Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of new patients/clients/enrolments (Weeneebayko Area Health Authority)	P	Number / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	CB	CB	Baseline data is currently being collected from June to December. This data will inform future target setting. Progress will be monitored monthly, with capacity reviews to support service planning and improvement.	

Change Ideas

Change Idea #1 Monitor new patient/client enrolment trends regularly

Methods	Process measures	Target for process measure	Comments
Track and review new enrolments on a regular basis to inform demand and capacity planning. Monthly	Percentage of months where new patient/client enrolment data is reviewed Numerator: Number of months enrolment data is reviewed Denominator: Total number of months in the reporting period	Monthly review of new patient/client enrolment trends Target: 100% of months with documented enrolment review	Lead by Director of Indigenous Primary Care Team

Change Idea #2 Escalate capacity or access concerns as required			
Methods	Process measures	Target for process measure	Comments
Percentage of identified access or capacity concerns escalated within established timelines Numerator: Number of access/capacity issues escalated Denominator: Total number of access/capacity issues identified	Escalate staffing, appointment availability, or capacity concerns that may limit new enrolments.	Escalation of identified access or capacity concerns Target: =90% of identified access or capacity concerns escalated within established timelines	Lead by Director of Indigenous Primary Care Team

Change Idea #3 Review barriers to accepting new patients/clients			
Methods	Process measures	Target for process measure	Comments
Quarterly Review common barriers (e.g., staffing, scheduling models, clinic capacity) that affect enrolment growth.	Percentage of quarters with documented review of barriers to accepting new patients/clients Numerator: Number of quarters with a completed barrier review Denominator: Total number of quarters in the reporting period	Quarterly review of barriers to accepting new patients/clients Target: 100% of quarters with a completed and documented barrier review	Lead by Director of Indigenous Primary Care Team/ Clinical Leads.

Measure - Dimension: Timely

Indicator #7	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 (Weeneebayko Area Health Authority)	P	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	CB	CB	The target is to go above and equal to 10% improvement in patient-reported timely access, informed by survey implementation and QIP guidance. From September onward, performance will be monitored monthly to support access improvements.	

Change Ideas

Change Idea #1 Monitor patient access survey results regularly			
Methods	Process measures	Target for process measure	Comments
=10% improvement from baseline by Q4, regardless of the number of surveys received.	Percentage of reporting periods where patient access survey results are reviewed	100% of reporting periods with documented review Baseline = 0 (no existing data); baseline established through initial data collection =10% improvement from baseline by Q4, regardless of number of surveys received	Lead by Director of (IPCT) Indigenous Primary Care Team/Patient Experience (Quality)

Change Idea #2 Escalate access concerns and barriers to Primary Care Team as required			
Methods	Process measures	Target for process measure	Comments
100% of identified access concerns are escalated to the Primary Care Team as required. Quarterly	Percentage of identified access concerns escalated to the Primary Care Team	100% of identified access concerns escalated as required Reviewed and reported quarterly	Director of (IPCT) Indigenous Primary Care Team/Clinical Team

Change Idea #3 Initiate ad hoc meetings with patient/client input when timely access perception scores fall below target.			
Methods	Process measures	Target for process measure	Comments
Ad hoc meetings, including patient/client input, are initiated when timely access perception scores fall below target.	Percentage of instances where timely access perception scores fall below target and an ad hoc meeting (with patient/client input) is initiated	100% of instances trigger an ad hoc meeting once thresholds are defined Escalation thresholds finalized after baseline establishment	Lead by Director of (IPCT) Indigenous Primary Care Team

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	P	Minutes / Patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	15.00	0.00	Progress will be monitored monthly (June-September ongoing), with capacity reviews to mitigate risks related to flow, staffing, and surge.	

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

Change Ideas

Change Idea #1 Monitor trends monthly

Methods	Process measures	Target for process measure	Comments
Trends are reviewed on a monthly basis.	Percentage of months where ambulance offload time trends are reviewed % of months offload time trends reviewed	Monthly review of ambulance offload time trends Target: 100% of months with documented review of offload time trends	Lead by Manager of ED/ Paramedic Service

Change Idea #2 Initiate ad hoc meetings if offload time approaches 30 minutes			
Methods	Process measures	Target for process measure	Comments
Ad hoc meetings are always initiated when ambulance offload time approaches for 30 minutes.	Percentage of instances where an ad hoc meeting is initiated when ambulance offload time approaches 30 minutes % of offload time threshold events with ad hoc meeting initiated	100% of instances where ambulance offload time approaches 30 minutes have an ad hoc meeting initiated	Lead by Manager ED/ Paramedic Services

