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

West Elgin CHC 153 Main Street, West Lorne, ON N0L 2P0

	Measure								Change				
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
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Effective	**Coordinating care**	Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach	A	% / Patients meeting Health Link criteria	In house data collection / most recent 3 month period	92245*							Health-Links Roll-Out is expected in the coming year. Initially anecdotal identification process is envisioned. Will move forward by exploring how clients who meet criteria can be identified using available data sources. Once this has happened we will be able to measure a baseline rate.
	Effective transitions	Percentage of patients who have had a 7-day post hospital discharge follow up. (CHCs, AHACs, NPLCs)	P	% / Discharged patients	See Tech Specs / Last consecutive 12 month period	92245*							WECHC QIP focus for 2018-19 will not include this measure. We currently have agreement with 2 local hospitals to ensure that follow-up appointments are offered as part of discharge planning. In addition, we have no way of collecting numbers of client who needed to be seen within 7 days and who did.
		Percentage of patients who were discharged in a given period for a condition within selected HBAM Inpatient Grouper (HIGs) and had a non-elective hospital readmission within 30 days of discharge, by primary care practice model.	A	% / Discharged patients with selected HIG conditions	DAD, CAPE, CPDB / April 2016 - March 2017	92245*	6	6.00	Performance data is from practice profile report (out of date & recommends to interpret with caution). We will continue to monitor progress on this indicator through review of new practice profile reports.				6.0	WECHC QIP focus for 2018-19 will not include this measure. We currently have agreement with 2 local hospitals to ensure that follow-up appointments are offered as part of discharge planning. We hope to see an improvement in performance as reporting data currently precedes agreements.
		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	92245*							WECHC QIP focus for 2018-19 will not include this measure. We currently have agreement with 2 local hospitals to ensure that follow-up appointments are offered as part of discharge planning.
	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	92245*	CB	CB					Not working towards this indicator. Instead focus will be on continuing to improve Hb1AC screening rate. See 'custom' indicator.
Efficient	**Access to right level of care**	Add other measure by clicking on "Add New Measure"	A	Other / Other	Other / Other	92245*							
Equitable	**Population health - cervical cancer screening**	Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period.	A	% / PC organization population eligible for screening	CCO-SAR, EMR / Annually	92245*			1)				See custom indicator for cervical-cancer screening

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	Percentage of 20 – 69 year old clients who received or were offered a Pap Smear test in the last 3 years. (Tests that were offered but declined, refused, ineligible or done elsewhere are included if recorded in EMR.)	C	% / PC organization population eligible for screening	EMR/Chart Review / 3 year period	92245*	70	75.00	SWLHIN MSAA Target. We expect to see continued improvement with use of bi-monthly feedback system implemented last year.	1)				No new change initiatives planned. PHC Team will continue to review bi-monthly performance and identify plan to offer screening to eligible clients as they are identified through report reviews. Note that performance on this indicator may be affected by projected staffing shortages.
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	92245*		CB		1)				See custom indicator for colorectal cancer screening
Population health - diabetes	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months	A	% / patients with diabetes, aged 40 or over	ODD, OHIP-CHDB,RPDB / Annually	92245*	60			1)				See "Custom" indicator for HbA1C screen-rate. Primary Healthcare Team (PHC) Team input suggests that there may be instances where >1 HbA1c test is not necessary.
	Percentage of clients with a diagnosis of diabetes who are offered a HbA1c in last 6 months.	C	% / patients with diabetes, aged 18 or older	In house data collection / 6 month period	92245*	CB	75.00	In-house reporting for HbA1c indicator on progress report suggested 61% testing rate for eligible clients. We suspect rate could be higher due to inclusion errors in denominator (e.g. we have identified source of error in enumerating paper reports). In addition we expect performance in offering tests will be higher than those who have completed (as some clients choose not to follow-up with testing despite recommendations).Current performance is "Collecting Baseline" because report is still being refined.	1)Improve reporting & develop process for regular review & follow-up.	Continue to work with Data Management Coordinator (DMC) to 'clean-up' reporting from EMR & refine process for reviewing non-EMR sources (manual review). Make monthly reports available to providers and ask them to develop follow-up plans for clients who are eligible for testing.	Accuracy of monthly reports. Frequency of review and action plan development.	Aim for accurate data to be reviewed monthly at team meetings. Aim for action plans to be developed for all clients who are eligible to be offered test.	We recognize that some clients will decline testing, including some who are elderly and who have had no changes in their diabetes management for several years. We will also report on clients who decline the test as that is outside of our control for improvement.
	Population health - colorectal cancer screening	Percentage of clients ages 50=74 *up to 75th birthday) who received or were offered a fecal occult blood test (FOBT) in the last 2 years.	C	% / PC organization population eligible for screening	EMR/Chart Review / 2yrs	92245*	69	75.00	MSAA target from SWLHIN. We expect to see continued improvement with use of bi-monthly feedback system implemented last year.	1)				No new change initiatives planned. PHC Team will continue to review bi-monthly performance and identify plan to offer screening to eligible clients as they are identified through report reviews. Note that performance on this indicator may be affected by projected staffing shortages.
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	92245*	94	95.00	We are pleased with current performance.	1)				Will continue to monitor through client satisfaction survey. No change ideas identified as team is pleased with current performance.

