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

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	**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	92309*	57	75.00	We did not meet our performance target last year and we did not create an emr tool to track out appointments. We expect to do so this year.	1)Fully implement nurse phone triage for post discharge pts from CMH, adapting to CMH PODS	CMH to fax discharge notice the day following discharge Clerical staff to check of appointment booked, if not send message to appropriate nurse Nurse to call patient, to triage and recommend appropriate follow-up, clinician phone or in-person appointment. Work with CMH when PODS implement to adopt above protocol	Manual fax, f/u action	Revise nursing triage form as needed. Create/Revise Custom Form April/May Train nursing staff May/June Roll out full protocol July	
										2)Track appointments with any provider	Create a better tracking system, to record all actions on behalf of the patients, including f/u phone and in-person appointments. Adapt as needed to include PODS	Work with OntarioMD Practice Enhancement consultant to create a tool to track patient from CMH fax through nurse triage and onto follow-up recommendations and appointment type.	Work with OntarioMD Practice Enhancement consultant to create a tracking tool Implement tool in April/May Train Nursing staff May/June for phone triage Revise when needed with	
		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 performance target last year and we did not create an emr tool to track out appointments.	1)Fully implement nurse phone triage for post discharge pts from CMH, adapting to CMH PODS	CMH to fax discharge notice the day following discharge Clerical staff to check of appointment booked, if not send message to appropriate nurse Nurse to call patient, to triage and recommend appropriate follow-up, clinician phone or in-person appointment. Work with CMH when PODS implement to adopt above protocol	Manual fax, f/u action	Revise nursing triage form as needed Create/revise custom form April/May Train nursing staff . May/June	
										2)Track appointments with any provider	Create a better tracking system, to record all actions on behalf of the patients, including f/u phone and in-person appointments	Work with OntarioMD Practice Enhancement consultant to create a tool to track patient from CMH fax through nurse triage and onto follow-up recommendations and appointment type. Adapt as needed to include PODS	Work with OntarioMD Practice Enhancement consultant to create a tracking tool Implement tool in April/May Train Nursing staff May/June for phone triage Revise when needed with	
Efficient	**Chronic Disease Management**	Percentage of patients with diabetes up-to-date with glycated hemoglobin (HbA1C) tests	C	% / patients with diabetes, aged 40 or over	EMR/Chart Review / April 2018 - March 2019	92309*	61.3	90.00	We did not obtain our target last year	1)Create an electronic diabetic registry	Work with OntarioMD Practice Enhancement Consultant to identify diabetic patients by IC-9 codes. Create a diabetic registry Review data issues in our emr, HB A1C testing	% of diabetic patients with IC-9 Code 250	Starting with main clinic: Identify all suspected diabetics Have family physician review list to ensure patients are appropriate Add IC-9 250 code for appropriate patients Include all satellite offices 100% of patients appropriately coded with IC-9 Code 250	This protocol will serve as a model for other chronic disease programs.
										2)Create protocol for reminder and recall	Work with OntarioMD Practice Enhancement Consultant to use emr reminder system	Create reminder reports for diabetic follow-up appointments	Following on from the creation of electronic diabetic registry, create reminder reports for quarterly and annual diabetic	This protocol will serve as a model for other chronic disease programs.
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	92309*	62.3	70.00	We did not achieve our target last year.	1)Better use data and the EMR to identify overdue patients	Use reminder reports to identify overdue patients and to record if patients do not wish to participate in screening	Decrease in rate of patients who are overdue for testing	Work with OntarioMD Practice Enhancement Consultant to create reminder reports for cancer screening Add patient preferences from previous lists.	