Change Idea #3 Escalate concerns to ED/Paramedic team as required			
Methods	Process measures	Target for process measure	Comments
All ambulance offload time concerns are escalated to the ED team for review and action.	Escalation of ambulance offload time concerns to ED / Paramedic teams Target: =90% of identified ambulance offload time concerns are escalated to the ED and Paramedic teams within established timelines	Percentage of identified ambulance offload time concerns escalated to the ED and Paramedic teams for review and action	Lead by Manager of ED/ Paramedic Services

Measure - Dimension: Timely

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with low acuity	P	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	6.17	4.00	The 4-hour target aligns with Ontario Health benchmarks and represents improvement from the current 6.17 hours. Performance will be monitored monthly from June to December, with capacity reviews to support sustained access and flow improvements.	

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

Change Ideas

Change Idea #1 Monitor trends monthly

Methods	Process measures	Target for process measure	Comments
Ad hoc meetings are initiated as required when prolonged 90th percentile ED length of stay trends is identified for non-admitted, low-acuity patients.	Percentage of months where 90th percentile ED length-of-stay trends for non-admitted, low-acuity patients are reviewed	100% of months with documented trend review	Lead Manager ED

Change Idea #2 Escalate concerns to ED Team as required			
Methods	Process measures	Target for process measure	Comments
100% of identified concerns related to prolonged ED length of stay for non-admitted, low-acuity patients are escalated to the ED team as required.	Percentage of identified prolonged ED length-of-stay concerns escalated to the ED team	100% of identified concerns escalated as required	Lead by Manager ED

Change Idea #3 Initiate ad hoc meetings when thresholds are exceeded			
Methods	Process measures	Target for process measure	Comments
Ad hoc meetings are initiated 100% of the time when thresholds for the 90th percentile emergency department length of stay for non-admitted, low-acuity patients are exceeded.	Percentage of threshold exceedance events where an ad hoc meeting is initiated	100% of threshold exceedance events trigger an ad hoc meeting	Lead by Manager ED

Change Idea #4 Review common causes of prolonged length of stay for low-acuity patients by analyzing patient flow to identify bottlenecks, delays, and high-impact time frames.			
Methods	Process measures	Target for process measure	Comments
Demonstrate improvement in the 90th percentile emergency department length of stay for non-admitted, low-acuity patients compared to baseline, monitored monthly and reported quarterly.	Percentage of quarters with a completed patient-flow analysis identifying bottlenecks, delays, and high-impact timeframes	100% of quarters with documented patient-flow review	Lead by Manager ED

Measure - Dimension: Timely

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with high acuity	P	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	17.30	7.00	The 7-hour target aligns with Ontario Health benchmarks and represents a meaningful improvement from the current 17.5 hours. Performance will be monitored monthly from June to December, with capacity reviews to support access and flow improvements.	

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

Change Ideas

Change Idea #1 Monitor trends monthly

Methods	Process measures	Target for process measure	Comments
Monthly ED length-of-stay trend reports are completed and reviewed each month	Percentage of months where ED length-of-stay trend reports are completed and reviewed	100% of months with documented ED LOS trend review	Lead by Manager ED

Change Idea #2 Escalate concerns to ED Team as required			
Methods	Process measures	Target for process measure	Comments
100% of identified concerns related to the 90th percentile emergency department length of stay for non-admitted, high-acuity patients are escalated to the ED team as required.	Percentage of identified concerns related to the 90th percentile ED length of stay for non-admitted, high-acuity patients that are escalated to the ED team	100% of identified concerns escalated as required	Lead by Manager ED

Change Idea #3 Initiate ad hoc meetings when thresholds are exceeded			
Methods	Process measures	Target for process measure	Comments
100% identified concerns related to the 90th percentile ED length of stay for non-admitted; high-acuity patients are escalated to the ED team as required.	Percentage of threshold exceedance events for the 90th percentile ED LOS (non-admitted, high-acuity) that trigger an ad hoc meeting	100% of threshold exceedance events result in an ad hoc meeting	Lead by Manager ED

Change Idea #4 Review and address common causes of delay for low-acuity emergency department patients through patient-flow analysis to identify bottlenecks, system blocks, and high-impact time frames			
Methods	Process measures	Target for process measure	Comments
Achieve a 10% reduction from baseline in the 90th percentile ED length of stay for non-admitted, low-acuity patients	Percentage of quarters with completed patient-flow analysis identifying bottlenecks, system blocks, and high-impact timeframes	100% of quarters with documented patient-flow analysis completed	Lead by Manager ED

Measure - Dimension: Timely

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	X	3.40	From June to December, improvement efforts will focus on provider training, mandatory EHR documentation fields, and ER tracker reporting. Progress will be monitored monthly, with capacity reviews to support access and flow.	

