2015/16 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

West Elgin Community Health Centre 153 Main Street, West Lorne, ON N0L 2P0

AIM		Measure								Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Access	**Access to primary care when needed**	Percent of patients/clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	92245*	67.44	70	**Special Note** In-house survey responses did not align with response options in QIP. Actual performance may be lower (1 or 2 day wait was counted as "next day" in survey but not in QIP).		1)Have increased availability of same-day appointments. Implement Advanced Access in June 2015.	Implementing Advanced Access According to guidelines outlined in the 'Quality Roadmap'.	"Supply and Demand Survey", 3rd next available appointment monitoring and several PDSAs related to processes and improving efficiencies underway for individual PHC providers. Annual in-house survey. Pre & Post measures of Advanced Access changes being measured.	Advanced Access to be implemented in June/July of 2015. We will then continue to run PDSA cycles to fine tune A.A. processes over remainder of year. Our goal is to have 100% of clients be offered appointments to see an MD or NP on the same day or next day when needed in addition to continuing to offer some pre-booked appointments for those who need time to plan for appointment (arrange transportation, family accompaniment, translator etc)	PDSA Process. May need to re-evaluate as data is collected and reviewed and greater understanding of how panel complexity relates to efficiency of process.
		Wait time length for all services at WECHC. (Wait length defined as first available appointment.	Days / Clients	Staff survey / Before Q4	92245*	CB		Aim to achieve for at least 1 quarter this year and will scale up?		1)Have all service providers track wait list time in a uniform method.	To be determined.	Wait time in days. From date of referral to appointment offered.	N/A - baseline	

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	Reduce ED use by increasing access to primary care	Percent of patients/clients who visited the ED for conditions best managed elsewhere (BME).	% / PC org population visiting ED (for conditions BME)	Ministry of Health Portal / April 1 2013 - March 31 2014	92245*	17.1	17.1	Current baseline = 129 patients/year or 2.5/week.		1)- work with STEGH and Middlesex Health Alliance to identify why clients are presenting to ER (reason for visit) - improve communication to clients that we have after hours telephone on-call support to help them troubleshoot their needs as a possible safe alternative to visiting E.R. - Develop working processes with primary care providers and new Chronic Disease NP (CDNP) to help provide support to clients living with Chronic illness - monitor responses to pre and post A.A. surveys and E.R. visit stats to see if implementation of A.A. has decreased ER visits	- Receive reports from hospital - work with providers and CDNP to identify trends on hospital ER conditions BME for our clients - develop enhanced communication plan to encourage utilization of after hours on-call	- we will receive regular monthly reports from hospitals regarding our client ER activity BME - we will monitor utilization of our after-ours on-call(current utilization for 2014 calendar year was 12 calls, 2013 = 14 calls) - we already provide on-call information to 100% of new clients, we will develop a plan to remind clients of after-hours on-call service	- 100% of new clients are aware of on-call service - develop a communication plan to remind current clients of on-call service - we will measure ER visits BME before and after implementation of AA - we will receive reports monthly from hospitals on our client ER BME utilization - develop processes to integrate new CDNP position into care of clients to assist them in managing their health better	

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Integrated	**Timely access to primary care appointments post-discharge through coordination with hospital(s).**	Percent of patients/clients who saw their primary care provider within 7 days after discharge from hospital for selected conditions (based on CMGs).	% / PC org population discharged from hospital	Ministry of Health Portal / April 1 2013 - March 31 2014	92245*	5	15	(Report data shows <5% is baseline)We have the capacity to see clients post discharge from hospital. The issue we face is to receive notification that clients are in hospital and when they are discharged so we can connect with them to offer a post-discharge appointment. We will meet with hospitals to encourage improvements in their communication to primary care team. We will also implement systems to educate clients on informing their provider of admissions/discharges.		1)- Explore use of CSWO/LENS to identify who is in hospital. - Meet with local hospitals (STEGH and Middlesex Hospital Alliance to start) to try and identify processes where they notify us which of our clients are in hospital no matter who the primary provider is(MD or NP). - Negotiate with local hospital discharge planners (STEGH, Middlesex Health Alliance to start, then LHSC) to implement protocol where PHC follow-up appointments are booked before discharge.	- Connecting with Hospital Management to develop protocols. - Advocate that all providers (or generic notification to WECHC)are notified when their clients are in hospital - Advocate that brief and legible discharge summary accompanies client - Once we receive notification, assess processes to ensure client is offered appointment within 7 days of discharge	- Goal is to receive notification that client is in hospital. Once we receive notification, we will need to develop process to be notified of client discharge. - we will monitor either mean number of notifications from Hospital Discharge Planners? Investigate possibility of tracking this on NOD.	100% of STEGH or Middlesex Health Alliance discharges that we are notified of will be offered an appointment with their primary care team within 7 days of discharge.	
	Reduce unnecessary hospital readmissions	Percentage of acute hospital inpatients discharged with selected CMGs 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	Ministry of Health Portal / April 1 2013 - March 31 2014	92245*	CB		Will connect with AOHC Regional Decision Support Specialist to ask this be included in Practice Profile Report.		1)Work with Middlesex Health Alliance and St Thomas Elgin General Hospital to improve consistency and timeliness of receiving hospital admission and discharge reports for all of our primary care clients	Meet with hospital management to determine method to provide client reports to us. Once reports are being regularly received, identify internal processes to make follow-up appointments with clients	Meetings will be held with hospitals. Hospitals will send us a notification on each of our clients on admission to hospital and discharge. Post notifications in all exam rooms reminding clients to inform us if they are admitted to hospital or upon discharge.	Meetings will be held. Reports on our clients shall be received. Post notification reminders to clients throughout centre.	We will rely on hospital process improvements for this indicator to be successful.

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Patient-centred	Receiving and utilizing feedback regarding patient/client experience with the primary health care organization.	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) give them an opportunity to ask questions about recommended treatment?	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	92245*	85.26	85.26	Aim to maintain this level of performance during transition to Advanced Access.						
		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 1 2014 - March 31 2015	92245*	94.24	94.24	Aim to maintain this level of performance during transition to Advanced Access.						
		Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) spend enough time with them?	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	92245*	93.23	93.23	Aim to maintain this level of performance during transition to Advanced Access.						
		Percent of clients who are invited to discuss Advance Care Planning (ACP), Advanced Care Directives (ACD) and Allow Natural Death (AND)	% / Clients	In-house survey / Annual from implementation date	92245*	CB				1)Develop a protocol for WECHC Providers to follow surrounding discussion re: ACP,ACD,AND. Educate Providers Monitoring implementation levels	Asking providers to document discussions in EMR	EMR Frequency Reports	- Protocols developed - Education Sessions Held - Tracking is started in EMR	All providers in centre.