2014/15 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

Prince Edward FHT 35 Bridge Street, Picton, ON K0K 2T0

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 / TBD	92302*	89	89	Slight change in wording of this year's survey question, and survey was not conducted in all offices, so plan is to maintain consistency in result	1)Monitor Third Next Available appointment time, report as a range, highest and lowest, and an average. If provider is known to be away, use the time for his or her pod	Once monthly review of all PCP office appointment schedules	# of days (high, low and average), % of offices with 3rd next available of less than 2 days	Maintain an average less than 2 days on monthly reviews	
									2)Improve access to primary care during vacation or holiday periods though coverage within pods	i)Promote communication between providers ii)let people know about the pod system iii)let patients know who to call as an alternative to their own provider	Survey subset of patients regarding knowledge of cross-coverage	90% of patients are aware	Christmas season 2013, a memo was sent to all PEFHT reminding of the pods, and which offices had clinic on which days.
	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 / TBD	92302*	0	0	No plans to set a target for this measure as our ED is used outside of office hours per our FHO agreement	1)None	None	None	0	
	Ensure patients on waiting list for primary care provider are being enrolled in reasonable time	# of new patients enrolled, and # of patients on waiting list through Health Care Connect	Counts / Patients requesting primary care	Health Care Connect / report quarterly	92302*	CB	30	Expect fewer than 30 patients to be on the waiting list for a PCP for more than two reporting periods	1)Ensure patients on waiting list are being enrolled in a timely manner	Quarterly reports compiled by Cindy, information from Health Care Connect. Report to members and board.	Wait time for enrolment (knowing this can vary with patient health status)	Establish baseline, improve by 25%	

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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 / TBD	92302*	14	30	Expect improvement in data collection process will improve the measure	2)Use a consistent appointment type for post-discharge visits, to allow tracking through EMR	Cindy reviews all discharges, checks on post-discharge visits	% of visits with correct appt type used	50% by March 2015	Initially tried using a central phone # for appointments, received feedback that it was not being used. Subcommittee still working on best process.
									3)% of patients who saw PCP within 7 days of hosp discharge for select CMG's	EMR inquiry and manual search to compare to data from Health Portal	# patients who saw PCP within 7 days / # patients discharged with select CMG's = %	50%	Purpose: to compare our own data with the ministry - find out where the information comes from
	Reduce unnecessary hospital readmissions	Percent of a primary care organization's patients/clients who are readmitted to hospital after they have been discharged with a specific condition (based on CMGs).	% / PC org population discharged from hospital	Ministry of Health Portal / TBD	92302*	22	10	It will take time to improve data collection process, goal is to show a decrease in the next year and to establish a set target at that point.	1)% of patients readmitted within 30 days.	Continue manual/EMR information collection and compare to Health Portal	# re-admitted within 30 days / # admitted within the selected group = %	10%	
									2)Track patients who are readmitted to hospital for any reason (not just the selected groups) and patients who had 3 or more admission in the previous year	EMR and manual search	% readmitted for any reason / total # discharged % patients admitted in current year/ # with >3 admissions in previous year	collect baseline, < 20%	We want to see if admission rate in subgroups of Hospital at Home and Complex Care Plan have lower admission rates than general population.
									3)What is the readmission rate of patients enrolled in the Hospital at Home program?	EMR/manual search for given time period (fiscal year?)	# patients readmitted to hospital / total patients in program = %	establish baseline, <20%	

