2014/15 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 performa	Target	Target justification	Planned improvement initia	Methods	Process measures	Goal for change ide	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 / TBD	91569*	CB		The current client experience survey asks primary care clients if their appointments begin on time but we need to change our question on the survey to ask them if they are able to see a doctor or nurse practitioner on the same day or next day when needed.	1)Include a question about clients' perception about being able to receive an appointment for their physician or nurse practitioner on the same day or next day, when needed.	Addition of clients' perception about being able to receive an appointment for their physician or nurse practitioner on the same day or next day, when needed to the annual Client Experience Survey	Percentage of Client Experience Survey respondents that answer "same day" or "next day" to the question of clients' perception about being able to receive an appointment for their physician or nurse practitioner on the same day or next day, when needed.	Goal is that 10% of primary care clients complete a Client Experience Survey by March 31, 2015 to provide baseline data.	
									2)Using Advanced Access principles and EMR scheduling data, continue to monitor third next available appointment (TNA) availability for all physicians and nurse practitioners.	Continue to monitor weekly TNA data for all primary care physicians and nurse practitioners using EMR scheduler data. Review weekly TNA data at weekly QI team meetings.	Percentage of primary care physicians and nurse practitioner who have TNA between 0 and 3 days.	90% of all primary care physicians and nurse practitioners will have TNA between 0 and 3 days by March 31, 2015.	
		Increase primary care roster size	% / PC organization population	EMR/Chart Review / TBD	91569*	74	85	2014/17 MSAA data indicates that NHCHC primary care is at 74% of the total number of rostered clients the CHC is expected to serve based on the NHCHC Standardized ACG Morbidity Index (SAMI). The MSAA target for 2014/15 is 70%.	1)Primary Care Department will welcome new clients onto the existing roster.	Review existing wait list. Contact eligible potential clients to come to orientation sessions. Work with partnering agencies regarding taking on priority clients that meet eligibility criteria.	Percentage of total number of rostered primary care clients the CHC is expected to served based on the SAMI.	85% of total number of rostered primary care clients the CHC is expected to served based on the NHCHC SAMI by March 31, 2015.	
	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 / TBD	91569*	13.7	10	Current performance of 13.7% provided by ICES - practice profile. The overall current performance for SW Ontario CHCs for this indicator is 11.9%.	1)Improve communication system with hospitals to understand client usage of ED in timely manner.	Train all primary care providers to utilize clinical Connect system which provides real-time data regarding client ED usage in the HNHB LHIN area. Provide access to all primary care providers to utilize Clinical Connect system . Monitor Clinical Connect usage by all primary care providers through survey on a quarterly basis.	Percentage of primary care providers trained and utilizing Clinical Connect system to monitor ED usage of clients.	100% of all primary care providers are utilizing Clinical Connect system to monitor ED usage by clients by March 31, 2015.	
									2)Use IDS (Integrated Decision Support) to identify Primary Care clients that are using ED services.	Use IDS to identify top 10 Primary Care clients that are using ED. Connect with those clients to develop wrap around care plans that will better support their conditions that can best be managed elsewhere.	Percentage reduction of Primary Care client usage of ED services for conditions best managed elsewhere.	15% reduction of Primary Care client usage of ED services for conditions best managed elsewhere by March 31, 2015.	

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	Access to diabetes education services when needed	Percent of MOH benchmark of 2,750 clients registered with the Diabetes Education program.	% / Community members diagnosed with Diabetes Mellitus	EMR/Chart Review / TBD	91569*	35	55	The current performance is 35% of the Ministry benchmark for Diabetes Education programs, we aim to implement change ideas to gain a 20% increase client participate rates.	1)Improve outreach initiatives to help promote the Diabetes Education program services throughout the community. Connect with clients and community stakeholders to promote Diabetes Education Program services.	Identify and connect with past clients who have not been utilizing the Diabetes program services in the last 2 years. Contact community medical networks (Shelter health Network, YWCA, Women's Immigration Centre, stand alone physicians, optometrists, dentists and pharmacists) and provide updated promotional and referral material. Establish new community partners (EMS, CCAC, Riverdale Community Centre)	Percentage increase in community referrals to Diabetes Education Program services.	40% increase in community referrals to Diabetes Education Program services by March 31, 2015.	
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 / TBD	91569*	40	60	50% improvement from baseline. Current performance of 40.0% provided by ICES - practice profile. The overall current performance for SW Ontario CHCs for this indicator is 29.9%.	1)Begin communication with local hospital staff (Hamilton Health Sciences & St. Joseph Healthcare Hamilton) to establish NHCHC primary care staff involvement pre and post discharge.	Utilizing Health Links partnerships, initiate connection of NHCHC staff to local hospital staff involved in discharge planning. Develop a process for hospital staff to involve NHCHC staff pre and post discharge.	Percentage of NHCHC staff involved in pre and post hospital discharge process.	50% of primary care providers involved in pre and post hospital discharge process by March 31, 2015.	
