Access and Flow

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Timely follow-up with hospital discharged patients This indicator measures the percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 4 days of discharge.	C	% / Discharged patients	EMR/Chart Review / Q2-3	CB	70.00	Previous QIP measure - hardwiring process between DRHC IP Unit and DAFHT.	Dryden Area Family Health Team

Change Ideas

Change Idea #1 All discharged inpatients of DRHC will receive a post – discharge telephone call from the Patient Care Navigator or designate to ensure safe transition home. The goal of the program is to improve patient satisfaction rates, decrease post-hospital discharge Emergency Room (ER) visits and readmissions to hospital.

Methods	Process measures	Target for process measure	Comments
•The Hospital Discharge Planner or designate will send a list of appropriate discharged patients to the Patient Care Navigator or designate on a daily basis. •The initial post-hospital discharge telephone call will be conducted by the Patient Care Navigator or designate. •The Patient Care Navigator or designate will telephone the patient, ask the scripted question set, and document the patient's responses in the Electronic Medical Records (EMR) – Currently PSS. • The goal is to have each appropriate discharged patient called within 4 business days of discharge from Dryden Regional Health Centre (DRHC).	In-scope DRHC discharged inpatients will receive a post-discharge follow up by the FHT Patient Navigator within 4 days of discharge.	70% of in-scope DRHC discharged inpatients will receive a post-discharge call/follow up by the FHT Patient Navigator within 4 days of discharge by the end 30 June 2024.	Out of Scope: patients transferred to alternative facility; deceased; admissions related to orthopedic surgeries. In-scope: Patients living within the Dryden Regional Health Centre catchment area.

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Patient/client perception of timely access to care: percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted (Dryden Area FHT)	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	CB	CB	New patient experience survey question	

Change Ideas

Change Idea #1 This is a new question for the Dryden Area Family Health Team (DAFHT) patient experience survey. The question will be added to the survey commencing April 1, 2024. DAFHT will collect a baseline for six months and then review for improvement opportunities beginning of Q3 2024-2025.

Methods	Process measures	Target for process measure	Comments
DAFHT will add the question to the patient experience survey, commencing April 1, 2024. The survey will be available to all patients on-site and on the website/face book page. Once a baseline is collected for six months, the team will review for improvement opportunities. This will be reported quarterly to the Senior Resource Team/ DRHC Quality Committee of the Board of Directors.	Patient experience survey will be updated and available for patient completion on April 1,2024. Between April 1, 2024 and September 30, 2024 the team will collect a baseline. By November 30, 2024, the DAFHT will review the data for future improvements opportunities.	By November 30,2025 the DAFHT will have a analyzed baseline data and identified patient experience improvement opportunities, reporting to the Senior Resource Team/ DRHC Quality Committee of Board of Directors in Q4 2024-2025.	

Measure - Dimension: Timely

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to inpatient bed	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	8.10	7.00	Q1/2 (2023-2024 fiscal period) 90th percentile emergency department wait time to inpatient bed = 7.9 hrs.	

Change Ideas

Change Idea #1 The DRHC Director Inpatient/Emergency Department will identify a working group and facilitate an administrative process review to determine opportunities for improvement related to the 90th percentile emergency department wait time to inpatient bed. Once the process review is complete, appropriate change concepts will be implemented by the working group.

Methods	Process measures	Target for process measure	Comments
The DRHC Director Inpatient/Emergency Department will identify a working group and facilitate an administrative process review to determine opportunities for improvement related to the 90th percentile emergency department wait time to inpatient bed. Once the process review is complete, appropriate change concepts will be implemented by the working group.	Working group identifies opportunities for improvement to address the 90th percentile emergency department wait time to inpatient bed.	By January 2025, the Emergency Department/Inpatient Unit Working group will begin implementing the change idea (s) for improving the 90th percentile emergency department wait time to inpatient bed.	

Equity

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	0.00	100.00	Executive/Management Organizational Target	Dryden Area Family Health Team

Change Ideas

Change Idea #1 The DRHC Equity, Diversity, and Inclusion (EDI) Committee will identify appropriate education that is relevant to the equity, diversity, inclusion, and anti-racism training needs of the management team.

