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

Flemingdon Health Centre 10 Gateway Blvd., Toronto, ON M3C 3A1

AIM		Measure						
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification
Effective	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	92231*	43.2	50.00	We are setting a stretch target.
	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	92231*	63.42	70.00	Data issues have been identified at a sector level regarding the extraction of BIRT data for this indicator.
	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	% / PC organization population eligible for screening	See Tech Specs / Annually	92231*	54.46	60.00	Data issues have been identified at a sector level regarding the extraction of BIRT data for this indicator.

Equitable	**Collecting equity data**	Percent of clients who have completed the Measuring Health Equity demographic questionnaire as per the TC-LHIN specifications.	% / Clients	EMR/Chart Review / 2017-2018	92231*	48	65.00	Set a stretch target
Patient-centred	**Person experience**	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else	% / PC organization population (surveyed sample)	In-house survey / April 2016 - March 2017	92231*	91	91.00	Aim to maintain this excellent result.
Safe	**Medication safety**	Percentage of patients with medication reconciliation in the past year	% / All patients	In house data collection / Most recent 12 month period	92231*	CB	CB	As this is a new indicator we will collect baseline data this year.
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	92231*	38.61	45.00	Continue to set a stretch target for this indicator.

Change				
Planned improvement initiatives (Change Ideas)	**Methods**	**Process measures**	**Target for process measure**	**Comments**
1)FHC will continue to work with Health Links, Sub-Region tables, hospital partners and CCAC to improve discharge planning	Participate in Health Links and Sub-Region tables and collaborative projects.	FHC's Director, Health Services will actively participate in Health Links and Sub-Region tables.	By March 31st, 2018 FHC's Director, Health Services will have attended at least	
2)Initiate a client education initiative at FHC to ensure clients are aware of when they should schedule an appointment post hospital	QI Committee to pilot 1 client education method	One client education method is piloted during the 2017-18 year that focuses on when clients should follow-up with their primary care provider	In 2017-18 FHC will implement the change idea and evaluate it in 2018-19 through our	
1)Address data issues both internally and at a sector wide level	QI and Data Team to lead this work	Issues are identified and addressed	By March 31st, 2018 data is being entered and extracted accurately	
2)On a quarterly basis pull lists of clients who are overdue for cervical cancer screening so providers can offer this service.	Quarterly reports generated by Data Management Coordinator and disseminated to MD/NP/RN teams	Quarterly reports generated and used	By March 31st, 2018 FHC providers (MD/NP/RN) are regularly analyzing their practice for	
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1)Train additional administrative staff to be able to collect and input Health Equity Demographic data for existing primary	Identify additional administrative staff and schedule a training with existing Measuring Health Equity principles and practices' curriculum	100% of identified administrative staff are trained	By March 31st, 2018 all identified administrative staff are trained	
2)Expand implementation of Measuring Health Equity to additional health promotion programs	Identify appropriate programs for implementing this questionnaire	Implement MHE questionnaire in relevant programs	By March 31st, 2018 30% of health promotion group clients will have completed the	
1)Increase the sample size of clients surveyed so the ideas and opportunities to improve coming out of the survey have impact	FHC will implement an rolling survey to ensure a wide sample of clients are surveyed	Develop and implement rolling survey plan	By March 31st, 2018 6% of clients (approximately 600 clients) are surveyed	
1)Understand how we currently reconcile medication and document this work	The QI Committee will conduct a focus group with clinicians and data staff	Develop focus group guide and data collection plan	By October 1, 2017 focus group is completed	
2)Develop a standard protocol for medication reconciliation	An inter-disciplinary working group to develop protocol	Working group membership is diverse and has the right people at the table	By March 31st, 2018 FHC has developed a medication reconciliation	
1)Implement 'same day' appointments in every shift of MDs and NPs schedule	Staff teams implement same day appointments	This initiative will be led by reception staff	By June 1, 2017 all MDs and NPs will have same day appointments carved out in each	
2)Implement consistent post vacation planning for MDs and NPs schedule using Advanced Access principles	Ensure post vacation schedule follows Advanced Access recommendations (e.g. admin time, urgent appointments, etc)	Teams to work together to implement standard post vacation practices per provider	By March 31st, 2018 all MDs and NPs have consistent post vacation	
3)Establish target for Third Next Available (3NA) for each MD and NP practice	Work in teams to establish a target for 3NA	Teams meet regularly to monitor and work on lowering their 3NA	By March 31st, 2018 100% of MD and NP teams have established a 3NA target	