	Reduce unnecessary hospital readmissions	Percent of a primary care organization's patients/clients who are readmitted to hospital after they have been discharged with a specific condition (based on CMGs).	% / PC org population discharged from hospital	Ministry of Health Portal / TBD	91569*	5	3	Current performance of < =5% provided by ICES - practice profile. The overall current performance for SW Ontario CHCs for this indicator is 6.2%.	1)Work with local hospitals (Hamilton Health Sciences & St. Josephs Healthcare Hamilton) to determine process to reduce hospital readmission rates.	Utilizing Health Links partnerships, initiate connection of NHCHC staff to local hospital staff involved in Health Links discharge projects. Understand and provide input regarding the Health Links discharge projects "HNHB LHIN Discharge Transitions Bundle for COPD patients" and "Heart Failure Bundle".	Percentage of primary care staff who have common understanding of hospital discharge projects aimed at reducing hospital readmission rates	100% of primary care providers have common understanding of hospital discharge projects aimed at reducing hospital readmission rates by March 31, 2015.	
	Access to Caring for My COPD Program post-discharge through coordination with hospital(s).	Number of new patients/clients that are assessed by the CRE coordinator prior to entry in the Caring for My COPD program.	Counts / Patients/clients with mild/moderate COPD discharged from hospital	EMR/Chart Review / TBD	91569*		250		1)Work with referring hospitals to provide access to patients/clients discharged with COPD to participate in the Caring for My COPD program.	Communicate with referring hospital staff to ensure appropriate referrals to the Caring for My COPD program are being made. Continuing monitoring and communicating with referring hospital staff to ensure referral process continues.	Percentage of patients/clients referred from hospital that participate in the Caring for My COPD program.	75% of patients/clients referred from hospital that participate in the Caring for My COPD program by March 31, 2015.	

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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 / 2014/2015	91569*	86.9	85	Current results indicate clients are satisfied with the opportunity to ask questions about recommended treatment.	1)In addition to including this question on the annual client experience survey, provide multiple opportunities for patients/clients to provide feedback on an ongoing basis.	Continue to monitor responses to patient/client engagement questions on annual client experience survey. Post question in waiting rooms by comment/suggestion boxes and on waiting room TV monitors.	Percentage increase in patient/client engagement satisfaction.	85% satisfaction of respondents regarding having the opportunity to ask questions about recommended treatment by March 31, 2015.	
		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 / 2014/2015	91569*	97.9	85	Current results indicate clients are satisfied with the involvement in decisions regarding care and treatment.	1)In addition to including this question on the annual client experience survey, provide multiple opportunities for patients/clients to provide feedback on an ongoing basis.	Continue to monitor responses to patient/client engagement questions on annual client experience survey. Post question in waiting rooms by comment/suggestion boxes and on waiting room TV monitors.	Percentage increase in patient/client engagement satisfaction.	85% satisfaction of respondents regarding involvement in decisions regarding care and treatment by March 31, 2015.	
		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 / 2014/2015	91569*	91.4	85	Current results indicate clients are satisfied with health care providers spending enough time with them.	1)In addition to including this question on the annual client experience survey, provide multiple opportunities for patients/clients to provide feedback on an ongoing basis.	Continue to monitor responses to patient/client engagement questions on annual client experience survey. Post question in waiting rooms by comment/suggestion boxes and on waiting room TV monitors.	Percentage increase in patient/client engagement satisfaction.	85% satisfaction of respondents regarding health care providers spending enough time with them by March 31, 2015.	
	Engage NHCHC clients to participate in Goal Setting Initiatives	Percentage of NHCHC clients that are offered to participate in goal setting initiatives.	% / PC organization population	EMR/Chart Review / TBD	91569*	CB		Currently we have been monitoring the percentage of Primary Care clients that have been offered to participate in goal setting initiatives. All health care providers have been trained in goal setting initiatives and EMR documentation.	1)Encourage all health care providers to offer goal setting initiatives to all clients of Health Centre.	Ensure all health care providers receive orientation and refresher training for goal setting with clients. Ensure all health care providers receive orientation and refresher training for documenting all goal setting in the EMR. Perform quarterly audits of all health care providers regarding client goal setting.	Percentage of NHCHC clients records that indicate that they have been offered to participate in goal setting initiatives.	75% of all NHCHC client records will indicated that they have been offered to participate in goal setting initiatives by March 31, 2015.	