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									4)What is the re-admission rate of patients with a Complex Care Plan	EMR and manual collection	# of patients readmitted / # of patients with plan = %	Establish baseline, <20%	Use this information to determine if # of admissions is a good criteria for Complex Care Plan patients
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 / 2014/2015	92302*	96	96	Goal is to maintain this result consistently	1)Improve access to completing the patient experience survey. Try an online version through website	survey	# of surveys completed online, and % of total surveys	20 surveys	
									2)Run a patient focus group	Small group (3 patients) to provide feedback on our new website	# of changes suggested and # implemented	implement 100% of feasible suggestions	First step towards developing a patient advisory group
									3)Begin documenting patient's own goals of care	Use self-management goal template, test in select primary care offices	# of plans complete	collect baseline	Work out the process first, test other methods, then spread
									4)Provide summary of survey results to individual offices/providers	Summary table and comments	% of offices where survey was conducted	100%	
		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 / 2014/2015	92302*	93	93	Goal is to maintain this result consistently	1)as above	as above	as above	as above	

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		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 / 2014/2015	92302*	94	94	Goal is to maintain this result consistently	1)as above	as above	as above	as above	
	Improve patient knowledge and confidence in managing complex health issues	Self-efficacy score improvement pre- and post- program. Measure % of patients with an improved score	% / Identified patients with complex needs	EMR/Chart Review / collect monthly	92302*	CB	10	Target will be set over the longer term once we have established criteria and measures	1)Initiate Complex Care Plan for identified patients.	Test various criteria to identify patients, complete Care Plan, use a measure for patient satisfaction and self-efficacy	# of plans created, % of plans with ACP done, % of plans with medication reconciliation done, % of patients with goals of care documented, % of patients with self-efficacy score completed, # of eligible patients according to developed criteria, % of primary care providers involved in process	Establish baseline for all measures, goal for 40% of PCPs to use the complex care process at least once	
									2)Plan education for primary care and allied health providers for consistent documentation of patient goals, ACP and med rec	test methods including: small group learning, office visits, staff day presentation	% of health care providers attending	40%	
									3)Formalize evaluation of our Stanford self-management programs, by comparing self-efficacy scores before and after completion of 6 week workshops. Work on standardizing input into EMR.	review scores on paper surveys and put in a database	% improvement in score pre and post, % of participants with 50% improvement or more	Collect baseline, 20% with some improvement, 5% with 50% improvement or more	

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Population health	**Reduce influenza rates in older adults by increasing access to the influenza vaccine.**	Percent of patient/client population over age 65 that received influenza immunizations.	% / PC organization population aged 65 and older	EMR/Chart Review / TBD	92302*	54	60	We presume our actual rate of immunization is higher, and are working on better capturing all activity with consistent EMR documentation	1)Improve communication and documentation for patients receiving flu shots outside of primary care offices (at community clinics and pharmacies)	i) Display a poster at community clinics and pharmacies advising patients to let their PCP know of immunization ii) provide wallet-sized cards to community clinics and pharmacies for patients to bring back to PCP	# of wallet cards returned to select PCP offices in 14/15 flu season, track time spent on this activity	20 cards returned per office, spend 2 minutes per card on documentation	see how many we get and then decide if it was worth the time spent
									2)Improve EMR documentation of influenza immunization	i) e-mail QI tip of the month for flu shot documentation ii)circulate a cheat sheet with EMR shortcuts, billing codes, quick text iii)share information on using and customizing the preventive care prompt iv)offer individual office visits by QI team member	# of offices asking for an individual visit from QI team member % of offices using the preventive care prompt	- to make at least 2 office visits - collect baseline on % of offices using the preventive prompt (20% of offices)	- include this information in staff education session, as mentioned in Complex Care plan patients, change idea #2
	Reduce the incidence of cancer 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 / TBD	92302*	CB	50	Working on improving data entry and collection process	1)Track eligible patients with breast screening done in the past two years	EMR inquiry	% of female patients 50-74 years of age who have had a mammogram in the past two years, excluding patients with total mastectomy	collect baseline (50%)	
									2)Improve identification and documentation of preventive care	ideas as described under influenza	improve % screening documented each quarter	reach 50% by end of year	see influenza idea #2
		Percent of eligible patients/clients who are up-to-date in screening for colorectal cancer.	% / PC organization population eligible for screening	EMR/Chart Review / TBD	92302*	58.3	70	April 2013 result was 70.1% in a sub-population of providers. In October 2013 we included all providers and this decreased to 58%, goal is to get back to 70%	1)Track eligible patients with FOBT done in past 2 years or colonoscopy in past 10 years	EMR inquiry, as developed during QIIP	% complete	70	Past results are available on our intranet