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

Change Ideas

Change Idea #1 Collaborate with Informatics to identify which MDs/NPs require additional training in completing mandatory fields within Meditech Expanse, ensuring appropriate documentation and timing.

Methods	Process measures	Target for process measure	Comments
Achieve =90% completion of the required Expanse field by MDs/NPs, monitored monthly and reported quarterly.	Percentage of months where MD/NP documentation compliance reports are reviewed Percentage of identified MDs/NPs receiving targeted follow-up or education	100% of months with documentation compliance reviewed	Lead by Manager ED/ Informatics

Change Idea #2 Explore the possibility of making certain fields mandatory in MEDITECH Expanse.			
Methods	Process measures	Target for process measure	Comments
Identify, validate, and document MEDITECH Expanse fields that can be made mandatory within 1–3 months.	Percentage of identified MEDITECH Expanse fields reviewed and validated for mandatory status Documentation of Informatics and clinical approval decisions	100% of identified candidate fields reviewed, validated, and documented Completion within 1–3 months of review initiation	Lead by Manager ED/ Informatics/ IT

Change Idea #3 Develop reports to track compliance.			
Methods	Process measures	Target for process measure	Comments
Achieve =90% completion of required MEDITECH Expanse fields by MDs/NPs, monitored monthly an	Percentage of months where MEDITECH Expanse compliance reports are generated and reviewed Percentage of managers with access to and use of compliance reports	100% of months with compliance reports generated and reviewed =90% completion of required MEDITECH Expanse fields by MDs/NPs Monitoring monthly, reporting quarterly 100% of months with compliance reports generated and reviewed =90% completion of required MEDITECH Expanse fields by MDs/NPs Monitoring monthly, reporting quarterly	Lead by Manager of ED/Informatics/Decision Support

Change Idea #4 Provide education to all MDs/NPs (including locums).			
Methods	Process measures	Target for process measure	Comments
Ensure 100% of MDs/NPs receive education and training, monitored monthly and reported quarterly.	Percentage of MDs/NPs who receive standardized MEDITECH Expanse education Percentage of Locum MDs/NPs receiving onboarding education prior to or at start of service	100% of MDs/NPs (including Locums) receive education and training Education tracked monthly, reported quarterly	Lead by Manager ED/Informatics/Physician services

Change Idea #5 Standardize workflows and review and implement approved medical directives aligned with CTAS/ECTAS

Methods	Process measures	Target for process measure	Comments
Implement a visible ER tracker on the department TV by June/July and ensure 100% of MDs/NPs and nursing staff are aware	Percentage of approved medical directives reviewed and implemented Percentage of MDs/NPs and nursing staff aware of standardized workflows and ER tracker use	Visible ER tracker implemented by June/July -100% of MDs/NPs and nursing staff aware of ER tracker and standardized workflows -Alignment with approved CTAS/ECTAS medical directives documented	Lead by Manager ED/Education/Informatics/Physician Services

Measure - Dimension: Timely

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	P	Number / ED patients	CIHI NACRS / April 1, 2024, to March 31, 2025 (i.e., FY 2024)	0.05	0.04	The target reflects a 25% reduction from the current performance of 0.05, aligned with QIP guidance. From June to December, progress will be monitored monthly, with capacity reviews to support patient flow and mitigate risks related to bed availability and demand.	