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Population health	**Reduce influenza rates in older adults by increasing access to the influenza vaccine.**	Percent of patient/client population over age 65 that received influenza immunizations.	% / PC organization population aged 65 and older	EMR/Chart Review / TBD	91569*	14	20		1)Reach out to primary care client over age 65 to inform them of availability of influenza vaccine at Health Centre.	Obtain list of all primary care clients over age 65 from EMR. Using automated telephone reminder system (VOIP) send out reminder calls to those clients to inform them of availability to receive influenza vaccination at Health Centre. Send written material regarding influenza vaccination benefits and information regarding availability to all those clients identified from the EMR. Post client education material in waiting rooms at Health Centre regarding influenza vaccination benefits and availability.	Percentage of primary care clients over age 65 that receive influenza vaccination.	20% of all eligible clients over age 65 receive influenza vaccination by March 31, 2015.	
	Reduce the incidence of cancer through regular screening.	Percent of eligible patients/clients who are up-to-date in screening for breast cancer.	% / PC organization population eligible for screening	EMR/Chart Review / TBD	91569*	51	50	Current performance is 51% according to MSAA report from EMR data. New MSAA target for 2014/15 is 50%	1)Reach out to primary care client 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 reminders for re-screening via mail. We will also utilize the EMR system to generate a list of eligible clients and 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.	Percentage of eligible 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, 2015.	
		Percent of eligible patients/clients who are up-to-date in screening for colorectal cancer.	% / PC organization population eligible for screening	EMR/Chart Review / TBD	91569*	68	70	Current performance is 68% according to MSAA report from EMR data. New MSAA target for 2014/15 is 70%	1)Reach out to primary care client who are eligible to receive screening for colorectal cancer.	Utilize the EMR system to generate a list of eligible 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 waiting rooms at Health Centre regarding cancer screening benefits and availability.	Percentage of eligible 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, 2015.	
		Percent of eligible patients/clients who are up-to-date in screening for cervical cancer.	% / PC organization population eligible for screening	EMR/Chart Review / TBD	91569*	64	70	Current performance is 64% according to MSAA report from EMR data. New MSAA target for 2014/15 is 70%	1)Reach out to primary care client who are eligible to receive screening for cervical cancer.	Utilize the EMR system to generate a list of eligible 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 waiting rooms at Health Centre regarding cancer screening benefits and availability.	Percentage of eligible 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, 2015.	

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	Increase opportunity for prevention or early detection of diabetes-related problems by increasing interprofessional diabetes care rate.	Percentage of eligible patients/clients diagnosed with diabetes who receive inter-professional diabetes care at NHCHC.	% / PC organization population diagnosed with diabetes	EMR/Chart Review / TBD	91569*	96	90	Current performance is 96% according to MSAA report from EMR data. New MSAA target for 2014/15 is 90%.	1)Ensure eligible clients 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.	Percentage of 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, 2015.	
	Increase opportunity for prevention or early detection of diabetes-related problems by increasing rate of annual foot exams.	Percentage of eligible patients/clients diagnosed with diabetes who receive inter-professional diabetes care at NHCHC.	% / PC organization population diagnosed with diabetes	EMR/Chart Review / TBD	91569*	94	90	Current performance is 94% according to MSAA report from EMR data. New MSAA target for 2014/15 is 90%	1)Ensure eligible clients identified, Feet First 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 Feet First services. Diabetes Nurse Educators to coordinate process.	Percentage of clients diagnosed with diabetes who receive annual foot exam at NHCHC.	90% of clients diagnosed with diabetes who receive annual foot exam at NHCHC by March 31, 2015.	
	Increase opportunity for prevention or early detection of health-related problems by increasing periodic health examinations.	Percentage of patients/clients receiving periodic health examinations.	% / PC organization population	EMR/Chart Review / TBD	91569*	41	60	Current performance is 41% according to MSAA report from EMR data. New MSAA target for 2014/15 is 60%	1)Engage and encourage all primary health care providers to include and document periodic health examinations for all primary care clients.	Ensure all primary care providers are trained to correctly document periodic health examinations in the EMR. Quarterly audit of this indicator and report performance back to primary health care providers.	Percentage of primary care patients/client records that indicate periodic health examination has been undertaken.	60% of all primary care patients/client records that indicate periodic health examination has been undertaken by March 31, 2015.	
