Access and Flow

Measure - Dimension: Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of people with Chronic Obstructive Pulmonary Disease (COPD) who get admitted or return to ED within 30 days after they have been triaged by the Nurse Navigator	C	% / Patients	Hospital collected data / Fiscal Quarters	32.39	27.00	Goal of the ICPs is to advance the quintuple aim (improved patient outcomes, better patient and provider experience, better value, and improved health equity) through integrated, population health-focused and equitable approaches to care. Each chronic disease pathway in this project will be measured against local indicators to evaluate its effectiveness and impact.	FLA OHT

Change Ideas

Change Idea #1 Improve COPD patient access to specialist care.

Methods	Process measures	Target for process measure	Comments
Initiate regular rapid access clinics in Kingston and Napanee.	- Number of Clinics offered in Kingston and Napanee every quarter. - Percentage of the eligible patients with suspected or known COPD who are referred to the rapid access clinic.	- At least 2 clinics offered monthly in Kingston & Napanee. - Above 75% every quarter.	

Measure - Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of people with Heart Failure who get admitted or return to ED within 30 days after HF admission and being optimized by the HF physician assistant.	C	% / Patients	Hospital collected data / Fiscal Quarters	35.20	30.00	Goal of the ICPs is to advance the quintuple aim (improved patient outcomes, better patient and provider experience, better value, and improved health equity) through integrated, population health-focused and equitable approaches to care. Each chronic disease pathway in this project will be measured against local indicators and process measures to evaluate its effectiveness and impact.	FLA OHT

Change Ideas

Change Idea #1 Improve the community access to heart failure specialist services.

Methods	Process measures	Target for process measure	Comments
1) Augment the current HF clinic capacity to accommodate more patients after hospital discharge. 2) Start a new post-discharge HF clinic with capacity to see 3-4 additional patients per week.	- Percentage of people hospitalized for heart failure who are referred to specialist after discharge. - Percentage of referred patients seen by a specialist provider after discharge.	- Above 50% every quarter. - Above 50% every quarter.	

Change Idea #2 Optimize heart failure patients during their hospital stay, improve care transition, and coordinate with community partner.

Methods	Process measures	Target for process measure	Comments
1) The HF physician assistant will see most HF patients admitted to internal medicine service for medication optimization. 2) the HF physician assistant will provide education to all these patients at the time of discharge, and connect them to remote care monitoring with Ontario Health at Home. 3) Upon discharge, the HF physician assistant will call and follow HF patients until they are seen by specialist provider. 4) The HF physician assistant will coordinate with patients' PCPs, Ontario Health at Home and community paramedics to identify higher risk patients whom she will fast-track for rapid follow-up.	- % of patients admitted with heart failure under internal medicine service who are seen and optimized by physician assistant. - % of patients seen by HF PA that are provided education and connected to appropriate post discharge care. - % of eligible patients receiving follow up care by HF PA. - % of eligible patients that are fast tracked and seen by HF specialist in 14 days.	- Above 50% every quarter. - Above 80% every quarter. - Above 50% every quarter. - Above 50% every quarter.	

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	70.00	In alignment with the KHSC Strategic direction, in FY 24-25 an overarching inclusion framework for the organization was developed and the framework will roll out in 2025-26 which will embed priorities such as education, Indigeneity, anti-racism, equity, access, and leadership. This year the priorities related to education and learning includes the Foundations for Inclusion @ KHSC course not only assigned to new hires, but also all employees with a goal of 70% completion.	

Change Ideas

Change Idea #1 Assign the foundational inclusion training to all KHSC staff as a part of their annual training			
Methods	Process measures	Target for process measure	Comments
On demand e-Learning course will be assigned through the Learning Management System which alerts via email to each employee that a mandatory training is required.	Percentage of eligible employees that are assigned the course	Above 80% every quarter	

Change Idea #2 Follow up with leaders to ensure completion of training for their staff			
Methods	Process measures	Target for process measure	Comments
Reminders sent directly via email with a timeline for completion. Communication broadly and to leaders regarding the initiative will also occur. Completion reports will be conducted monthly and broken down by department and individuals. The rate captures a moment in time and will inform leaders of their staff completion	Percentage of employees that complete the mandatory training in assigned time frame, including grace period	Above 50% starting Q2	

Safety

Measure - Dimension: Safe

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
This indicator measures the organization's compliance with Accreditation Canada's ROPs and High Priority standards.	C	% / Staff	Hospital collected data / Fiscal Quarters	33.00	100.00	Following a comprehensive self-assessment in FY25, KHSC will implement targeted improvement tactics to address identified gaps. The goal is to be 100% complaint by March 2026.	

Change Ideas

Change Idea #1 Systematic Testing of Compliance with Required Organizational Practices (ROPs)

Methods	Process measures	Target for process measure	Comments
- Improvement tactics/plan established for the identified gaps from Self-Assessment for each ROP - Implement unit-based mock tracers to assess adherence to ROPs in real-time patient care scenarios. - Standardized documentation review – policies, procedures and staff education materials to meet AC ROP's	- Proportion of Improvement plan reported for each ROP - Number of Mock Tracers/walk about completed per program for each ROP - Percentage of ROP's with appropriate documentation	- 100% by Q2 - 90% programs have 3-4 tracers/walk about completed per quarter across all ROPs by Q3 - 100% ROPs have complete documentation by Q3	

Change Idea #2 Ensuring compliance with High Priority Standards for online and site attestation.

Methods	Process measures	Target for process measure	Comments
- Establish a real time compliance tracking system with designated accountability leads to address deficiencies. - Conduct mock tracers/walk abouts to include attestation for High Priority standards.	- Percentage of High Priority Standards without deficiencies. - Number of mock tracers/walk abouts completed.	- 100% by end of Q3. - 90% programs have 3-4 tracers completed per quarter across all ROPs starting Q2.	