2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Coordinating care	Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach	% / Patients meeting Health Link criteria	In house data collection / Most recent 3 month period	91569*	CB	CB	Collecting baseline data.	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	Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions.	% / Discharged patients with selected HIG conditions	CIHI DAD / April 2015 - March 2016	91569*		30.00	Unable to provide current performance at this time as NHCHC Practice Profile is pending as per Jennifer Raynor. HQO is aware of situation with CHC practice profiles at this time.	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.	

2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
		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.	% / Discharged patients with selected HIG conditions	CIHI DAD / April 2015 - March 2016	91569*		3.00	Unable to provide current performance at this time as NHCHC Practice Profile is pending as per Jennifer Raynor. HQO is aware of situation with CHC practice profiles at this time.	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, 2018.	
		Percentage of patients for whom discharge notification was received who were followed up within 7 days of discharge, by phone or in-person visit, with any clinician.	% / Discharged patients	In house data collection / Last consecutive 12 month period.	91569*	CB	CB	Collecting baseline data.	1)Connect with discharged clients after receiving discharge notification from hospital in a timely manner.	Track all client hospital discharges received. Follow up with clients discharged from hospital for selected conditions via telephone to determine if phone or in-person visit is required.	Client hospital discharges received for selected conditions are followed up via telephone.	75% of all client hospital discharges received for selected conditions are followed up via telephone.	

2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
	Population health - cervical cancer screening	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*	62	70.00	MSAA target for 2017/18 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 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 primary care clients will be contacted to participate in cancer screening opportunities by December 31, 2017.	
	Population health - colorectal cancer screening	Percentage of screen eligible patients aged 50 to 74 years who had a FOBT within the past two years, other investigations (i.e., flexible sigmoidoscopy) within the past 10 years or a colonoscopy within the past 10 years.	% / PC organization population eligible for screening	See Tech Specs / Annually	91569*	54	70.00	MSAA target for 2017/18 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 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 December 31, 2017.	
	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	% / patients with diabetes, aged 40 or over	ODD, OHIP-CHDB,RPDB / Annually	91569*	34	50.00	Baseline data collected in 2016/17 indicated performance at 34% at December 31, 2016.	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.	

2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
		% of clients diagnosed with diabetes who receive interprofessional diabetes care at NHCHC.	% / PC organization population, clients diagnosed with diabetes	EMR/Chart Review / 2017	91569*	98	90.00	MSAA target for 2017/18 is 90%. 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 - breast cancer screening	% of eligible clients who are up to date in screening for breast cancer.	% / PC organization population eligible for screening	EMR/Chart Review / 2017	91569*	47	50.00	MSAA target for 2017/18 is 50%.	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 December 31, 2017.	
	Population health - influenza	% of primary care clients, aged 65 years or older, who report having a seasonal flu shot in the past year.	% / PC organization population aged 65 and older	EMR/Chart Review / 2017	91569*	35	45.00	MSAA target for 2017/18 is 45%. At December 31, 2016 performance of this indicator was 35%.	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 December 31, 2017.	

2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
	Population health - self management	# of NHCHC clients that are participating in a self-management initiative.	Counts / PC organization population	EMR/Chart Review / 2017	91569*	1002	1200.00	At December 2016, 1002 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.	
Efficient	**Client access to care**	Number of New Primary Care Clients	Counts / PC organization population, primary care registered clients	EMR/Chart Review / 2015 - 2017	91569*	1043	1000.00	From data collected in 2016/17, approximately 1000 new clients were seen in PC within a 2 year period. We want 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 300 from January 1, 2017 to December 31, 2017.	
		Total number of clients registered to MDs and NPs.	Counts / PC organization population, primary care registered clients	EMR/Chart Review / 2017-2018	91569*	4124	4459.00	At December 2016, the target panel size was determined to be 6370. At December 2016, the target panel size achieved was 65%.	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 300 from January 1, 2017 to December 31, 2017.	

2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Equitable	Equitable services available	Analyze cancer screening data to assess inequities, if any.	% / PC organization population eligible for screening	EMR/Chart Review / 2017 - 2018	91569*	27	50.00	For the entire primary care population, cancer screening targets set according to the 2017/18 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 clients who are up to date for cancer screening for breast, cervical and colorectal cancer.	60% of all clients are up to date for cancer screening for breast, cervical and colorectal cancer.	
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.	% / PC organization population (surveyed sample)	In-house survey / April 2016 - March 2017	91569*	92.86	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.	

2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Safe	Medication safety	Percentage of patients with medication reconciliation in the past year	% / All patients	In house data collection / Most recent 12 month period	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 patients with medication reconciliation.	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 provider 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.	

2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
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.	% / PC organization population (surveyed sample)	In-house survey / April 2016 - March 2017	91569*	49.11	60.00	In 2015 performance on this indicator was 52%, in 2016 it dropped to 49%. We believe with concerted change efforts we will be able to increase our performance to 60%.	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 December 31, 2017.	
									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.	Counts / PC organization population, COPD clients	EMR/Chart Review / 2017 - 2018	91569*	161	250.00	At December 2016, 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.	

2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
		% of target panel achieved.	% / PC organization population, primary care clients	EMR/Chart Review / 2017	91569*	65	70.00	MSAA target for 2017/18 is 70%. At December 31, 2016 performance of this target was 65%.	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.	
		Number of clients registered with Diabetes Education Program.	Counts / PC organization population, clients with diabetes	EMR/Chart Review / 2017 - 2018	91569*	1421	1850.00	Annual HNHB LHIN target at December 2016 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.	300 new clients enrolled in program.	