Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients/clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring (Weeneebayko Area Health Authority)	O	% / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	CB	CB	WAHA will aim to establish our current performance.	

Change Ideas

Change Idea #1 Establish baseline and data collection methods

Methods	Process measures	Target for process measure	Comments
Biweekly director of primary care, decision support, diabetes department and quality department to establish baseline and data collection methods.	we will measure the number of meetings per month.	Start of March 2025 2 meeting per month until baseline and data collection measures established. This will be obtained by June 30th, 2025.	This will be facilitated and monitored by primary health Director.

Change Idea #2 Patient reminders on the importance of the HBA1c testing and when it needs to be completed.

Methods	Process measures	Target for process measure	Comments
This will be done using a social media campaign. The following departments will meet during that quarter to develop the campaign (Mino, Diabetes, Primary Care, Chronic Disease Prevention)	1 social media reminder per quarter (4 per year).	We expect to see the post by the last month of quarter (the end June 2025, September 2025, December 2025 and March 2026)	This will lead by Chronic Disease and Wellness Director.

Change Idea #3 Prevention Specialist conversations to encourage goal setting with Clients with type 2 diabetes for updated HBA1C.			
Methods	Process measures	Target for process measure	Comments
Prevention Specialist will meet with clients and track goal settings and referrals for HBA1C.	We are going to measure the number of clients per month that have had conversations about HBA1C testing.	We will have 5 client conversations per month. (there will be 6o conversations by March 2026)	Chronic Disease and Prevention Director will facilitate and lead this.

Change Idea #4 Establish a flagging mechanism/pre-scheduling process			
Methods	Process measures	Target for process measure	Comments
We will have bi-monthly discussions for potential software upgrades and workflows that can be implemented. (feasibility on using MediTech Expanse)	The number of meetings held during the year.	We will have at total of 6 meetings by March 31, 2026.	The Primary Health Director will lead this.

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for admitted patients. (Weeneebayko Area Health Authority)	C	Hours / ED patients	CIHI portal / 2025-2026	29.00	24.65	We have challenges with bed availability and the human resources required for housekeeping and transporting patients timely. We are looking to improve by 15%.	

Change Ideas

Change Idea #1 Identify root cause of delays.

Methods	Process measures	Target for process measure	Comments
Conduct monthly meetings to review data and identify trends.	We will conduct a total of 6 meeting to identify the trends and opportunity for improvement.	By October 1st, 2025, we will have 6 meetings.	This will be led by ED Manager.

Change Idea #2 Improve accuracy of documentation by providing staff education.

Methods	Process measures	Target for process measure	Comments
Staff education will be done through Surge learning.	Measure number of staff who have completed the education in surge.	50% of ED staff will have completed the education by August 2025.	This will be led by education Department.

Change Idea #3 Education for IPD and facility services on the importance timely bed availability.

Methods	Process measures	Target for process measure	Comments
This education will be provided at departmental meetings.	Number of meetings held.	2 meeting held before the end of August 2025.	This will be led by IPD Manager.

Equity

Measure - Dimension: Equitable

Indicator #2	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	27.01	33.80	The goal is to improve by 25% each year, working toward the theoretical best target of 100% of staff completing the education	

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 Manager education on running reports.

Methods	Process measures	Target for process measure	Comments
A presentation will be held at leadership meeting to manager on how to run reports in Surge learning.	Number of meetings with presentation provided.	This will be done twice a year- due to high turnover of managers.	This will be led by Education department.

Change Idea #2 Providing time at home or at work to complete as soon as employee arrives.			
Methods	Process measures	Target for process measure	Comments
Staff will be given the time to complete education from home or at work once assigned.	The number of staff who are able to complete education within the first two weeks of being assigned.	15% of staff will have the annual education completed 1 month after assigned (determine date).	This will be led Education department.

Change Idea #3 Manager outreach.			
Methods	Process measures	Target for process measure	Comments
The Education Department to reach out on bi-annually to individual managers to communicate staff completion rates outreach will take place halfway through the completion timeframe and 1 month before the due date.	Bi-Annual outreach completed.	The Education Department will reach out to 5 individual managers with the most outstanding number of incomplete modules.	This will be led by Education Department.

Change Idea #4 Start incentives like early bird raffle prizes.			
Methods	Process measures	Target for process measure	Comments
All staff that have completed the modules within the first month of assignment will be entered into the draw.	Number of raffles held.	1 Raffle held per year.	This will be led by Education Department.

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of new hires with documentation of indigenous cultural awareness and competency training within a 12 months period (Weeneebayko Area Health Authority)	C	% / Staff	Local data collection / Most recent consecutive 12 months period	30.00	36.00	WAHA will improve by 20% each year, working toward the theoretical best possible performance for this indicator of 100%.	

Change Ideas

Change Idea #1 Manager education on running reports.

Methods	Process measures	Target for process measure	Comments
A presentation will be held at leadership meeting to manager on how to run reports in Surge learning.	Number of meetings with presentation provided.	This will be done twice a year- due to high turnover of managers.	This will be led by Education department.

Change Idea #2 Providing time at home or at work to complete as soon as employee arrives

Methods	Process measures	Target for process measure	Comments
Staff will be given the time to complete education from home or at work once assigned.	The number of staff who are able to complete education within the first two weeks of being assigned.	15% of staff will have the annual education completed 1 month after assigned (determine date).	This will be led Education department.

Change Idea #3 Manager outreach.

Methods	Process measures	Target for process measure	Comments
The Education Department to reach out on bi-annually to individual managers to communicate staff completion rates outreach will take place halfway through the completion timeframe and 1 month before the due date.	Bi-Annual outreach completed.	The Education Department will reach out to 5 individual staff with the most outstanding number of incomplete modules.	This will be led by Education Department.