Methods	Process measures	Target for process measure	Comments
The DRHC Equity, Diversity, and Inclusion Committee will identify appropriate education that is relevant to the equity, diversity, inclusion, and anti-racism training needs of the management team.	DRHC Management Operations Team will attend equity, diversity, inclusion, and anti-racism training as identified by the EDI committee.	100% of the DRHC Management Operations Team will attend equity, diversity, inclusion, and anti-racism training as identified by the organization by the end of December 2024.	

Measure - Dimension: Equitable

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Eligible non-rostered patients screened for cervical cancer within the recommended timelines (Dryden Area FHT)	C	% / PC organization population eligible for screening	EMR/Chart Review / 2024-2025	34.00	40.00	Current FHT target	

Change Ideas

Change Idea #1 To implement quarterly pap clinics, targeting individuals that are non-rostered and requiring a cervical cancer screen based on recommended timelines

Methods	Process measures	Target for process measure	Comments
To identify a pap clinic screening team and implement quarterly pap appointment (s) targeting individuals that are non-rostered and requiring a cervical cancer screen based on recommended timelines. Reported quarterly to the Senior Resource Team/ DRHC Board of Directors Quality Care Committee	quarterly cervical cancer screening clinics for non-rostered patients	4 cervical cancer screening clinics for non-rostered patients in the fiscal period 2024-2025.	

Experience

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: 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?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	74.07	CB	New survey methodology - collecting baseline	

Change Ideas

Change Idea #1 The DRHC is in the initial stages of implementing our patient experience survey on a new platform, Qualtrics.

Methods	Process measures	Target for process measure	Comments
The DRHC is in the initial stages of implementing our patient experience survey on a new platform, Qualtrics. Ensure a process is hardwired for collecting email addresses for submission to Qualtrics.	Ensure a process is hardwired for collecting email addresses for submission to Qualtrics.	Process is developed/implemented by June 1, 2024.	Total Surveys Initiated: 54

Measure - Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Do patients/clients feel comfortable and welcome at their primary care office? (Dryden Area FHT)	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	CB	CB	New question for the FHT.	

Change Ideas

Change Idea #1 This is a new question for the Dryden Area Family Health Team (DAFHT) patient experience survey. The question will be added to the survey commencing April 1, 2024. DAFHT will collect a baseline for six months and then review for improvement opportunities beginning of Q3 2024-2025.

Methods	Process measures	Target for process measure	Comments
DAFHT will add the question to the patient experience survey, commencing April 1, 2024. The survey will be available to all patients on-site and on the website/face book page. Once a baseline is collected for six months, the team will review for improvement opportunities. This will be reported quarterly to the Senior Resource Team/ DRHC Quality Committee of the Board of Directors.	Patient experience survey will be updated and available for patient completion on April 1,2024. Between April 1, 2024 and September 30, 2024 the team will collect a baseline. By November 30, 2024, the DAFHT will review the data for future improvements opportunities.	By November 30,2025 the DAFHT will have a analyzed baseline data and identified patient experience improvement opportunities, reporting to the Senior Resource Team/ DRHC Quality Committee of Board of Directors in Q4 2024-2025.	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	94.24	100.00	Theoretical Best	

Change Ideas

Change Idea #1 Discharge prescription will be scanned and uploaded to the pharmacist for review and verification. Pharmacist will make recommendations on medication reconciliation as necessary

Methods	Process measures	Target for process measure	Comments
Discharge prescription will be scanned and uploaded to the pharmacist for review and verification. Pharmacist will make recommendations on medication reconciliation as necessary. Reported to the Senior Leadership Team/DRHC Quality Committee of Board of Directors.	Qualifying discharges will be scanned/uploaded to pharmacist for review/verification/ recommendations.	By the end of Q1, 2024-2025, 100% of qualifying discharges will be scanned/uploaded to pharmacist for review/verification/ recommendation.	Continued from QIP fiscal period, 2023-2024. In-Scope: Qualifying discharges = medications ordered, alive, not newborn, no transfers, no AMA, no surgeries.

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	0.00	0.00	Maintain current performance	

Change Ideas

Change Idea #1 Established a workplan to implement RNAO Best Practice Guideline.

Methods	Process measures	Target for process measure	Comments
Establish and implement a workplan focused on the RNAO Best Practice Guideline.	Established a workplan to implement RNAO Best Practice Guideline.	Established a workplan to implement RNAO Best Practice Guideline by 31 May 2024.	