										2)Create a Woman's Health program	Woman's Health Program, centred on Cervical Cancer screening, will review appropriate screening (breast, cervical and colorectal), immunizations and risk factors, such as smoking.	CCO-SAR, Smoking Status	Develop Woman's Health Program Develop a custom form to track advice Launch program Measure	
										3)Reach out to overdue patients during other scheduled appointments	New toolbar easily identifies overdue patients to prompt clinicians to discuss during scheduled appointments.	CCO-SAR	Increase screening rate	
										4)Call overdue patients	Use CCO-SAR data to find "triple threats", overdue for breast, cervical and colorectal screening, as priority for first wave of phone calls.	CCO-SAR	On a quarterly basis use CCO-SAR Identify Triple Threats for priority follow-up, followed	
	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	A	% / PC organization population eligible for screening	See Tech Specs / Annually	92309*	38	35.00	Improve on our performance from last year	1)Better use data and the EMR to identify overdue patients	As preventive care toolbar pulls testing data and exemptions from emr, ensure colonoscopies are properly identified in chart. Use reminder reports to identify overdue patients and to record if patients do not wish to participate in screening	Decrease in rate of patients who are overdue for testing	Create searches to identify all colonoscopies Check if the report is properly identified as colonoscopy With OntarioMD Practice Enhancement Consultant create reminder reports Add patient preferences from	
										2)Reach out to overdue patients during scheduled appointments	New toolbar easily identifies overdue patients to prompt clinicians to discuss during scheduled appointments and provide FOBT kits. Woman's Health Program, centered on Cervical Cancer screening, will review appropriate screening (breast, cervical and colorectal), immunizations and risk factors, such as smoking	CCO-SAR	Develop Woman's Health Program, centering around Cervical Cancer screening Launch program	
										3)Call overdue patients	Use CCO-SAR data to find "triple threats", women overdue for breast, cervical and colorectal screening, as first list of patients to call, followed by rest of patients.	CCO-SAR	On a quarterly basis use CCO-SAR Identify Triple Threats for priority follow-up, followed	
	population health - breast cancer screening	% of eligible patients/clients who are up-to-date in screening for using Cancer Care Ontario letters. CCO-SAR, EMR)	C	% / PC organization population eligible for screening	CCO-SAR, EMR / April 2018 - March 2019	92309*	62.8	70.00	We did not make our target last year.	1)Better use data and the EMR to identify overdue patients	Use reminder reports to identify overdue patients and to record if patients do not wish to participate in screening	Increase the % of patients who are screened	Work with OntarioMD Practice Enhancement Consultant to create reminder reports Add patient preferences from previous lists. Run reports quarterly for	
										2)Create a woman's health program	Woman's Health Program, centered on Cervical Cancer screening, will review appropriate screening (breast, cervical and colorectal), immunizations and risk factors, such as smoking	CCO-SAR, Smoking Status	Develop Woman's Health Program Develop a custom form to track advice Launch program Measure	
										3)Reach out to overdue patients during scheduled appointments	New toolbar identifies overdue patients to prompt clinicians to discuss during scheduled appointments.	CCO-SAR	Increase screening rates	
										4)Call overdue patients	Use CCO-SAR data to find "triple threats", overdue for breast, cervical and colorectal screening, as priority for first wave of phone calls.	CCO-SAR	On a quarterly basis use CCO-SAR Identify Triple Threats for priority follow-up, followed	
	Population health - senior mental health	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	As the program is just being implemented, we will need to develop guidelines, goals and program measures. The baseline will then allow further improvements to be measured.	1)Establish a Memory Clinic	For in-house follow-up, create a memory clinic, run by clinicians trained by Dr. Linda Lee	To be developed	Finish training clinicians, physicians and nurses Develop a clinical protocol for our team Test protocol Establish process measures and tools Schedule regular	
										2)Better identification of patients for referral to specialists	Use best practices to test for cognitive impairment Identify early to provide best prognosis Rate the level of impairment to ensure appropriate follow-up	To be developed	Establish clinic wide testing standard Establish protocol and tools for testing	
										3)Better follow-up	From testing, screen best follow-up for patients for: Referral to specialists In house follow-up Connection to community agencies for added care and caregiver support	To be developed	Establish protocol and tools for appropriate referral Establish connections with community agencies to support patient and caregiver	
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	92309*	92.6	95.00	We exceeded our target of 90% last year.	1)Continue to offer high quality health care	Give patients enough time to ask questions and be involved in decision-making, provide useful information, respect privacy and work well as a team	Patient survey	Continue to work well as a team to offer high quality care	
										2)Continue to to ask the question "When you see your doctor or nurse practitioner, how often do they or someone else in the office involve you as much as you want to be in decisions about your care and treatment?"	Streamline patient survey, reorder to prioritize most important questions to guard against survey drop-out rates.	Reduce drop-out rates prior to the question from 14% to 5%.	Revise patient survey in April/May In May: Post on Website Start sending patient email invitations in May Have paper copies available in all clinics. Report quarterly to Quality Improvement Committee and	
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	92309*	63.5	70.00	Improvement on last year	1)Balance appointment supply & demand	Investigate ways to reduce demand, i.e. max pack appointments, eliminate unnecessary follow-ups, group medical visits	3rd next available Booking clerks feedback Patient survey	Identify practices that may benefit from a better balance of supply & demand Present various demand-reduction options for providers	
										2)Continue to offer best appointment options for patients	Offer same/next day appointments as available to patients, also offer appointments that better suit patient's needs for urgent care, to allow patients to make arrangements for transportation or family member to attend if necessary, time off work, etc	On the patient survey Ask the question, "The last time you were sick or concerned you had a health problem, did you get the appointment on the date you wanted?"	85% of patients to respond Yes	

										3) 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 next day appointment?"	Streamline patient survey, reorder to prioritize most important questions to guard against survey drop-out rates	Reduce drop-out rates prior to the question from 14% to 5%.	Revise patient survey in April/May In May: Post on Website Start sending patient email invitations in May Have paper copies available in all clinics. Report quarterly to Quality Improvement Committee and	