Access and Flow

Measure - Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ED length of stay	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)	5.67	5.00	Looking for an achievable reduction, acknowledging that access to primary care continues to be a district wide gap which impacts ED volumes.	

Change Ideas

Change Idea #1 Completion of ER Flow Quality Improvement project to identify opportunities for improvement.

Methods	Process measures	Target for process measure	Comments
Manual tracking of progress by ER Director and Quality Manager.	Completion of current state process map. Development of future state process map with identified change ideas for implementation.	100% completion of process maps.	Ongoing project.

Change Idea #2 Introduction of a Nurse Practitioner in the ED to support non-urgent visits and follow-ups.			
Methods	Process measures	Target for process measure	Comments
HR for hiring process. ED Manager to develop roles and responsibilities.	Hiring of a Nurse Practitioner.	1 Nurse Practioner employed to support the ED.	An increase in patients with no primary care provider has led to patients seeking medication renewals or non-urgent care in the ED.

Change Idea #3 Implementation of medical directives in the ER to enhance patient comfort and create efficiencies with diagnostic testing.			
Methods	Process measures	Target for process measure	Comments
Confirmed implementation of medical directives for treatment and ordering of diagnostic tests.	Clinical staff utilizing the medical directives to provide minor treatment (ex: gravol, antipyretics) and lab/diagnostic imaging.	The use of medical directives in the ER will be established by the end of Q1, in alignment with the Meditech Expanse project.	

Change Idea #4 Implementation of ER diversion initiatives.			
Methods	Process measures	Target for process measure	Comments
Working with the Timmins Academic Family Health Team (TAFHT), refer non-urgent patient to the TAFHT for same day appointment. Promote access to NE Episodic Virtual Care Clinic.	# of ER patients successfully diverted to TAFHT for same day or next day appointment. # of social media posts re: virtual clinic.	10% of non-urgent patients with a PCP at the TAFHT are booked for same-day or next day appointment.	

Measure - Dimension: Timely

Indicator #3	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)	14.63	13.50	Looking to improve performance while maintaining an achievable target. In addition to high ED volumes, the Hospital is undoing a big change to our EMR which will initially impact clinical efficiency and has required extensive resources.	

Change Ideas

Change Idea #1 Completion of ER Flow Quality Improvement project to identify opportunities for improvement.

Methods	Process measures	Target for process measure	Comments
Manual tracking of progress by ER Director and Quality Manager.	Completion of current state process map. Development of future state process map with identified change ideas for implementation.	100% completion of process maps.	Ongoing project.

Change Idea #2	Implementation of weekly meetings to review medical in-patient admissions above 10 days to support discharge planning.		
Methods	Process measures	Target for process measure	Comments
Medical unit manager and Patient Flow Coordinator will coordinate the weekly meetings with Discharge Planner and other team members.	Implementation of reoccurring meetings. Identification of discharge barriers or causes of increased length of stay.	5% reduction in length of stays above 10 days.	

Change Idea #3	Identify opportunities for improved integration of specialized geriatric roles across Hospital services to support risk identification and coordinated discharge planning.		
Methods	Process measures	Target for process measure	Comments
Review process of patient identification and referral to geriatric in-patient assessment team to identify gaps and opportunities. Facilitate the referral process to specialized team members. Evaluate performance indicators/statistics for GIA team.	# of patients assessed by GEM nurse. # of comprehensive geriatric assessments completed by geriatric in-patient assessment team.	Completion of review of patient identification process and communication of recommendations to care team.	A multidisciplinary Geriatric Inpatient Assessment Team was newly introduced to the organization in 23-24; the program is in development and continues to grow.

Equity

Measure - Dimension: Equitable

Indicator #1	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	CB	100.00	*focus on executive level and management staff for 2024-25	

Change Ideas

Change Idea #1 Establish ongoing EDI and Cultural Safety training requirements for managers and Senior Leadership Team members.

Methods	Process measures	Target for process measure	Comments
Human Resources will develop a training schedule and identify required training for leadership members to complete.	Identification of training modules for completion. Development of a tracking system for training.	100% of leadership team members will complete the required training modules (or in-person session) on a yearly basis.	