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

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

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
Effective	Effective transitions	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	92231*	CB	CB	We will be focusing on hospital discharges for the 7 conditions best managed in primary care (as opposed to any condition as noted above).	1)Develop a tracking and reporting system for hospital discharges received within 48 hours (for the seven conditions best managed in primary care)	Convene a working group of front desk, clinical and data staff to examine how to best track and report this work	Working group has met and developed a protocol	By June 30th, 2018 develop a protocol for tracking these discharge summaries	As flagged, this will only be for a sub-set of conditions
										2)Develop a follow-up system for offering appointments to clients when we receive a hospital discharge for the seven identified conditions	Convene a working group of front desk, clinical and data staff to examine how to best implement this appointment system	Working group has met and developed a protocol	By September 30th, 2018 develop a protocol offering and tracking these appointments	As flagged, this will only be for a sub-set of conditions
										3)Develop a tracking for the number of clients who have received follow-up (phone or in person) including those who declined follow-up within 7 days of discharge for select conditions	Convene a working group of front desk, clinical and data staff to examine how to best track and report this work	Working group has met and developed a protocol	By March 31st, 2019 test the follow-up and tracking system for at least one clinician	As flagged, this will only be for a sub-set of conditions
	Wound Care	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	A	% / patients with diabetes, aged 18 or older	EMR/Chart Review / Last consecutive 12 month period	92231*	CB	CB	As this is a new indicator for us to work on we will start by collecting baseline.	1)Understand how we currently provide and document diabetic foot ulcer risk assessments	QI Committee member(s) will conduct a focus group with staff from primary care, chiropody and diabetes management	Develop some key questions in order to map our current process	By September 30th, 2018 conduct focus group and provide recommendations on diabetic foot ulcer risk assessment and documentation	
Equitable	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	92231*	39	33.00	At Q3 of 2017/18 FHC's MSAA stated 61% of our eligible clients had received colorectal cancer screening implying 39% had not. We will set a stretch target by aiming to improve this outcome by 15% which will result in 33% of clients overdue for the screening.	1)On a quarterly basis pull lists of clients who are overdue for colorectal 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, 2019, FHC providers (MD/NP/RN) are regularly analyzing their practice for gaps in colorectal cancer screening and actively initiating care for clients who require screening	

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)

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	92231*	87.42	90.00	Continue to strive for consistently high performance.	1)Provide an in-service for all clinicians around involving clients in decisions in their care	A working group will be struck to research training opportunities and to arrange for a training that will have impact	Working group meets at least twice and a training is arranged	By March 31st, 2019 a training has been delivered to clinicians around involving clients in decisions in their care	
Safe	**Medication safety**	Percentage of patients with medication reconciliation in the past year	A	% / All patients	EMR/Chart Review / Most recent 12 month period	92231*	4	20.00	We will be ensuring appropriate charting in our EMR that allows for this indicator to be captured. We will focus on complex clients.	1)Define 'complex clients' for this initaitive	A working group made up of diverse clinicians will identify who is most in need of regular medication reconciliation	Working group struck and a minimum of one meeting is held	By September 30, 2018 'complex clients' have been defined for this initiative	
										2)Develop a standard protocol and data workflow to capture this information	A working group of clinicians and our Data Management Coordinator to develop protocol	Working group is convened with diverse perspectives and has met a minimum of three times	By March 31st, 2019 FHC has developed a medication reconciliation protocol that clinicians are using	
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	92231*	36.68	45.00	Continue to set a stretch target for this indicator	1)Client education on same day appointments	Create a client education tool (e.g. poster, pamphlet) that describes FHC's same day and urgent appointment booking process	Working group struck, minimum of 3 meetings, client education tool produced	By March 31, 2019 a client education tool is rolled-out to clients across all three sites	
										2)Focus on improving access in the practices where obstetrical care is provided (as these are the practices with the most access challenges)	Reach out to local primary care and obstetric clinicians in the East Sub Region to learn best practices around managing access for clients given the challenges with OB scheduling	At least two clinicians/teams are consulted on their approach to managing their practice	By March 31, 2019 a plan will have been developed and one change idea tested to improve access in practices with obstetrics	
										3)Implement consistent post vacation planning for all MDs and NPs schedule using Advanced Access	Ensure post vacation schedule follows Advanced Access recommendations - including opening up appointments while clinician is away on vacation for urgent needs upon return	Teams to work together to implement standard post vacation practices per provider	By March 31, 2019 all MDs and NPs will have consistent post vacation scheduling practices	This is an expansion on the work started in the previous QIP - we will be spreading the learning of post vacation Advanced Access scheduling for urgent appointments and follow-up to all providers