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

Change Ideas

Change Idea #1 Monitor trends monthly			
Methods	Process measures	Target for process measure	Comments
Trends are reviewed on a monthly basis	Percentage of months where ED inpatient bed wait and LOS trends are reviewed	100% of months with documented trend review	Lead by Manager ED

Change Idea #2 Escalate concerns to ED Team as required			
Methods	Process measures	Target for process measure	Comments
Meetings are initiated when ED inpatient bed wait numbers approach established thresholds.	Completion of baseline data collection and definition of escalation thresholds Percentage of identified inpatient bed wait concerns escalated once thresholds are established	100% completion of baseline data collection within the first 4 months 100% of identified concerns escalated once thresholds are defined Escalation includes reminders or review meetings as required	Lead by Manager ED

Change Idea #3 Initiate ad hoc meetings when thresholds are exceeded			
Methods	Process measures	Target for process measure	Comments
Monthly monitoring with ad hoc meetings triggered by prolonged 90th percentile ED LOS trends; quarterly reporting.	Percentage of threshold exceedance events that trigger an ad hoc meeting	100% of threshold exceedance events result in an ad hoc meeting Monitoring monthly, reporting quarterly	Lead by Manager ED

Change Idea #4 Implement a Daily 8 a.m. Bed Readiness Huddle			
Methods	Process measures	Target for process measure	Comments
A daily 8 a.m. Bed Readiness Huddle is held to review ED inpatient bed readiness. Function designated/implemented within QIP year	Percentage of days a Bed Readiness Huddle is conducted at 8 a.m.	=90% of operational days with a documented 8 a.m. Bed Readiness Huddle	Lead by Manager ED

Change Idea #5 Use Bed Flow Coordinator or equivalent to support movement of patients through the system.

Methods	Process measures	Target for process measure	Comments
Function designated/implemented within QIP year	Monthly monitoring of ED inpatient bed readiness, baseline establishment with defined thresholds, escalation and ad hoc review, and daily Bed Readiness Huddles to support patient flow.	100% monthly review of inpatient bed wait/LOS trends 100% baseline established within first 4 months 100% escalation of concerns once thresholds defined 100% ad hoc meetings when thresholds exceeded =90% daily completion of 8 a.m. Bed Readiness Huddle	Lead by Manager ED

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	106.93	143.30	The target reflects an increase from 10% to 34%, aligned with QIP guidance for meaningful improvement. From June to December, progress will be monitored monthly, with strategies in place to support staff participation in EDI and anti-racism education.	

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 Manager education in running reports and interpreting data dashboard.

Methods	Process measures	Target for process measure	Comments
Bi-annual live training sessions (twice per year) plus recorded module for refresher access.	Count of manager education sessions delivered on running and interpreting reports; attendance per session	Deliver 2 live manager education sessions per year; achieve =80% manager attendance across sessions	Lead: Education Department. Sessions will include hands-on report generation, interpretation guidance, and Q&A; recordings and handouts posted to the intranet for ongoing reference.

Change Idea #2 Allow Staff protected time (1–2 hours paid) during shift or permit completion at home within 30 days of assignment. pa			
Methods	Process measures	Target for process measure	Comments
Offer 1–2 hours paid protected time on first shift (scheduled by manager) OR allow completion at home within 30 days with LMS reminders Communicate option in onboarding, add to orientation checklist, and ensure managers schedule/approve paid protected time Track protected-time use via manager logs and LMS completion timestamps	Percentage of staff provided protected time (at home or work) to complete requirements within one month of arrival/start % of new staff provided protected time (paid) within first month % of new staff completing required education within 30 days Average days-to-completion for new hires of managers scheduling protected time (compliance)	15% improvement in completion rates 100% of applicable staff complete requirements within 1 month Achieve a 15% relative improvement in completion rates within 3 months of implementation Long-term goal: 100% of applicable new staff complete requirements within 30 days Manager scheduling compliance =90% within 3 months	Lead by education

Change Idea #3 Manager outreach- Bi-Annual outreach to the top 5 managers with outstanding staff			
Methods	Process measures	Target for process measure	Comments
10 outreach per year	Number of targeted outreach activities conducted with managers who have the highest number of outstanding staff completions	100% of top 5 managers contacted twice/year (10 outreaches/year).	Lead by Education Department

Change Idea #4 Require 2 group viewing slots per Department/Site per quarter; attendance recorded and sent to Education Department for credit.			
Methods	Process measures	Target for process measure	Comments
# of sessions held / expected sessions (target: 2 per Department/Site per quarter).	Managers pick two dates per quarter, book meeting room/virtual link, and notify staff.	Each Department or site holds at least 2 groups per quarter.	Lead by Site/Dept. Managers and Education.

