Item 7.3.3.2

2015/16 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
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	91569*	37.93	60	Approximately 38% of clients surveyed reported that they were seen either the same day or next.	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, 2016.	At our Health Centre we work as an interdisciplinary team, where clients are rostered to a particular primary health care provider (NP or MD) but see other members of the team based on client needs, complexity of care required and provider scheduling (i.e., primary care providers are not always on site each day the Health Centre is open). We do not believe that the main indicator for this measure captures the accurate data regarding client access to primary care when needed as it is based on a survey question that only a portion of our clients are asked and their perception or recollection of this information may not be accurate.
									2)Using Advanced Access principles and EMR scheduling data, continue to monitor third next available appointments (TNA) 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.	% of primary care physicians and nurse practitioners 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, 2016.	

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		Increase Primary Care roster size	% / PC organization population (surveyed sample)	EMR/Chart Review / 2015/16	91569*	65	70	Due to the filled MD vacancies on our Primary Care team, we will be able to accept new clients into our care. We also understand that due to the new SAMI (client complexity score) we will be required to increase our target panel size. The 2015/16 MSAA target 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.	% 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, 2016.	The target is based on our 2015/16 MSAA target and understanding that our current SAMI score will change.
	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	91569*	13.4	10	Current performance of 13.4% provided by ICES - practice profile. the overall current performance for SW Ontario CHCs for this indicator is 11.7%	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 10 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, 2016.	
	Access to Diabetes Education services when needed	% of MOH benchmark of 750 registered with the Diabetes Education Program	% / % Community members diagnosed with Diabetes Mellitus	EMR/Chart Review / 2015/16	91569*	74	85		1)Increase access to diabetes education programs through outreach with other diabetes programs/services.	Develop a procedure to triage clients for the Feet First program. During the screening process 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.	
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	91569*	20.6	40	Current performance of 20.6% provided by ICES - practice profile. The overall current performance for SW Ontario CHCs for this indicator is 29.5%	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.	Reduce primary care client have been discharged from hospital for selected conditions to 40% for conditions best managed elsewhere by March 31, 2016.	

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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
	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	91569*	4.9	3	Current performance is 4.9% provided by ICES - practice profile. the overall current performance for SW Ontario CHCs for this indicator is 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, 2016.	
	Access to Caring for my COPD Program	Number of clients that enroll in my COPD program.	Counts / Clients with COPD	EMR/Chart Review / 2015/16	91569*	100	200	The LHIN has provided the target of 200 clients for the 2015/16 year.	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.	% 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, 2016.	
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	91569*	86.17	85	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.	
		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	91569*	94.38	85	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.	
		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	91569*	90.43	85	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.	

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	Engage NHCHC to participate in Self-management initiatives	% of NHCHC clients that are participating in a self-management initiative	% / Clients	EMR/Chart Review / 2015/16	91569*	CB		Want to provide a basket of self-management tools to suitable clients through a variety of interventions - group toolkit programs, care passports, goal setting coaching.	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.	Number of clients who participate in self-management initiatives.	1000 clients participate in at least one self-management initiative by March 31, 2016.	
Population health	**Reduce Cancer mortality 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 / n/a	91569*	56	50	Current performance is 56% according to MSAA report from EMR data. MSAA target for 2015/16 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, 2016.	
		Percent of eligible patients/clients who are up-to-date in screening for colorectal cancer.	% / PC organization population eligible for screening	EMR/Chart Review / n/a	91569*	92	70	Current performance is 92% according to MSAA report from EMR data. MSAA target for 2015/16 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, 2016.	
		Percent of eligible patients/clients who are up-to-date in screening for cervical cancer.	% / PC organization population eligible for screening	EMR/Chart Review / n/a	91569*	61	70	Current performance is 61% according to MSAA report from EMR data. MSAA target for 2015/16 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, 2016.	
	Increae opportunity for prevention or early detection of diabetes-related problems by increasing interprofessional diabetes care	% of clients diagnosed with diabetes who receive interprofessional diabetes care at NHCHC.	% / Clients diagnosed with diabetes mellitus	EMR/Chart Review / 2015/16	91569*	96	90	Current performance is 96% according to MSAA report from EMR data. MSAA target for 2015/16 is 90%.	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, 2016.	
	Increase opportunity for prevention or early detection of diabetes related problems by increasing rate of annual foot exam.	% of clients diagnosed with diabetes who receive annual foot exam at NHCHC.	% / % Community members diagnosed with Diabetes Mellitus	EMR/Chart Review / 2015/16	91569*	95	90	Current performance is 95% according to MSAA report from EMR data. MSAA target for 2015/16 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.	% 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, 2016.	

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	Reduce influenza rates by increasing access to the influenza vaccine.	% of Primary care clients over age 6 months that received influenza immunizations.	% / PC organization population (surveyed sample)	EMR/Chart Review / 2015/16	91569*	16	15	Current performance is 16% according to MSAA report from EMR data. MSAA target for 2015/16 is 15%.	1)Reach out to primary care clients over 6 months of age 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.	20% of all eligible clients over 6 months of age receive influenza vaccination by March 31, 2016.	
Other	**Be an Employer of Choice**	Improve and maintain staff satisfaction in survey areas below 75% satisfaction.	% / NHCHC staff	Staff survey / 2015/16	91569*	75	75		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%. Share work plan and action items with Board Quality and Safety Committee.	% 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, 2016.	
	Ensure organizational safety	% of staff that are competent and confident in responding to Code White incidents.	% / NHCHC staff	Staff survey / 2015/16	91569*	75	75		1)Increase Health Centre staff orientation and refresher training regarding Code White incidents.	Continue to incorporate Code White demonstrations and refresher training to all NHCHC staff.	% of NHCHC staff that indicate that they feel confident and competent in responding to Code White incidents.	90% of all NHCHC staff indicate that they feel confident and competent in responding to Code White incidents.	
		Complete health provider credentialing documentation	% / Health providers in the entire facility	NHCHC HR file audit / 2015/16	91569*	100	100		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, 2016.	
		Complete HR documentation on each employee.	% / NHCHC staff	NHCHC HR file audit / 2015/16	91569*	100	90		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, 2016.	
	To determinine with evidence if populations experience significant unintended health impacts (postive or negative) as a result of planned policies, programs or initiatives.	Using EMR data, analyze cancer screening data to assess inequities, if any.	% / PC organization population eligible for screening	EMR/Chart Review / 2015/16	91569*	CB			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.	