Access and Flow | Timely | Custom Indicator

	Last Year		This Year	
Indicator #5 Timely follow-up with hospital discharged patients (Algoma NPLC)	**79.60** **Performance (2023/24)**	**85** **Target (2023/24)**	**77** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue ongoing process with allied health team and nurse practitioners and monitor for any potential trends that might require intervention.

Process measure

- Each month we will review the average rate of patient discharge follow up and act accordingly.

Target for process measure

- The target we aim for is 85% or greater.

Lessons Learned

Challenges: System heavily relies on the MRP compliance to workflow in order to provide accurate statistics. Schedule restrictions. This parameter also relies on the local hospital providing discharge summary promptly.
Success: The whole Allied Health team involved in providing timely post hospitalization follow-up.

Safety | Effective | Custom Indicator

	Last Year		This Year	
Indicator #1 Overdue for Colorectal Cancer Screening (Algoma NPLC)	**55.31** Performance (2023/24)	**60** Target (2023/24)	**43.53** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Assigned team leads for each preventative care indicator. Implementation and monitoring of Ontario MD's i4C Dashboard for progress on eligible patients screened. Contact patients who remain unscreened on a quarterly basis.

Process measure

- Percentage of eligible patients screened for colorectal cancer screening

Target for process measure

- Our target is 60 percent of eligible patients screened.

Lessons Learned

Challenges: Staff retention, lab communication discrepancies, and patient willingness to participate. System heavily relies on the user data entry to provide accurate statistics.
Success: Student project enabled us to have the patients due for testing contacted twice a year if eligible.

Indicator #3

Percentage of screening eligible patients up-to-date with a mammogram (Algoma NPLC)

Last Year		This Year	
43.46	**60**	**47**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Assigned team leads for each preventative care indicator. Implementation and monitoring of Ontario MD's i4C Dashboard for progress on eligible patients screened. Contact patients who remain unscreened on a quarterly basis.

Process measure

- Percentage of eligible patients screened for breast cancer

Target for process measure

- Our target is 60 percent of eligible patients screened.

Lessons Learned

Challenges: Staff retention, lab communication discrepancies, and patient willingness to participate. System heavily relies on the user data entry to provide accurate statistics.
Success: Student project enabled us to have the patients due for testing contacted twice a year if eligible.

Indicator #4

Percentage of screening eligible patients up-to-date with Papanicolaou (Pap) tests (Algoma NPLC)

Last Year		This Year	
54.56	**60**	**50.55**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Assigned team leads for each preventative care indicator. Implementation and monitoring of Ontario MD's i4C Dashboard for progress on eligible patients screened. Contact patients who remain unscreened on a quarterly basis.

Process measure

- Percentage of eligible patients screened for cervical cancer.

Target for process measure

- Our target is 60 percent of eligible patients screened.

Lessons Learned

Challenges: Staff retention, scheduling restrictions, and patient willingness to participate. System heavily relies on the user data entry to provide accurate statistics.
Success: Student project enabled us to have the patients due for testing contacted twice a year if eligible.

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #2 Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system. (Algoma NPLC)	**CB** Performance (2023/24)	**CB** Target (2023/24)	**CB** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Systematic use of Opioid Manager for all patients on narcotic medication.

Process measure

- Percentage of client charts on opioid based therapy whom have a opioid manager form in their chart.

Target for process measure

- Our target is for 70% of our patient who have been prescribed an opioid to have the appropriate follow up completed.

Lessons Learned

EMR query challenges remain. additional work is required to optimize accuracy of data