority and to and current equity-oriented improvement projects and initiatives. 2. Update inventory collection tools and methodology to improve clarity and offer more guidance on what is an equity-oriented initiative. 3. The Office of Indigenous Wellness, Reconciliation and Partnership (IWRP) in partnership across the organization will begin to roll out improvements prioritized from the community engagement report. 4. The Anti-racism, Equity and Social Accountability (ARESA) office to provide ongoing and direct support to three units or departments per annum.	Tracking of local quality boards Submissions will be analyzed for clarity and quality 75 recommendations have been proposed. A steering group of VPs is working with the Office to prioritize each recommendation and assign accountable leader(s) who will begin to action and implement over the next three years. We will monitor and track the number of partnerships on equity-oriented initiatives in care.	Develop guidance for updating boards and reflecting equity-oriented improvement work. Percent of submissions rejected due to not meeting the criteria of equity oriented. Percent of the assigned recommendations for the current year that have a realistic implementation plan. Completion of quality training by three ARESA members; Number of quality committees where the offer for consultation is present or shared.	By Q3 2025-26 every quality board will have one initiative that is tracked and monitored by the respective unit that goes beyond education Less than 5% of initiatives submissions rejected due to not meeting criteria of "equity-oriented initiative" definition. 100% of the 75 recommendations have been prioritized and assigned to a lead VP 100% of the assigned recommendations for the 2025-26 fiscal year will be implemented 100% of the recommendations that are assigned an "on-going status" will be started in the current fiscal year. By Q4 2025-26 ARESA will have partnered with three or more departments on equity-oriented initiatives.	The Office of Anti-Racism, Equity and Social Accountability (ARESA) to share guidance with Program Quality Committees. Success factors include the continued implementation of quality boards in more outpatient areas Success in this initiative will require teams to know this offer for support is available. Methods will include sharing through Program Quality Councils, updates to department intake form and/or ARESA's intranet website to explicitly show this as a request option.
		Percentage of staff and leadership in the Houses of Providence who have completed relevant equity, diversity, inclusion and antiracism education.	% / Health providers in the entire facility	In house data collection / Q1-Q3 2024/25	**100% Leadership team 88% Staff/Physicians**	**100% Leadership team 95% Staff/Physicians**	Leadership team to maintain current performance at 100%. We are aiming for 95% completion of EDI education for staff and physicians in 2025 which would amount to a 7% improvement from baseline (88%).	CARESA - Council on Anti-racism, Equity, and Social Accountability at Unity Health Toronto	1. Leadership team to complete Braver Conversations and Let's Talk about Race education sessions. 2. Staff and Physician completion of relevant EDI education modules in Surge Learning and Elevate Learning Management System (LMS). 3. Support staff who encounter racism during the resident-provider interaction. 4. Increase the leadership team's awareness of Unity Health's Provider Preference policy.	We are planning additional education for the leadership team to build on foundational education completed as part of our 2024-25 QIP. These sessions aim to empower leaders to take action when it comes to issues of equity, diversity or discrimination. Attendance at education sessions will be tracked by DOC. Informatics Specialist to pull a quarterly report of percent completion from April 1, 2025 – December 31, 2025 for staff. Medical Director to provide report for Physicians. In collaboration with frontline staff, develop process to support individuals who experience incidents of racism while caring for a resident or family. Bring process to general staff meeting for feedback. Raise awareness of support process through staff education. Review the policy and provide feedback to CARESA.	Percentage of leadership team who completed Braver Conversations and Let's talk about race. Percent completion of relevant EDI courses in Surge Learning for staff. Percent completion in Elevate LMS by December 31, 2025 for Physicians. Number of times the support process has been utilized. Percent of staff that have received education on the support process Feedback provided.	100% of leadership team to complete Braver Conversations and Let's talk about Race by September 30, 2025. 95% of staff to have completed relevant EDI education by December 31, 2025. 100% of Physicians to have completed relevant EDI education by December 31, 2025. Trial process to be fully developed by July 31, 2025. 70% of staff have received education on the support process by August 31, 2025. Introduce CARESA's Provider Preference policy to leadership team by April 31, 2025. Offer feedback on policy by June 30, 2025.	Training to be facilitated by CARESA (Unity Health Toronto's Council on Anti-Racism, Equity, and Social Accountability).