2016/17 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

North Hamilton Community Health Centre 438 Hughson Street North, Hamilton, ON L8L 4N5

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	**Improve rate of cancer screening.**	Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years	% / PC organization population eligible for screening	See Tech Specs / Annually	91569*	83	70.00	MSAA target for 2016/17 is 70%	1)Reach out to primary care clients who are eligible to receive screening for colorectal cancer.	Utilize the EMR system to generate a list of eligible primary care clients and ensure that communication is made in appropriate languages to ensure that they are made aware of the opportunity to be screened. Post client education material in the waiting rooms at Health Centre regarding cancer screening benefits and availability.	% of primary care clients that are contacted to participate in cancer screening opportunities.	90% of all eligible clients will be contacted to participate in cancer screening opportunities by March 31, 2017.	
		Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years	% / PC organization population eligible for screening	See Tech Specs / Annually	91569*	64	70.00	MSAA target for 2016/17 is 70%	1)Reach out to primary care clients who are eligible to receive screening for cervical cancer.	Utilize the EMR system to generate a list of eligible primary care clients and ensure that communication is made in appropriate languages to ensure that they are made aware of the opportunity to be screened. Post client education material in the waiting rooms at Health Centre regarding cancer screening benefits and availability.	% of primary care clients that are contacted to participate in cancer screening opportunities.	90% of all eligible primary care clients will be contacted to participate in cancer screening opportunities by March 31, 2017.	
		Percent of eligible patients/clients who are up-to-date in screening for breast cancer.	% / PC organization population eligible for screening	EMR/Chart Review / 2016/17	91569*	52	50.00	MSAA target for 2016/17 is 50%.	1)Reach out to primary care clients who are eligible to receive screening for breast cancer.	In partnership with the Ontario Breast Screening Program, all eligible clients will receive invitations to begin screening, as well as reninders for re-screening via mail. We will also utilize the EMR system to generate a list of elible clietns to ensure that follow up communication is made in appropriate languages to ensure that they are made aware of the opportunity to be screened. Post client education material in waiting rooms at health Centre regarding cancer screening benefits and availability.	% of eligible primary care clients are contacted to participate in cancer screening opportunities.	90% of all eligible clients will be contacted to participate in cancer screening opportunities by March 31, 2017.	
	Improve rate of HbA1C testing for diabetics	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months	% / All patients with diabetes	Ontario Diabetes Database, OHIP / Annually	91569*	CB	CB	This year we will be collecting baseline data to better understand what improvement initiatives will need to be implemented to ensure an increase in HbA1C testing for clients with diabetes.	1)Reach out to clients who are diagnosed with diabetes to ensure HbA1C tests are being offered	Obtain list of all clients diagnosed with diabetes from EMR. Ensure all clients are contacted to perform HbA1C testing at least 2 times per year.	% clients with diabetes who are contacted for HbA1C testing	75% of all clients with diabetes are contacted and encouraged to complete HbA1C testing at least 2 times per year	
	Improve seasonal Immunization rates	Percentage of people/patients who report having a seasonal flu shot in the past year	% / PC organization population eligible for screening	EMR/Chart Review / Annually	91569*	14	15.00	MSAA target for this population was set at 15%	1)Reach out to primary care clients who are eligible to receive vaccination to inform them of availability of influenza vaccine at NHCHC.	Obtain list of all primary care clients over 6 months of age from EMR. Send written material regarding influenza vaccination benefits and information regarding availability to all clients identified in the EMR. Post client education material in waiting room at NHCHC regarding influenza vaccination benefits and availability.	% of primary care clients over 6 months of age that receive influenza vaccination.	15% of all eligible clients over 6 months of age receive influenza vaccination by March 31, 2017.	

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	Reduce hospital readmission rate for primary care patient population	Percentage of acute hospital inpatients discharged with selected HIGs that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission, by primary care practice model.	% / PC org population discharged from hospital	DAD, CAPE, CPDB / April 2014 – March 2015	91569*	4.1	3.00	According to the data provided by the RDSS, as of March 2014, 4.1% of clients were readmitted to hospital within 30 days of discharge, which is lower than the provincial percentage of 6.2%	1)Using client information systems to identify primary care clients that have been readmitted to any acute inpatient hospital for non-elective patient care within 30 days of discharge.	Use Integrated Decision Support (IDS)system and Clinical Connect (CC)system to identify primary care clients that have been readmitted to any acute inpatient hospital for non-elective patient care within 30 days of discharge to enable health care providers to provide timely follow up care, education and action plans for ongoing care.	% of primary care clients who have been readmitted to any acute inpatient hospital for non-elective patient care within 30 days of discharge as identified by IDS and CC.	Reduce primary care client have been readmitted to any acute inpatient hospital for non-elective patient care within 30 days of discharge to 3% by March 31, 2017.	