Change Idea #5 Targeted reminders campaign: kickoff email to execs/managers/staff + monthly newsletter reminders to units until they achieve target; remove unit from mailings once it reaches the stop□rule.			
Methods	Process measures	Target for process measure	Comments
send kickoff, monthly reminders, pull LMS monthly, update dashboard, stop-mail when unit =34%.	Target: reach 34% unit completion within 12 months; =10-point gain by month 3. Measure: % completion by unit (monthly).	Reach 34% unit completion within 12 months (baseline <10%).	lead by Communication

Experience

Measure - Dimension: Patient-centred

Indicator #3	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	0.00	90.00	Increase the percent of patients who report feeling comfortable and welcome at their primary care office from baseline to 90% by 09/30/2026.	

Change Ideas

Change Idea #1 Implement a standardized patient experience survey across services by April 1st 2026.

Methods	Process measures	Target for process measure	Comments
Implement a standardized patient experience survey across services by July 2025 did not occur because of delays with qualtrics-survey live March 23, 2026.	Survey tool implemented and available to patients/clients across all service areas; number of service locations offering the survey; monthly survey distribution counts	One standardized patient experience survey fully implemented and available system-wide by July 2025; =80% service locations offering the survey within one month of rollout	Lead: Patient Experience (Quality). Project includes staff training, translation into required languages, data collection plan, and monthly reporting of response rates and themes.

Change Idea #2 Educate staff on patient survey process and reminder workflows to increase survey distribution and completion

Methods	Process measures	Target for process measure	Comments
Training rollout: develop by June; initial sessions June–September; refresher and expansion through December	Number of training sessions delivered (live and e-learning) % of staff completing the training % of service locations using survey reminders as specified Monthly count of surveys distributed pre- and post-training	Training plan completed by June 30% of targeted staff trained by September (initial) Expand training to 80% of targeted staff by December =90% of service locations implementing survey reminders by December	Lead by Patient Experience (Quality)

Change Idea #3 Posters with QR codes in communities to increase patient survey access and engagement

Methods	Process measures	Target for process measure	Comments
Design print-ready poster with QR code linking to electronic survey; produce poster templates in multiple sizes and languages; coordinate with community partners for display locations; track distribution and replacement schedule (ipad use)	Number of poster designs finalized and approved Number of posters printed and distributed by community Number of community locations displaying posters QR code scan-to-survey conversion rate (scans resulting in a completed survey) Timeline adherence (design by June, partial distribution by September, full distribution by December)	Poster design and print-ready files completed by June Posters distributed to 3 communities by September Posters distributed to all 6 target communities by December Achieve posters displayed in =90% of identified locations within each community Attain a QR scan-to-completion conversion rate of =10% within first three months post-rollout	Lead by Communication's Team

Change Idea #4 Launch targeted patient engagement kiosks and outreach to boost survey reach and response quality. (Ipad)

Methods	Process measures	Target for process measure	Comments
Provide an iPad with a secure, lockable tablet stand at each of the 6 pilot sites for kiosk-based survey access; include charging station and tamper-resistant security.	of kiosks installed and operational by site % of service locations offering at least one survey modality (kiosk, QR, paper) of staff trained on survey distribution Monthly number of surveys distributed and completed (by modality) Monthly survey response rate and scan-to-completion conversion	Install iPads/stands at 6 sites by 07/01/2026. Tablet uptime =98%. =80% staff trained by start. =90% sites using QR/poster/paper by week 2. =50 surveys/site/month (=300 total) within 3 months. Response rate =12% (or +20% vs baseline) in 3 months. QR conversion =10% in 3 months. Weekly security checks; zero tampering.	Ipads installed at 6 target sites and survey available in 100% of service locations by 04/01/2026. Train =80% of front-line staff on survey distribution by rollout. Achieve =50 completed surveys/month system-wide within 3 months of rollout and a system-wide response rate =12% (or +20% over baseline) by 06/30/2026. Lead: Patient Experience (Quality) with Communications and IT

Safety

Measure - Dimension: Safe

Indicator #4	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	37.63	34.00	WAHA's current performance is 38%, demonstrating a need to improve safe transitions of care. The target of 74% by December 2026 represents a significant but achievable improvement, nearly doubling current performance June–September 2026: Education, workflow standardization, and discharge tools October–December 2026: Monitoring, reinforcement, and optimization	