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									2)Track % of patients with positive FOBT who have been referred to colonoscopy within 2 weeks	EMR inquiry as developed during QIIP	% referred	100%	
									3)Improve identification and documentation of preventive care	ideas as described under influenza	improve % screening documented each quarter	reach 70% by end of year	see influenza idea #2
		Percent of eligible patients/clients who are up-to-date in screening for cervical cancer.	% / PC organization population eligible for screening	EMR/Chart Review / TBD	92302*	CB	50	Work on improving data entry and collection process	1)Track eligible patients with cervical cancer screening done in the past three years	EMR inquiry	% of female patients 21-69 years of age who have had a pap smear in the past three years, excluding patients who have had a hystectomy	collect baseline (50%)	
									2)Improve identification and documentation of preventive care	Use the FHN pap exclusion code, improve accurate identification of eligible patients	Improve % screening documented each quarter	reach 50% by end of year	See influenza idea #2
	Improve compliance and outcomes with the 18 Month Enhanced Well Baby Visit according to Ministry guidelines	% of patients with 18 Month EWBV complete	% / all children 18 months	EMR/Chart Review / annual	92302*	90	90	Goal is to maintain this result consistently, giving consideration for parental choice	1)Track # of patients with one or more positive result(s) on Nipissing. Would like to be able to track electronically and stop the manual search	EMR Inquiry and manual search.	# of patients at 22 m that have had a complete 18m Enhanced Well Baby Visit and has one or more positive Nipissing. Range so far has been 1 - 8 each month	100% match between electronic and manual search.	All results being reviewed monthly for timely follow up, report annual totals on the QIP
									2)Track # patients who had a positive result to ensure referral completed	EMR inquiry as well as a manual search	% of pts with a positive result and a referral was made	100% referrals made	
	Reduce the number of smokers in our population	% of patients who are not smokers	% / FHT patients age 12 or over with smoking status documented	EMR/Chart Review / track every 6 months	92302*	79	80	It will take time to show a population change. Goal is a 1% absolute increase over 5 years	1)Improve documentation of smoking status	Spread EMR tips	% of patients 12 yrs or older with smoking status documented. EMR inquiry every 6 months, use yearly data for QIP	65% by March 2015	Current performance (March 2014) is about 58%.

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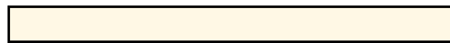
									2)Improve % of current smokers with status changed from current to previous, indicating that they have stopped smoking since last encounter.	Spread best documentation practice through QI committee and smoking cessation steering group	EMR inquiry, % of patients with status changed from current to previous	25% for the year	measure was 23% in April 2013
Other	**Improve consistency of care for patients with Type 2 diabetes (under the dimension of Effective care)**	(i) % of patients with diabetes who have had A1c done in past 6 months (ii) % of patients with diabetes who have had BP checked in past 12 months (iii) % of patients with diabetes who have had urine ACR checked in past 12 months	% / all FHT patients with diabetes	EMR/Chart Review / .	92302*	80.4	80.4	Goal is to maintain this result consistently (i) 80.4% (ii) 90.2% (iii)55.8%	1)Spread the use of these measures/indicators to other PCPs within the FHT	Staff day or session at Annual General Meeting	# of staff attending	40% of staff	Has been tracked for a specific population of FHT patients since involvement in QIIP
									2)Train staff to run reports for individual offices	Staff day or AGM presentation	# of staff attending	40% of staff	Alternate goal would be to have one primary care office begin routinely running reports



Part shaded in this colour show these are mandated HQO Primary Care Priority or Additional Indicators

Parts shaded in this colour show that these are indicators set up by and for PEFHT