2019/20 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

Trent Hills FHT 119 Isabella Street, Campbellford, ON K0L 1L0

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	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) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	Percentage of patients who have had a 7-day post hospital discharge follow up for selected conditions. (CHCs, AHACs,NPLCs)	P	% / Discharged patients	See Tech Specs / Last consecutive 12-month period.	92309*	57	75.00	We did not reach our target during the previous year.		1)Track hospital discharges in emr	Work with OntarioMD Practice Enhancement Consultant and Telus PSS (QISS/Software Support Specialist)	% of hospital discharges tracked	25% of hospital discharges tracked (CMH) by April 10, 2019 75% by July 31, 2019 100% by	
											2)Expand to include other area hospitals	Contact area hospitals regarding notification of discharges. (QISS/Software Support Specialist)	% of local hospitals to be contacted and process completed	100% to be contacted by July 31, 2019 75% to have a process working by Dec 31	
											3)Expand to include request for Best Possible Medication Discharge Plan (BPMDP) for patients	Contact area hospitals to set up method to ensure family physicians receive BPMDP automatically. (QISS/Software Support Specialist)	% of outside facilities contacted and process completed	100% to be contacted by July 31, 2019 75% to have a process working by Dec 31	
											4)Expand to include satellite sites.	Train nurses (Nurse Supervisor)	# of satellite offices to use the custom form and process	2/3 satellite offices to use the custom form and full process, encompassing	
		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.	P	% / Discharged patients	EMR/Chart Review / Last consecutive 12-month period.	92309*	CB	75.00	We did not meet our target the past year.		1)Track hospital discharges in emr	Work with OntarioMD Practice Enhancement Consultant and Telus PSS (QISS/Software Support Specialist)	% of hospital discharges tracked	25% of hospital discharges tracked (CMH) by April 10, 2019 75% by July 31, 2019 100% by	
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											4)Expand to include satellite sites.	Train nurses (Nurse Supervisor)	# of satellite offices to use the custom form and process	2/3 satellite offices to use the custom form and full process, encompassing	
	Timely	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 2018 - March 2019	92309*	85.37	86.00	We will be investigating other methods to obtain data on this measure as patients are surveyed only after recent appointment.		1)Develop and test strategies to balance appointment supply & demand	Manually track phone calls and appointments booked for baseline data. (QISS/Clerical Supervisor) Develop strategies dependent upon baseline data. (QIC)	# of months baseline data	6 months data by October 31, 2019 Analyze data by November 15, 2019 Present to QIC and	
											2)Continue to ask the question "The last time you were sick or were concerned you had a health problem, were you offered a same or	Streamline survey method (QIC)	Use additional software (Cliniconex)	Begin survey by September 1, 2019. Gather 6 months survey data by March 31, 2020	
Theme II: Service Excellence	**Patient-centred**	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else	P	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	92309*	94.52	95.00	This is higher than our current performance.		1)Continue to ask the question "When you see your doctor or nurse practitioner, how often do they or someone else in the office	Streamline survey method (QIC, QISS)	Use additional software (Cliniconex)	Begin survey by September 1, 2019. Gather 6 months survey data by March 31, 2020	
		Improve screening and identification of cognitive impairment and dementia	C	% / PC organization population aged 65 and older	EMR/Chart Review / April 2018 - March 2019	92309*	CB	CB	Program is still in the early stages		1)Involve outside agencies	Decide what agencies (i.e. Alzheimer society) should be contacted (Memory Clinic Clinicians) Create streamlined process to connect to these agencies (QISS/Memory Clinic nurses)	# of agencies to be contacted % of above agencies for which a process is created.	Decide which agencies to contact by April 30, 2019 Create a process for patients and	