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
30% initial staff education target via 20–30 minute e-learning module + 15–20 minute live demos and unit huddles; job-aid and EHR screenshots provided; LMS assignment, calendar invites, and refresher microlearning	Percentage of clinical staff educated on completing BPMH at the time of admission Percentage of admissions with a completed BPMH documented in the patient record % of clinical staff completing BPMH education (LMS) % of admissions with a completed BPMH documented at admission Time from admission to BPMH documentation (median hours) BPMH accuracy rate from periodic chart audits	=74% BPMH completion at admission Education tracked monthly, reported quarterly 30% of targeted staff educated (initial phase); education tracked monthly, reported quarterly 74% of admissions have BPMH completed at time of admission (primary target) Median time-to-documentation =4 hours within 3 months of rollout BPMH audit accuracy =85% within 6 months	Pharmacy Department
Change Idea #2 Provider education on the importance/how to (last years)			
Methods	Process measures	Target for process measure	Comments
1 demo-At least 1 live demonstration session plus recorded demo and job-aid distributed to providers	Number of provider education sessions or demonstrations delivered Percentage of providers receiving medication reconciliation education Number of provider education/demo sessions delivered Percentage of providers receiving and documenting medication reconciliation education Number of completed competency checks or return-demonstrations	At least 1 formal education/demo session delivered Provider education completed and documented within the QIP cycle Deliver =1 formal education/demo session during the QIP cycle =90% of providers complete and document the education within the QIP cycle =75% competency pass rate on return-demonstration checks	Lead by Education Department
Change Idea #3 Pharmacy team to provide provider reminders to complete medication reconciliation at discharge.			
Methods	Process measures	Target for process measure	Comments
Increase medication reconciliation at discharge to =74% by year-end through Pharmacy-led reminders.	Percentage of discharges where pharmacy-led reminders are provided to providers Percentage of discharges with medication reconciliation completed and documented	Increase medication reconciliation at discharge to =74% by year-end Monitoring monthly, reporting quarterly	Lead by Pharmacy/Physician Team

Change Idea #4 User friendly checklist for discharges (last years)

Methods	Process measures	Target for process measure	Comments
Create a standardized checklist template with input from clinical staff, pilot on unit, finalize and roll out system-wide; provide brief training and job-aid	Completion and implementation of a standardized, user-friendly discharge checklist Percentage of discharges using the checklist once implemented Completion of checklist development and pilot % of discharges using the checklist after implementation Number of staff trained on checklist use Number of workflow issues reported during pilot	standardized discharge checklist developed and implemented Checklist adoption monitored post-implementation Standardized discharge checklist developed and piloted by 06/30/2026 System-wide implementation by 09/30/2026 =80% of discharges use the checklist within three months of rollout =90% of targeted staff trained within one month of implementation	Lead by(IPD) Inpatient Department Manager

Measure - Dimension: Safe

Indicator #5	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	CB	CB	This indicator reflects staff safety and the impact of workplace violence. The target focuses on reducing the rate of incidents resulting in lost time injury, supported by staff education. Formal training will begin in June 2026, with most staff trained by September 2026. This phased approach is realistic given operational demands and supports improved prevention, awareness, and response. Progress will be monitored regularly, with the goal of reducing harm and improving a safe work environment.	

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 Educate staff on completing a violence risk assessment in Expanse (last years)			
Methods	Process measures	Target for process measure	Comments
% of targeted staff completing the VRA training module of live demo sessions delivered and attendance % of completed Violence Risk Assessments entered in Expanse within required timeframe (post-training)	% of targeted staff completing the VRA training module of live demo sessions delivered and attendance % of completed Violence Risk Assessments entered in Expanse within required timeframe (post-training)	30% of staff educated Tracked monthly, reported quarterly 30% of targeted staff trained (initial target) Training progress tracked monthly and reported quarterly Aim to increase VRA completion timeliness by 20% in trained units within 3 months	Lead by Education

Change Idea #2 Educate staff on how to flag a patient chart when there is a risk of violence and the interventions to be put in place. (last year)			
Methods	Process measures	Target for process measure	Comments
30-minute e-learning module plus 15–30 minute live demonstration and unit huddles Job-aid/quick-reference screenshots, sample documentation templates, and LMS assignment with calendar invites for live demos	Percentage of staff educated on how to flag patient charts for violence risk and apply required interventions % of targeted staff completing the flagging/intervention training of live demo sessions delivered and attendance % of flagged charts correctly documented with required interventions (audit sample)	30% of staff educated Tracked monthly, reported quarterly 30% of targeted staff trained initially (tracked monthly, reported quarterly) Within 3 months of training, =80% accuracy on documentation in audited flagged charts Plan to increase training coverage to 80% by end of QIP cycle	Lead by Education Department

