2018/19 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

North Hamilton CHC 438 Hughson Street North, Hamilton, ON L8L 4N5

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	Coordinating care	Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach	A	% / Patients meeting Health Link criteria	In house data collection / most recent 3 month period	91569*	61	60.00	Analysis of the Baseline data collected in 2017/18 indicated that the range of 40-60% of complex clients received follow up care from their primary care provider in a timely manner (2 week period).	1)Using client information systems to identify primary care clients that meet Health Links criteria.	Use Integrated Decision Support (IDS) and Clinical Connect data to identify our clients with multiple conditions and complex health care needs to encourage coordinated care planning and participation of self-management initiatives.	% of primary care clients identified as meeting Health Links criteria that are provided care planning and/or participate in a self-management initiative.	60% of primary care clients identified as meeting the Health Links criteria will participate in care planning and/or a self-management initiative.	
	Effective transitions	Percentage of patients who have had a 7-day post hospital discharge follow up. (CHCs, AHACs,NPLCs)	P	% / Discharged patients	See Tech Specs / Last consecutive 12 month period	91569*	31	40.00	According to the 2017 CHC Practice Profile for South West CHC region, the Ontario CHC average performance for this indicator is 41%.	1)Encourage clients to connect with Health Centre for follow up care after hospital discharge for selected conditions	Using hospital communication sources (i.e, fax notifications, Clinical Connect) track client discharges from hospitals for selected conditions on a weekly basis. When clients are identified as eligible, connect with clients and encourage them to follow up with Health Care provider in a timely manner.	% of primary care clients who have been discharged from hospital for selected conditions as identified by Clinical Connect and hospital discharge notices.	Increase identification of clients that have been discharged from hospital to ensure that we can connect with clients to encourage them to follow up with primary care within 7 days of discharge.	
		Percentage of patients who were discharged in a given period for a condition within selected HBAM Inpatient Grouper (HIGs) and had a non-elective hospital readmission within 30 days of discharge, by primary care practice model.	A	% / Discharged patients with selected HIG conditions	DAD, CAPE, CPDB / April 2016 - March 2017	91569*	9	7.00	According to the 2017 CHC Practice Profile for South West CHC region,the Ontario CHC average performance for this indicator is 7%.	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.	Using Integrated Decision Support (IDS) 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.	Reduce primary care clients who have been readmitted to any acute inpatient hospital for non-elective patient care within 30 days of discharge by March 31, 2019.	
		Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.												We will be using the CHC effective transitions indicator

	Wound Care	Percentage of patients with diabetes, age 18 or over, who have had a diabetic foot ulcer risk assessment using a standard, validated tool within the past 12 months	A	% / patients with diabetes, aged 18 or older	EMR/Chart Review / Last consecutive 12 month period	91569*	38	60.00	Analysis of the Baseline data collected in 2017/18 indicated approximately 40% performance.	1)Reach out to primary care clients, aged 18 and over, who are eligible to receive diabetic foot ulcer screening.	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 diabetic foot ulcer screening benefits and availability.	% of primary care clients that are contacted to participate in diabetic foot ulcer screening opportunities.	80% of all eligible primary care clients will be contacted to participate in diabetic foot ulcer screening opportunities by March 31, 2019.	
Efficient														
	Adequate access to NEW clients for primary care services	Total # of NEW clients registered to primary care providers within the last 2 years.	C	Count / PC population	EMR/Chart Review / 2017/2019	91569*	985	1000.00	We want to continue to maintain performance in this indicator.	1)Increase number of clients 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.	Number of newly registered primary care clients.	Increase number of newly registered primary care clients to 350 from April 1, 2018 to March 31, 2019.	
	Adequate access to primary care services	Total number of primary care clients registered to MDs and NPs.	C	Count / PC population	EMR/Chart Review / 2018/2019	91569*	5155	5500.00	Based on HNHB LHIN target panel size for NHCHC.	1)Increase number of clients 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.	Number of newly registered primary care clients.	Increase number of newly registered primary care clients to 350 from April 1, 2018 to March 31, 2019.	
Equitable	**Population health - cervical cancer screening**	Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period.	A	% / PC organization population eligible for screening	CCO-SAR, EMR / Annually	91569*	63	75.00	MSAA target for 2018/19 is 75%.	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 educational material in the waiting rooms at Health Centre regarding cancer screening benefits and availability.	% of eligible primary care clients that are contacted to participate in cancer screening opportunities.	80% of all eligible primary care clients will be contacted to participate in cancer screening opportunities by March 31, 2019.	
	Population health - colorectal cancer screening	Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for colorectal screening in each calendar year												We have prefer to use the colorectal screening indicator that is used by the HNHB LHIN.
		Percentage of screen eligible patients aged 50 to 74 years who had a FOBT within the past two years	C	% / PC organization population eligible for screening	EMR/Chart Review / 2018/2019	91569*	62	70.00	MSAA target is 70% for 2018/19.	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 educational material in the waiting rooms at Health Centre regarding cancer screening benefits and availability.	% of eligible primary care clients that are contacted to participate in cancer screening opportunities.	80% of all eligible clients will be contacted to participate in cancer screening opportunities by March 31, 2019.	
	Population health - diabetes	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months	A	% / patients with diabetes, aged 40 or over	ODD, OHIP-CHDB,RPDB / Annually	91569*	37	50.00	Analysis of the Baseline data collected in 2017/18 indicated approximately 40% performance.	1)Reach out to primary care clients who are diagnosed with diabetes to ensure HbA1C test are being offered.	Obtain list of all primary care clients diagnosed with diabetes from EMR. Ensure all clients are contacted to perform HbA1C testing at least 2 times per year.	% of primary care clients with diabetes who are contacted for HbA1C testing	75% of all primary care clients with diabetes are contacted and encouraged to complete HbA1C testing at least 2 times per year.	