	Engage NHCHC clients to participate in Self-management initiatives	% of NHCHC clients that are participating in a self-management initiative	% / Clients	EMR/Chart Review / 2016/17	91569*	718	1000.00	As of December 2015, we reached 71% of our target.	1)Engage clients in a variety of self-management initiatives that are client specific.	Keep clients informed and engaged in the various self-management initiatives offered by the Health Centre - counselling, behaviour modification programs, goal-setting, collaborative care passports/plans. Provide ongoing continuing education to health care providers regarding motivational interviewing, "choose wisely" and appropriate documentation processes in the EMR.	Number of clients who participate in self-management initiatives.	1000 clients participate in at least one self-management initiative by March 31, 2017.	
	Increase opportunity for prevention or early detection of diabetes-related problems by increasing interprofessional diabetes care	Percentage of clients diagnosed with diabetes who receive interprofessional diabetes care at NHCHC	% / Clients diagnosed with diabetes mellitus	EMR/Chart Review / 2016/17	91569*	98	90.00	MSAA target is set at 90% for 2016/17	1)Ensure eligible clients are identified, inter-professional referrals are made and health care staff are competent at encountering procedures provided.	All clinical staff participate in EMR refresher training. Eligible clients flagged in EMR and notified to attend diabetes care services. Diabetes Nurse Educators to coordinate process.	% clients diagnosed with diabetes who receive inter-professional diabetes care at NHCHC.	90% of clients diagnosed with diabetes who receive inter-professional diabetes care at NHCHC by March 31, 2017.	
Efficient	**Decrease Emergency Department visits for conditions best managed elsewhere (BME)**	Percentage of patients or clients who visited the emergency department (ED) for conditions "best managed elsewhere" (BME)	% / PC org population visiting ED (for conditions BME)	DAD, CAPE, CPDB / April 2014 – March 2015	91569*	12.7	10.00	According to the data provided by the RDSS, as of March 2014, 12.7% of clients visited teh ED for conditions that could have been best managed elsewhere, which is higher than the provincial percentage of 11.4%	1)Using client information systems to identify primary care clients that are visiting ED for conditions best managed elsewhere.	Use Integrated Decision Support (IDS)system and Clinical Connect (CC)system to identify our top ED users for conditions best managed elsewhere to enable health care providers to provide timely follow up care, education and action plans for ongoing care.	% of primary care clients who visit the ED for conditions best managed elsewhere as identified by IDS and CC.	Reduce primary care client ED visits to 10% for conditions best managed elsewhere by March 31, 2017.	
	Ensure adequate access for PC services	Total number of patients registered to MDs and NPs	Number / PC organization population	EMR/Chart Review / 2016/17	91569*	4332	4728.00	At December 2015, the target panel size was determined to be 4728 clients.	1)To increase the number of patients registered to MDs and NPs	Review existing waiting list. Contact eligible potential clients to come to an orientation session. Work with partnering agencies regarding taking on priority clients that meet eligibility criteria. NHCHC is working with the Syrian Refugee Health Table to ensure primary care access is available to government assisted and privately sponsored Syrian refugees living in Hamilton.	Number of registered primary care clients	Increase total number of registered primary care clients to 4728 by March 31, 2017.	
	Ensure adequate access to new patients for PC services	Percentage of newly registered primary care clients with a physician, NP, or PA within the last 2 years	% / PC organization population	EMR/Chart Review / 2016/17	91569*	CB	CB	Will be collecting baseline data this year to better understand % of new clients registered in 2 year period	1)To increase the number of patients registered to MDs and NPs	Review existing waiting list. Contact eligible potential clients to come to an orientation session. Work with partnering agencies regarding taking on priority clients that meet eligibility criteria. NHCHC is working with the Syrian Refugee Health Table to ensure primary care access is available to government assisted and privately sponsored Syrian refugees living in Hamilton.	Number of newly registered primary care clients	Increase number of newly registered primary care clients to 400 by March 31, 2017.	