Change Idea #3 Configure the Violence Assessment Tool (VAT) in Meditech to automatically pop up within the patient chart as part of the Standard of Care, prompting clinicians to complete the assessment and supporting early identification and escalation of violence risk.			
Methods	Process measures	Target for process measure	Comments
=90% completion of the Violence Assessment Tool (VAT) for applicable patients per patient-day within 3 months of automatic	Percentage of applicable patient-days where the VAT is completed once automatic pop-up is implemented	=90% VAT completion for applicable patients per patient-day Achieved within 3 months of automatic pop-up implementation Monitored monthly, reported quarterly	Lead by (IPD)In-Patient Department Manager, Informatics

Change Idea #4 Increase security/staff presence			
Methods	Process measures	Target for process measure	Comments
=95% coverage of identified high-risk shifts	Percentage of identified high-risk shifts with appropriate security or staff presence coverage	=95% coverage of identified high-risk shifts	Lead by Manager Security
Change Idea #5 NVCI training completed-for staff			
Methods	Process measures	Target for process measure	Comments
=30% staff completion within 12 months prioritizing high-risk clinical areas.	Percentage of staff completing NVCI training, with priority given to high-risk clinical areas	=30% staff completion within 12 months Priority focus on high-risk areas	Lead by HR and Education Department
Change Idea #6 Implement revised “stop work” policy (pilot in Atta)			
Methods	Process measures	Target for process measure	Comments
100% of Attawapiskat staff oriented to the revised Stop Work policy within 3 months of pilot implementation.	Percentage of Attawapiskat staff oriented to the revised Stop Work policy	100% of Attawapiskat staff oriented within 3 months of pilot implementation	Director of Patient Care Attawapiskat Site

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of faxes sent per 1,000 rostered patients (Weeneebayko Area Health Authority)	P	Number of faxes / PC patients/clients	/ Most recent quarter of data available (consecutive 3-month period)	CB	CB	This indicator reflects reliance on fax communication, which can impact efficiency and safety. The target of a 10% reduction from baseline by December 2026 is a realistic, incremental improvement given current workflows and limited benchmarks. Progress will be reviewed quarterly to monitor trends and adjust strategies. This supports safer, more efficient communication and movement toward digital practices.	

Change Ideas

Change Idea #1 Monitor fax volume trends regularly

Methods	Process measures	Target for process measure	Comments
Track the number of faxes sent per 1,000 rostered patients on a regular basis to establish patterns and opportunities for reduction	Percentage of months where fax volume (per 1,000 rostered patients) is tracked and reviewed	Target: 100% of months with documented fax volume monitoring Baseline established through initial data collection	Lead by Director of (IPCT) Indigenous Primary Care Team/Admin/IT/Decision Support

Change Idea #2	Identify high-volume fax workflows across Primary Care (e.g., IPS and other services) and assess opportunities to implement data-sharing or electronic communication solutions to reduce fax volume. IPS Innininew Patient Services		
Methods	Process measures	Target for process measure	Comments
Review common reasons for fax use (e.g., referrals, results, communication with external partners) to identify opportunities for alternative communication methods.	Percentage of quarters with a completed review of high-volume fax workflows (e.g., IPS, referrals, results, external partner communication)	100% of quarters with documented workflow review and identified opportunities for reduction	Lead by Director of (IPCT) Indigenous Primary Care Team/IT

Change Idea #3	Promote alternative communication methods where available.		
Methods	Process measures	Target for process measure	Comments
Encourage the use of electronic or non-fax communication tools where appropriate and available.	Percentage of identified workflows where an electronic or non-fax communication option is promoted or implemented	=90% of identified workflows have an alternative communication method promoted where feasible	Lead by Director of (IPCT) Indigenous Primary Care Team/IT

Change Idea #4	Initiate meetings when fax volume does not decrease.		
Methods	Process measures	Target for process measure	Comments
Initiate ad hoc discussions to review barriers and identify corrective actions when monthly monitoring shows fax volume remains above target.	Percentage of months where fax volume remains above target and an ad hoc review meeting is initiated	100% of instances where fax volume remains above target trigger an ad hoc discussion to identify barriers and corrective actions	Lead by Director of (IPCT) Indigenous Primary Care Team/IT