	Population health - breast cancer screening	% of eligible clients who are up to date in screening for breast cancer.	C	% / PC organization population eligible for screening	EMR/Chart Review / 2018/2019	91569*	46	55.00	MSAA target for 2018/19 is 55%.	1)Reach out to primary care clients who are eligible to receive screening for breast 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 educational material in the waiting rooms at Health Centre regarding cancer screening benefits and availability.	% of eligible 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, 2019.	
Patient-centred	**Person experience**	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?	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	91569*	89	85.00	Current client survey results indicated clients are satisfied with their involvement in decisions regarding care and treatment. We want to maintain performance in this indicator.	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 satisfaction.	85% satisfaction of respondents regarding client involvement in decisions about care and treatment.	
Safe	**Medication safety**	Percentage of patients with medication reconciliation in the past year	A	% / All patients	EMR/Chart Review / Most recent 12 month period	91569*	40	50.00	Analysis of the Baseline data collected in 2017/18 indicated 40% medication reconciliation documented.	1)Provide training to health care providers regarding the importance of medication reconciliation for clients.	Professional education will be provided to health care providers regarding benefits of medication reconciliation.	% of health care providers that attend a professional education session regarding medication reconciliation.	90% of health care providers attend a professional education session regarding medication reconciliation in a 12 month period.	
										2)Health Care providers are appropriately trained regarding appropriate EMR documentation regarding medication reconciliation in client charts.	Provide training session regarding appropriate methods to document medication reconciliation process in EMR.	% of health care providers that receive training regarding appropriate methods to document medication reconciliation process in EMR.	90% of health care providers receive training regarding appropriate methods to document medication reconciliation process in EMR.	
	Population health - diabetes	% of clients diagnosed with diabetes who receive interprofessional diabetes care at NHCHC.	C	% / PC clients with diabetes	EMR/Chart Review / 2018/2019	91569*	99	90.00	We want to maintain performance in this indicator.	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% clients diagnosed with diabetes who receive inter-professional diabetes care at NHCHC.	
	Population health - influenza	% of primary care clients, aged 65 years or older, who report having a seasonal flu shot in the past year.	C	% / PC organization population aged 65 and older	EMR/Chart Review / 2018/2019	91569*	24	45.00	MSAA target for 2018/19 is 45%.	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 aged 65 years and older from EMR. Contact all eligible clients via automated phone reminder system to inform them of vaccination opportunities. Provide client educational material in all exam rooms and waiting rooms to explain the benefits of influenza vaccination.	% of clients aged 65 years and older that receive influenza vaccination.	45% of all eligible clients receive influenza vaccination by March 31, 2019.	
	Population health - self management	# of NHCHC clients that are participating in a self-management initiative.	C	Count / Clients	EMR/Chart Review / 2019/2019	91569*	962	1200.00	At December 2017, 962 clients participated in self-management initiatives. We want to maintain performance in this indicator.	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, behviour 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.	# of clients participating in self-management initiatives.	1200 clients participating in self-management initiatives.	

Timely	**Timely access to care/services**	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	91569*	38	50.00	From the 2017 client survey, 41 PC clients out of 107 surveyed responded that they were able to see their MD/NP on the same day or next. This result is lower than last year's performance of 47%. The provincial average for this indicator is 43.6%.	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 due to unavailability same day or next. Will track if clients 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.	% of 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 are offered an appointment with another care provider on the team on the same day or next by March 31, 2019.	
										2)Using advanced access principles and EMR scheduling data, continue to monitor third next available (3NA) appointments for all physicians and nurse practitioners.	Continue to monitor weekly 3NA for all primary care physicians and nurse practitioners using EMR scheduling data. Review weekly 3NA data at bi-weekly QI team meetings.	% of primary care physicians and nurse practitioners who have 3NA below 10 days.	75% of all primary care physicians and nurse practitioners who have 3NA below 10 days.	
		# of clients enrolled in MyCOPD Program.	C	Count / Clients with COPD	EMR/Chart Review / 2018/2019	91569*	160	250.00	At December 2017, the HNHB LHIN target is 250 clients enrolled in program.	1)Work with 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 from the COPD and TAB programs will continue to promote referrals to the program in the community. NHCHC website will provide information about the program with a fill-able PDF referral form.	% of COPD referrals from all referral sources to participate in the MyCOPD program.	50% of COPD referrals from all referral sources participate in the MyCOPD program.	
		# of clients registered with Diabetes Education Program.	C	Count / Clients with Diabetes	EMR/Chart Review / 2018/2019	91569*	1282	1850.00	Annual HNHB LHIN target at December 2017 is 1850 clients.	1)Increase access to diabetes education programs through outreach with other diabetes programs/services.	During the screening process for clients accessing primary care, Feet First and fitness programs to 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.	# of new clients enrolled in program.	500 new clients enrolled in program.	
		% of target panel achieved.	C	% / PC population	EMR/Chart Review / 2018/2019	91569*	70	70.00	MSAA target for 2018/19 is 70%. We want to maintain performance in this indicator.	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 clients 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 SAMI.	