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	Ensure adequate staffing composition	Percentage of MD and NP permanent FTE positions that are occupied over the reporting period	% / MDs and NPs FTE	HR records / 2016/17	91569*	100	80.00	MSAA target is set at 80% for 2016/17	1)Maintain full staffing composition for MDs and NPs.	Ensure any vacancies are filled in a timely manner.	% MDs and NPs FTE	100% MD and NP FTE positions are filled	
	Ensure organizational safety	Complete health provider credentialing documentation	% / Health providers in entire facility	HR file audit / 2016/17	91569*	100	100.00	All health care providers must provide credentialing information annually.	1)Monitor and audit health professional credentialing documentation for all regulated health professionals.	Review health professional credentialing checklist. follow credentialing audit schedule. Ensure staff are provided information regarding outstanding documentation.	% of Health Centre health professional credentialing documentation that are complete.	100% of Health Centre health professional credentialing documentation are complete by March 31, 2017.	
		Complete HR documentation on each employee	% / NHCHC staff	HR file audit / 2016/17	91569*	68	90.00	All staff HR files are audited annually	1)Conduct HR file audit for all Health Centre employees	Review current HR audit checklist. Follow HR audit review schedule. Ensure staff are provided information regarding outstanding documentation.	% of Health Centre employee HR chart audits that are complete.	90% of Health Centre employee HR chart audits that are complete by March 31, 2017.	HR audit documentation to be included are: Performance Evaluation, work plan, learning passport, police check and OHS refresher training.
		Percentage of staff that are competent and confident in responding to Code Red incidents	% / NHCHC staff	Staff survey / 2016/17	91569*	CB	100.00	All staff members undergo safety training at orientation and periodic refresher training.	1)Increase Health Centre staff orientation and refresher training regarding Code Red incidents.	Incorporate Code Red drills and refresher training to all NHCHC staff.	% of NHCHC staff that indicate that they feel confident and competent in responding to Code Red incidents.	90% of all NHCHC staff indicate that they feel confident and competent in responding to Code Red incidents.	
Equitable	**Provide equitable services to all clients of NHCHC**	Analyze cancer screening data to assess inequities, if any	% / PC organization population eligible for screening	EMR/Chart Review / 2016/17	91569*	31	50.00	For the entire primary care population, cancer screening targets set according to the 2016/17 MSAA targets range between 50-70%.	1)Select small set of indicators, produce data reports, analyze. Identify opportunities for improvement in servicing populations who may experience inequities.	Using the primary care client cancer screening data, stratify the data by age and ethno-racial status. Compare data reports to identify any opportunities of improvement in servicing populations who may experience inequities.	% of eligible clients who are up to date for cancer screening for breast, cervical and colorectal cancer.	Develop improvement initiatives for any inequities found in cancer screening among the diverse populations served.	For the entire primary care population, cancer screening targets set according to the 2016/17 MSAA targets range between 50-70%. To ensure diverse populations are provided equitable care, we have set the target for this year at the minimum benchmark for the entire population. Any populations, based on age or ethnicity that performance falls below the target, change initiatives will be put into place.
		Percentage of clinical encounters by physician, NP or PA that include cultural interpretation services	% / PC organization population	EMR/Chart Review / 2016/17	91569*	CB	CB	Collecting baseline data.	1)Provide appropriate cultural interpretation services to be available for all non-English speaking clients	Promote use of cultural interpretation services that are available to clients. Ensure all providers know how to document all cultural interpretation services provided to clients in EMR.	% clients aware of cultural interpretation services	90% of clients aware of cultural interpretation services	

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Patient Experience	Improve Patient Experience: Opportunity to ask questions	Percent of respondents who responded positively to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office give you an opportunity to ask questions about recommended treatment?"	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91569*	89.36	85.00	Current results indicate clients are satisfied with the opportunity to ask question about recommended treatment.	1)Provide opportunities for input regarding client experience.	Provide multiple opportunities for clients to provide feedback on an ongoing basis (annual client survey, suggestion boxes, website).	% increase in client experience satisfaction.	85% satisfaction of respondents regarding having the opportunity to ask questions about recommended treatment.	
	Improve Patient Experience: Patient involvement in decisions about care	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) involve them as much as they want to be in decisions about their care and treatment?	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91569*	90.43	85.00	Current results indicate clients are satisfied with the involvement in decisions regarding care and treatment.	1)Provide opportunities for input regarding client experience.	Provide multiple opportunities for clients to provide feedback on an ongoing basis (annual client survey, suggestion boxes, website).	% increase in client experience satisfaction.	85% satisfaction of respondents regarding client involvement in decisions about care and treatment.	
	Improve Patient Experience: Primary care providers spending enough time with patients	Percent of patients who responded positively to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office spend enough time with you?"	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91569*	87.23	85.00	Current results indicated clients are satisfied with health care providers spending enough time with them.	1)Provide opportunities for input regarding client experience.	Provide multiple opportunities for clients to provide feedback on an ongoing basis (annual client survey, suggestion boxes, website).	% increase in client experience satisfaction.	85% of respondents regarding providers spending enough time with them.	