											2)Include medication reviews in process	Contact local pharmacists to discuss method of referral (Memory Clinic clinicians/ QISS) Create a process for nurse to liaise with pharmacies prior to intake appointment (Memory Clinic clinicians/ QISS) Implement process (Memory Clinic Clinicians)	# of local pharmacies contacted. % of above pharmacies that are on board with process % of Memory Clinic patients with medication reviews.	Contact pharmacists by April 30, 2019 Create process and documentation by	
											3)Expand scope of assessments	Determine needed assessments (Memory Clinic clinicians) Train nurses to do assessments (Memory Clinic clinicians /Nursing Supervisor) Implement process (Memory Clinic Clinicians)	# of new assessments # of nurses trained to do assessment % of Memory Clinic patients with added assessments	Decide what other assessments are required by May 30, 2019 Train nurses on new	
											4)Increase capacity	Train of satellite nurses to do assessments (Memory Clinic clinicians /Nursing Supervisor)	# of satellite offices to use the custom form and process	Train satellite nurses to do assessments by September 1, 2019	
Theme III: Safe and Effective Care	**Effective**	Proportion of primary care patients with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	92309*	CB	CB	As we implement palliative tools, it will become clear what performance measures will be relevant.		1)Identify patients who would benefit from palliative care, high risk cohort	Set parameters for identifying patients (QIC)	# of palliative patients identified (denominator for indicator)	Discuss parameters and methods to identify either in the emr or by family physician/nurse	
											2)Develop appropriate screening, assessment and advance care planning measures	Research current material and adapt for our use to assess current and future needs of patient and caregiver. (QIC)	# of standards developed (as denominator for processes)	Explore palliative care toolkit options. Set standards for palliative care needs, i.e. advance care	
											3)Develop EMR tools to track advanced care planning, educate patients/caregivers and manage ongoing needs.	Using custom forms, cohorts, reminder reports and handouts for advance care planning. (QIC, QISS)	% of processes developed into emr tools	By September 30, 2019, develop • internal processes for documentation, i.e. by custom form	
											4)Start advance care planning for appropriate patients and caregivers	Using above tools and procedures, assess and document palliative needs for appropriate patients and caregivers	% of patients identified as palliative who have had their palliative care needs identified.	Gather 6 months data by March 31, 2019	
	Safe	Percentage of non-palliative patients newly dispensed an opioid within a 6-month reporting period prescribed by any provider in the health care system within a 6-month reporting period.	P	% / Patients	CAPE, CIHI, OHIP, RPDB, NMS / Six months reporting period ending at the most recent data point	92309*	CB	CB	As we investigate methods to track opioid prescriptions, it will become clear what performance measures will be relevant.		1)Gather baseline data for washout period	Use emr searches to gather data for washout period (QISS)	# of months of baseline data	Gather 6 months data by April 30, 2019	
											2)Analyze Data and act on concerns	Set parameters for data, i.e. length of prescription, acute versus chronic, reason for prescription. Create strategies to avoid patterns or concerns (QIC)	# of parameters	Choose parameters to either include or eliminate from searches to highlight opioid	
											3)Gather new data after changes have been made	Search using same parameters as above (QISS)	# of months of comparable data	Gather 6 months of comparison data by March 31, 2019	
											4)Improve in-house chronic pain resources for patients	Review current CNCP nurse-led program (Program Lead, Nurse Supervisor) Incorporate internal mental health services (QIC, MHWs, Program Lead)	% of program reviewed % of referral process completed	Research other family health team chronic pain programs, pain assessments	
		Percentage of eligible patients/clients who are up-to-date in breast screening for using Cancer Care Ontario letters.	C	% / PC organization population eligible for screening	CCO-SAR, EMR / April 2018 - March 2019	92309*	62.3	70.00	We did not meet our target this past year		1)Fully implement the Women's Screening Program	Ensure all nurses are using the Women's Screening Program Custom Forms (Nursing Supervisor)	% of eligible patients/clients who are up-to-date in breast screening	Train all nurses for use of the form by April 30, 2019	
											2)Leading by Example Campaign	Posters featuring THFHT clinicians Patient draw, ballot for each eligible patient who is up-to-date on screening (Leading by Example Campaign Team)	% of eligible patients/clients who are up-to-date in breast screening	Post Leading by Example posters featuring FHT clinicians and staff by April 30, 2019	
											3)Call overdue patients	Use OntarioMD dashboard and custom form (Clerical Supervisor)	% of eligible patients/clients who are up-to-date in breast screening	Begin screening phone calls by December 31, 2019	

		Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for colorectal screening in each calendar year	C	% / PC organization population eligible for screening	CCO-SAR, EMR / April 2018 - March 2019	92309*	37.7	35.00	We did not meet our target this past year		1)Leading by Example Campaign	Posters featuring THFHT clinicians Patient draw, ballot for each eligible patient who is up-to-date on screening (Leading by Example Campaign Team)	% of Ontario screen-eligible individuals, who were overdue for colorectal screening	Post Leading by Example posters featuring FHT clinicians and staff by April 30, 2019	
											2)Call overdue patients	Use OntarioMD dashboard and custom form (Clerical Supervisor)	% of Ontario screen-eligible individuals, who were overdue for colorectal screening	Begin screening phone calls by December 31, 2019	
		Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period.	C	% / PC organization population eligible for screening	CCO-SAR, EMR / April 2018 - March 2019	92309*	64.7	70.00	We did not meet our target this past year		1)Fully implement the Women's Screening Program	Ensure all nurses are using the Women's Screening Program Custom Forms (Nursing Supervisor)	% of screen-eligible women, who completed at least one Pap test in 42-month period.	Train all nurses for use of the form by April 30, 2019	
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