Experience

Measure - Dimension: Patient-centred

Indicator #4	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	CB	CB	We are just establishing the survey process.	

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

Change Ideas

Change Idea #1 Implement a patient survey.

Methods	Process measures	Target for process measure	Comments
Utilizing software such Qualtrics for patient survey.	Measure the implementation of the system.	1 patient experience survey implemented by July 2025.	This will be led by Patient Experience Consultant.

Change Idea #2 Educate staff on the survey process so they can help do the reminders to complete			
Methods	Process measures	Target for process measure	Comments
Create surge learning module to have staff complete.	% staff who have completed the education.	30% of staff will have completed the education by the end of March 2026.	This will be led by Patient Experience Consultant.

Change Idea #3 Communication via social media to the communities about completing			
Methods	Process measures	Target for process measure	Comments
We will create a social media campaign and post publicly bimonthly for the first year.	Number of social media post per year.	A total of 3 social media posts by the end of March 2026.	This will be led by the Communication Department.

Change Idea #4 Create posters with QR codes to post			
Methods	Process measures	Target for process measure	Comments
We will create an educational poster with instructions on accessing the survey.	Number of posters created.	6 posters (1 for each community) will be created/posted by December 2025.	This will be led by the Communications Department.

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Do patients/clients feel comfortable and welcome at their primary care office? (Weeneebayko Area Health Authority)	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	CB	CB	Will need to collect baseline- as this is a new indicator. Will leverage technology qualtrics to get data.	

Change Ideas

Change Idea #1 Implement a patient survey.			
Methods	Process measures	Target for process measure	Comments
Utilizing software such as Qualtrics for patient surveys.	Measure the implementation of the system.	1 primary care patient experience survey implemented by July 2025.	This will be led by the patient experience consultant.

Change Idea #2 Educate staff on the survey process so they can help do the reminders to complete.			
Methods	Process measures	Target for process measure	Comments
Create a surge learning module for staff to complete.	% of staff who have completed the education.	30% of the staff will have completed the education by the end of March 2026.	This will be led by Patient Experience Consultant.

Change Idea #3 Communication via social media to the communities about completing			
Methods	Process measures	Target for process measure	Comments
We will create a social media campaign and post publicly bimonthly for the first year.	Number of social media posts per year.	A total of 3 social media posts by the end of March 2026.	This will be led Patient Experience Consultant.

Change Idea #4 Create posters with QR codes to post.			
Methods	Process measures	Target for process measure	Comments
We will create an education poster with instructions on accessing the survey.	Number of posters created.	6 posters (1 for each community) will be created/posted by December 2025.	This will be led by Communications Department.

Safety

Measure - Dimension: Safe

Indicator #6	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	CB	74.00	We will improve Medication Reconciliation at discharge by 15%.	

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 Staff education on completing the BPMH at the time of admission.

Methods	Process measures	Target for process measure	Comments
Remind staff of completing the BPMH timely as eviden by an increase	The percentage measures % of BPMH's completed within 24 hours.	The percentage measured %.	this will bel led by Pharmacy department.

Change Idea #2 Provider education on the importance of Medication Reconciliation and how to complete it.			
Methods	Process measures	Target for process measure	Comments
Demonstration during physician's meeting.	Number of demonstrations provided.	1 demonstration provided by June 30,2025.	This will be led by Education Dept.

Change Idea #3 Pharmacy team to help provide reminders.			
Methods	Process measures	Target for process measure	Comments
The pharmacy can use multiple channels to remind patients about their medications: text, phone, consults person, email.	Percentage of patients who receive reminders withing the recommended time frame.	Percentage of patients who engage with reminders, confirming receipt or acting on the reminders, such as by filing prescriptions, or adjusting their medications schedule.	Led by Pharmacy dept.

Change Idea #4 User friendly checklist for discharges.			
Methods	Process measures	Target for process measure	Comments
We will create a checklist with all the discharge requirements including the discharge medication reconciliation by June 30 2025.	the number of checklist created.	The checklist completed by June 30, 2025.	This will be led by the IPD manager.

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers within a 12 month period (Weeneebayko Area Health Authority)	C	Count / Worker	Local data collection / Most recent 12 consecutive months periods	46.00	69.00	The goal is a multi-year percent improvement approach until a corporate target. WAHA will aim to improve by 50% from current performance	

Change Ideas

Change Idea #1 Staff education on the workplace violence and when/what to report

Methods	Process measures	Target for process measure	Comments
Create and assign a module for surge learning for staff by June 30, 2025.	The percentage of staff who completed the module.	30% of staff to have completed the module by the end of December 2025.	Collaboration with OCC Health and Education Departments.

Change Idea #2 Staff education on how to report workplace violence

Methods	Process measures	Target for process measure	Comments
The Quality Department will provide education on how to report an incident in Meditech Expanse.	% of staff who have completed the education.	30% of staff will have completed education by end of December 2025.	Led by Quality and Education Departments.

Change Idea #3 Educate staff on completing a violence risk assessment in Expanse			
Methods	Process measures	Target for process measure	Comments
Create a surge learning module for staff to complete education completed by (June 30, 2025).	% of staff who have completed module in surge learning.	30% of staff will complete module in surge learning by the end of December 2025.	This will be led by Education Department.

Change Idea #4 Educate staff on how to flag a patient chart when there is a risk of violence and the interventions to be put in place.			
Methods	Process measures	Target for process measure	Comments
Create a surge learning module for staff. To be completed by June 30, 2025.	% of staff who have completed learning module in surge.	30% of staff will have completed module in surge learning by the end of December 2025.	Led by the Education Department.