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

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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 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.	91572*	CB	CB	Process in place to review discharge notices from GBHS - OS. This is not an HRM process. It is a separate list that is securely messaged to OSFHT. 2018-19 FHT and clinic staff reviewed list on daily basis to determine if patients had been scheduled for follow up. Review found most patients requiring follow		1)Discuss follow up from inpatient discharge at FHO medical staff meeting.	Add discharge follow up to medical staff mtg at June and October mtgs.	% physicians providing input to issue of timely follow up following hospital discharge	75% of physicians will contribute input to issue and identify areas for improvement as	Some FHO physicians manage care of their patients in hospital and are
											2)Focus on COPD discharges. Connect follow up to COPD rehab program. Collaborate with Asthma Research Group and	Design/test follow up pathway for COPD discharges to include a documented follow up with RT (phone call/appointment) within 7 days and communication to family doctor.	% of COPD discharges (ED/Inpatient) with a documented follow up communication by Respiratory Therapist within 7 days of discharge.	100% of COPD discharges occurring in Q3 will have a documented follow	Test timely follow up with patient population at risk for ED/inpatient readmission.
											3)Identify patients discharged from hospital with COPD related episode.	Develop/test search or notification process to flag notifications from Hospital Report Manager that specify respiratory related reason for visit. Difficult to determine from HRM as is. Look to try and filter notifications without opening each notification to find	% of respiratory related hospital discharge notifications identified by EMR search	Collect baseline. Develop search and test on discharge notifications by Q2	
											4)Match hospital discharge notifications with pulmonary rehab program list to find patients who may benefit from pulmonary	Routinely generate list of pulmonary rehab program participants and compare to review of hospital discharge notifications for patients with respiratory related hospital visits. Where applicable, contact patients to discuss option of participating in rehab	Frequency of comparison of up-to-date lists.	Monthly comparison of lists.	
	Timely	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or	P	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	91572*	CB	CB	Collecting baseline as we expand the survey outside of the Advanced		1)Retrain re script to triage booking between NP Advanced Access Clinic, After Hours Clinic and main Primary Care Provider same	Review triage booking script with scheduling staff and re-test use of script for 2 weeks to assess impact on balancing schedule across 3 urgent access streams.	% of staff familiar with script and using script on daily basis	100% of staff by end of Q2	Connect with Board Operational Committee to discuss
Theme II: Service Excellence	**Patient-centred**	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	P	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	91572*	CB	CB	Current survey (paper and tablet) made available to FHT program participants. Plan to expand use of survey to sample population access FHO		1)Implement dedicated Ocean tablet kiosk in waiting area to collect consent to use email. Survey can then be emailed to sample survey	Install kiosk. Communicate (inform, sign) to patients the purpose of the kiosk and survey and assist as necessary with the use of the tablet to complete the survey.	% of surveys completed per clinic pod	10% of patients attending clinic pod will have completed a patient survey	
											2)Partner with volunteers during busy clinic hours to help patients use Ocean tablet kiosks to improve email consent collection.	Train student volunteers to approach patients needing help using Ocean tablet on how to use tablet and answer any questions regarding purpose of survey.	# of student volunteers trained and on-site	5 student volunteers trained and providing on site support .5 day a week for up to 4	
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	91572*	CB	CB	Starting with smaller, defined patient population to assess ways to document initial advanced care planning conversation in a common way.		1)Create dialogue tool in EMR to capture if Power of Attorney/Substitute Decision Maker in place. Test with more	Use PSS SDM toolbar to capture conversation with patient about who to contact/discuss goals of care with.	% of COPD program patients (ARGI program) with completed SDM toolbar	50% of COPD program patients with completed SDM toolbar by Q3	
											2)Host information session regarding Advanced Care Planning/Substitute Decision Making	Provide information session to COPD program participants regarding Advanced Care Planning-Substitute Decision Making.	# COPD program participants participate in information session	20 participants by Q3	
		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	C	% / All patients	EMR/Chart Review / 2018-19	91572*	CB	50.00	Tested Inlows Foot Screen tool in 2 practices. Plan to spread to other nurses and to more DM patients (50% of DM patients across 50% of the practices)		1)Education session with Grey Bruce Health Services "off-load clinic" which looks after diabetic patients with active ulceration.	In-service provided by off-load clinic staff to nursing staff regarding diabetic foot care services and fit with FHT diabetic services. Review use of Inlows foot screen to spread use beyond initial 2 practices.	Inservice provided and staff attending.	Inservice by Q2. 75% of staff attend. Repeat as warranted.	
											2)Recruit/develop Foot Care program staff to offer preventative foot care to diabetics. Promote use of Inlows tool across	Develop as part of Schedule A program development a program plan, larger capability to provide evidence based footcare to patients.	Program developed (recruitment, goals, referral pathway) and initiated	Preventative foot care program with dedicated staff in place Q2.	Having implemented a standard foot ulcer assessment tool in last years
	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	91572*	4.4	4.40	New prescriptions for opioids trending down since Sept 2014 according to MPPC. Of the newly prescribed, FHT providers prescribe for <		1)Plan for program development to educate/support patients prescribed opioids and benzodiazepines.	As part of Schedule A program planning, develop an education program combined with a cognitive behavioural therapy program to support patients at risk for taking opioids or benzodiazepines.	Program developed (goals, methods, referral pathway)and initiated.	Cognitive Behaviour Therapy program seeing patients by Q3.	
											2)QI Committee Physician lead present their My Practice Primary Care at future FHO medical staff mtg. and encourage	Review MPPC at staff mtg coinciding with quarterly release of MPPC.	# times MPPC presented at staff mtg	Twice annually - present at June mtg and January mtg	
		Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 36-month period.	C	% / All patients	CCO-SAR, EMR / 2018-19	91572*	67.1	75.00	Have historically had this screening rate. With service disruption in 2018-19, rate has dipped. Plan is to get back to historically good performance with combination of change ideas.		1)Implement dedicated RPN as a Preventative Care Promoter to monitor preventative care status and initiate follow across roster.	Routine monitoring of preventative care status across rosters to initiate follow up reminders and support to schedule tests.	% of patients overdue for cervical screen contacted and supported to schedule appointment	75% of patients overdue for cervical screen will be contacted by preventative care	
											2)Continue to promote online booking to nurse-led cervical screening clinic to increase convenience options for patients.	Use waiting room displays and emails to promote use of online booking feature implemented in 2018-19.	# of promotions/instructions on Book an Appointment page (https://www.osfht.ca/displayPage.php?page=BookAnAppointment2)	Quarterly emails to patients reminding them of this feature. Daily reminder on	
											3)Continue to promote CCO Physician Linked Correspondence among primary care practices.	Current CCO correspondence users discuss CCO correspondence and its impact at medical staff mtg and encourage others to register with support from FHT.	% of physicians registered with CCO correspondence program	80% of physicians by Q4.	