2016/17 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	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification
Effective	**Improve rate of cancer screening.**	Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years	% / PC organization population eligible for screening	See Tech Specs / Annually	92231*	58	64.00	We are aiming to have a 10% increase in this indicator.
		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	69.00	We are aiming to have a 10% increase in this indicator.
	Improve rate of HbA1C testing for diabetics	Percentage of patients with diabetes, aged 40 or over, with two or more glycated	% / All patients with diabetes	Ontario Diabetes Database, OHIP / Annually	92231*	CB	CB	With an initial data pull we found FHC was performing at only 1% for this
Equitable	**Other**	Percent of clients who have completed the Measuring Health Equity demographic questions as per TC	% / All clients who have had an appointment (group or one-on-one) within the	EMR/Chart Review / 2016-7	92231*	34.9	50.00	We aim to significantly increase the percentage of clients who have

Patient Experience	**Improve Patient Experience: Opportunity to ask questions**	Percent of respondents who responded positively to the question: "When you see your	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	92231*	88	90.00	FHC will aim to maintain the excellent client experience results.
	Improve Patient Experience: Patient involvement in decisions about care	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 2015 - March 2016	92231*	91	93.00	FHC will aim to maintain the excellent client experience results.
	Improve Patient Experience: Primary care providers spending enough time with patients	Percent of patients who responded positively to the question: "When you see your doctor or	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	92231*	91	93.00	FHC will aim to maintain the excellent client experience results.
Timely	**Improve 7 day post hospital discharge follow-up rate for selected conditions**	Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions.	% / PC org population discharged from hospital	DAD, CIHI / April 2014 – March 2015	92231*	26.3	28.00	Please interpret the current performance with caution. The numerator is between 6-19 and the denominator is less than 99. Given the
	Improve timely access to primary care when needed	Percent of patients/clients who responded positively to the question: "The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone	% / PC organization population (surveyed sample)	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period available)	92231*	31	40.00	The results for this question were drastically different than from the previous year in which the result was 67%. We have provided two reasons why we think the result changed: 1) This year we used the HQO layout for the

Change				
Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
1)Improve provider recording practices to increase accuracy of data entry.	Develop quick reference guides and tip sheets.	1) Conduct staff education around data entry. 2) Distribute tip sheets for visual reminders.	By March 31st, 2017 increase this indicator by 10%.	
2)Work with our partners to ensure health promotion materials are available to clients around the importance of cancer	Display and distribute cancer screening materials.	Enhance partnerships to better incorporate cancer screening promotion and materials at FHC (possible partners include health promotion team at FHC, Cancer Care Ontario or Toronto Public Health).	By March 31st, 2017, have at least one health promotion initiative	
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1)Understand the challenges and opportunities to offering, recording and ensuring HbA1C tests are completed by patients with	FHC will analyze data entry practices of providers around HbA1C testing.	FHC will learn from colleagues how to best record HbA1C testing and implement improvement ideas with clinicians.	By March 31st, 2017 FHC will have a simple and effective plan to ensure HbA1c	We suspect some of our workflow processes are impeding the reporting of this
1)Currently FHC collects this demographic information with new and ongoing primary care clients, diabetes clients, chiropody	1) Train health promotion team members in the Measuring Health Equity principles and practices. 2) Develop process for collecting information in group format 3) Identify resources for data entry	1) 100% of health promotion staff are trained	By March 31st, 2017, 25% of health promotion group clients will have completed	

1)Increase the percentage of clients surveyed. In 2015-6 FHC surveyed 4% of active clients which was 9% of clients who were seen (both	Expand our survey methodology to beyond the 'blitz' format. FHC will also include an ongoing/periodic survey methodology this year.	1) QI Committee brainstorms best way to implement an ongoing/periodic survey methodology 2) Pilot the new methodology	By March 31st, 2017 FHC will have surveyed 5% of active clients which should result in	
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1)FHC will continue to work with Health Links and hospital partners to improve discharge planning and communication in order to	Participate in Health Links and Solutions Network initiatives including coordinated care planning and shared quality initiatives.	FHC's Director, Health Services is the Health Links and Solutions Network lead for FHC. She will actively participate in both networks through meetings and implementation of pilot projects. FHC will implement 100% of pilot projects, supported by Health Links and	100% of Health Links clients have interdisciplinary care plans.	
2)Initiate a client education initiative at FHC to ensure clients are aware of when they should schedule an appointment post hospital	1) QI Committee to identify client education opportunities 2) Consult clients 3) Pilot 1-2 client education methods	One client education method is piloted during the 2016-17 year that focuses on when clients should follow-up with their primary care provider.	In 2016-17 we will implement this change idea. In the Client Experience Survey	As FHC uses an inter-disciplinary team it may not always be the physician that
1)Use 3NA target to drive changes in specific providers practice.	FHC will set a target for 3NA for all MDs/NPs practices. For providers who's 3NA is above the target they will be supported to come up with strategies to decrease their 3NA.	3NA data trending.	By March 31st, 2017, FHC will decrease the 3NA for the two providers with the	
2)Use 3NA data to drive changes in scheduling of providers and clients across FHC.	Apply Advanced Access principles around setting up MD/NP schedules for number of same day appointments and number of pre-booked appointments.	Provide training to reception, nursing and MD/NP staff on scheduling principles. Implement client education on the upcoming change in booking.	By March 31st, 2017 all MDs/NPs at FHC have applied at least one Advanced Access	Our challenge is how to minimize the client and staff confusion around this
3)Improve phone triage process at FHC.	Develop a decision tree for who triage's what type of client and when.	Front desk and nursing team work together to draft a decision tree.	By March 31st, 2017 an improved phone triage process is in place and staff are using	