	Reduce influenza rates by increasing access to the influenza vaccine.	Percent of patient/client population over age 6 months that received influenza immunizations.	% / PC organization populatioon aged 6 months and older	EMR/Chart Review / TBD	91569*	14	15	Current performance is 14% according to MSAA report from EMR data. New MSAA target for 2014/15 is 15%.	1)Reach out to primary care client over 6 months of age to inform them of availability of influenza vaccine at Health Centre.	Obtain list of all primary care clients over 6 months of age from EMR. Using automated telephone reminder system (VOIP) send out reminder calls to those clients to inform them of availability to receive influenza vaccination at Health Centre. Send written material regarding influenza vaccination benefits and information regarding availability to all those clients identified from the EMR. Post client education material in waiting rooms at Health Centre regarding influenza vaccination benefits and availability.	Percentage of primary care clients over 6 months of age that receive influenza vaccination.	20% of all eligible clients over 6 months of age receive influenza vaccination by March 31, 2015.	
Effectiveness	**Be an Employer of Choice**	Improve and maintain staff satisfaction in areas below 75% satisfaction.	% / Health providers in the entire facility	In-house survey / TBD	91569*	75	75	Current performance is 75% satisfaction from 2014 Employee Engagement Survey.	1)Engagement with Health Centre staff to work on areas where staff satisfaction is below 75% on the annual Employee Engagement survey.	Report back to staff regarding findings of annual Employee Engagement Survey. Create work plan with improvement ideas for any areas where staff satisfaction is below 75%. Engage with staff to come up with creative and innovative solutions for areas where satisfaction is below 75%. Share work plan and action items with Board Quality and Safety committee.	Percentage of satisfaction reported by staff on the annual Employee Engagement Survey.	75% satisfaction reported by staff on the annual Employee Engagement Survey by March 31, 2015.	

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Safety	Ensure organizational and client safety	Percentage of staff that are competent and confident in responding to Code White incidents	% / Health providers in the entire facility	In-house survey / 2014/2015	91569*	90	90	Current performance is 90% based on the 2014 Employee Engagement Survey	1) Increase health centre staff orientation and refresher training regarding Code White incidents.	Create orientation manual regarding Code White protocols. Incorporate code white demonstrations and refresher training at departmental and all-staff meetings.	Percentage of health centre staff that indicate that they feel competent and confident in responding to Code White incidents.	90% of all health centre staff that indicate that they feel competent and confident in responding to Code White incidents by March 31, 2015.	
		Complete health professional credentialing documentation.	% / Health providers in the entire facility	NHCHC Human Resource Files / TBD	91569*	100	100	All health care professionals must supply proof upon hiring and annually thereafter.	1)Monitor and audit health professional credentialing documentation for all health professionals.	Review health professional credentialing checklist. Follow credentialing audit schedule. Ensure staff are provided information regarding outstanding documentation.	Percentage of Health Centre health professional credentialing documentation that are complete.	100% of Health Centre health professional credentialing documentation are complete by March 31, 2015.	
		Complete Human Resources documentation on each employee	% / Health providers in the entire facility	NHCHC Human Resource Files / TBD	91569*	100	90	Current performance of annual HR audit review is 100%.	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.	Percentage of Health Centre employee HR chart audits that are complete.	90% of all Heath Centre employee HR chart audits are complete by March 31, 2015.	
		Improve and maintain rate of blood work result reconciliation.	% / PC organization population	EMR/Chart Review / TBD	91569*	85	90	Current performance of 85% of ratio of primary care client blood work requests to blood work results received.	1)Improve blood work result reconciliation.	Train and encourage all health care providers to forward all primary client blood work requisitions to Laboratory Technician. Laboratory Technician responsible to reconcile blood work requisitions to blood work results received on a monthly basis. Audit process quarterly. Report ratios to primary care providers.	Percentage of primary care blood work results received in relation to total primary care blood work requisitions made.	90% reconciliation rate of primary care blood work results received in relation to total primary care blood work requisitions made by March 31, 2015.	

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Equity	**Health Equity provided in health services and programs**	Investigate 3 health issues (e.g., cervical cancer screening, periodic health exams, immunization rates) to see if any health equity barriers are creating lower responses to health interventions	% PC organization population	EMR/Chart Review	91569*	CB			1) Increase knowledge regarding health equity barriers and how they impact uptake/participation of health interventions.	Perform literature search. Engage with staff, volunteers and clients to determine perceptions of health equity barriers impacting health interventions. Analyse EMR data to investigate trends in health interventions impacted by health equity barriers. Determine baseline data to inform action plans to undertake to reduce the health equity barriers faced by clients.			Our goal for this year is to have a better understanding of the health equity barriers that our clients face to inform action plans that we can take as an organization to reduce the barriers faced by our clients by March 31, 2015.