Timely	Improve 7 day post hospital discharge follow-up rate for selected conditions	Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions.	% / PC org population discharged from hospital	DAD, CIHI / April 2014 – March 2015	91569*	26.2	30.00	According to the data provided by the RDSS, as of March 2014, 26.2% of clients had a 7-day post hospital discharge follow up, which is lower than the provincial percentage of 26.7%	1)Using client information systems to identify primary care clients that have been discharged from hospital for selected conditions.	Use Integrated Decision Support (IDS)system and Clinical Connect (CC)system to identify primary care clients that have been discharged from hospital for selected conditions to enable health care providers to provide timely follow up care, education and action plans for ongoing care.	% of primary care clients who have been discharged from hospital for selected conditions as identified by IDS and CC.	Increase percentage of primary care client that receive follow up care from their primary care provider to 30% by March 31, 2017.	
	Improve timely access to primary care when needed	Percent of patients/clients who responded positively to the question: "The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone else in their office?"	% / PC organization population (surveyed sample)	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period available)	91569*	52.27	60.00	Last year our target was set at 60% and we did see an improvement in this indicator this year of over 10%, up to 52.27% from 38% last year.	1)Enhanced promotion of advanced access initiatives to primary care clients.	Increase messaging to primary care clients regarding access to see another member of primary care team if they are unable to book an appointment with their main care provider is not available the same day or next. Will track if client was offered an timely appointment with another member of the primary care team on the same day or next via an additional question added to the client experience survey.	% primary care clients that were offered an appointment with another care provider on the team on the same day or next.	75% of primary care clients offered an appointment with another care provider on the team on the same day or next by March 31, 2017.	
									2)Using Advanced Access principles and EMR scheduling data, continue to monitor third next available appointments (3NAA) for all physicians and nurse practitioners.	Continue to monitor weekly 3NAAdata for all primary care physicians and nurse practitioners using EMR scheduler data. Review weekly 3NAA data at bi-weekly QI team meetings.	% of primary care physicians and nurse practitioners who have 3NAA below 10 days.	75% of all primary care physicians and nurse practitioners will have 3NAA below 10 days by March 31, 2017.	

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		Percentage of target panel achieved	% / PC organization population	EMR/Chart Review / 2016/17	91569*	70	70.00	HNHB LHIN target for 2016/17 is 70%	1)Primary Care department will welcome new clients onto the existing roster.	Review existing waiting list. Contact eligible potential clients to come to an orientation session. Work with partnering agencies regarding taking on priority clients that meet eligibility criteria. NHCHC is working with the Syrian Refugee Health Table to ensure primary care access is available to government assisted and privately sponsored Syrian refugees living in Hamilton.	% of total number of rostered primary care client the CHC is expected to serve based on the SAMI.	70% of total number of rostered primary care clients the CHC is expected to serve based on the NHCHC SAMI by March 31, 2017.	
	Access to Diabetes Education services when needed	Percentage of HNHB LHIN benchmark of 1750 registered with Diabetes Education Program	% / Community members diagnosed with diabetes mellitus	EMR/Chart Review / 2016/17	91569*	1540	1750.00	HNHB LHIN target set at 1750 clients registered	1)Increase access to diabetes education programs through outreach with other diabetes programs/services.	During the screening process for clients accessing Feet First and fitness programs we will assess clients' learning needs. Identify clients that require diabetes education or who are having diabetes management issues. If any concerns noted we will enroll clients into the Diabetes Education program or refer them back to the diabetes team.	Number of clients enrolled in program.	250 new clients enrolled in program.	
	Access to MyCOPD Program	Number of clients enrolled in MyCOPD Program	Number / Clients	EMR/Chart Review / 2016/17	91569*	132	250.00	HNHB LHIN target for 2016/17 is 250 clients enrolled in program	1)Work with all referral sources (hospitals, specialists, primary care agencies, community agencies) to provide access to individuals with COPD to participate in the MyCOPD program.	Continued communication with referral sources to ensure appropriate referrals to the MyCOPD program. Continuing monitoring and communication with referral sources to ensure referral process continues. An ambassador program from the COPD and TAB programs will be initiated to promote referrals to the program in the community. NHCHC website has been updated with information about the program and a fill-able PDF referral form.	% individuals with COPD referrals from all referral sources to participate in the MyCOPD program.	50% of individuals referred participate in the MyCOPD program by March 31, 2017.	