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Safe	**Medication safety**	Percentage of patients with medication reconciliation in the past year	A	% / All patients	EMR/Chart Review / Most recent 12 month period	92245*	CB	CB	Primary Care Team is currently meeting with local pharmacy to develop partnership plan to implement a process for medication reviews. Initial focus is determining criteria for clients who would most benefit from this process.	1)see comments				Primary Care Team is currently meeting with local pharmacy to develop partnership plan to implement a process for medication reviews. Initial focus is determining criteria for clients who would most benefit from this process.
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	92245*	63	72.00	Target remains unchanged from previous year's. There is growing concern at our centre that this metric is not a reflection of our ability to offer 'timely' access to services for clients who do not want or are not able to access our services through a same or next-day appointment. (We added the following question to our most recent client satisfaction survey: "The last time you were sick or were concerned you had a health problem did you get an appointment on the date you wanted?". The response was 73.6% YES). At the same time we aim to continue to improve access to our primary care and community-based services. The change ideas and process measures presented identify our plan to do so.	1)Develop and implement a plan to improve processes to timely/appropriate access primary to care services	Primary care and Admin staff to incorporate feedback (from client surveys and feedback) and develop proposal for improvements to booking system that can be implemented.	Primary care and Administrative team recommendations for change from their lived experiences in providing services to clients based on feedback and complaint investigations from primary care clients.	Aim to include at least one recommendation from clients, and primary care and administrative teams identified as barriers to client access to services.	In the last 2 years we have increased our same-next day access rate. The feedback we have received indicates that this presents access challenges to clients in our rural community (e.g. Our clients have voiced that many do not like same day scheduling as in this rural community. Many travel to work or are on a factory line where they need to wait until their breaks to make phone calls to try and get an appointment with their provider. Many require advanced notice to get time off work for medical appointments.). As such, the focus will be on improving PHC Team's ability to offer timely/appropriate care using a process that better meets clients needs. This may include striking a new balance between same/next day appointments and 'pre-booked' appointments.
										2)Continue to monitor effectiveness & efficiency of current AA booking system and identify/follow process improvement opportunities.	Continue with quarterly monitoring of AA 'metrics' via 'tick-sheets' at reception. Primary care and admin teams to partner with PHQ to ask for trending graphs on ability to meet care requests over-time. Primary care and admin teams to meet quarterly to review performance via 'dashboards' and identify opportunities for improvement to rate of care requests fulfilled.	Number of data sets collected. Trending plot graph completed & reviewed (YES/NO) Number of quarterly meetings to review performance	4 data sets (1/quarter) 1 plot graph 4 performance review meetings	This improvement measure is a continuation of previous year's.
										3)Aim to develop & implement a new communication strategy that increases client's awareness of & satisfaction with booking system.	Primary care and admin staff to identify what important elements need to be included in communication material. Engage WECHC's communication committee & request support with implementing communication strategy to reach as many clients as possible.	i) Recommendations from admin team and primary care teams based on client interactions/feedback/complaints to date ii) Present DRAFT communication strategy to Communication committee, Youth Advisory council and Client and Family Advisory Council for review prior to implementation	Increased client satisfaction pertaining to use of booking system on client satisfaction survey. (Look for increase on question "The last time you were sick or were concerned you had a health problem did you get an appointment on the date you wanted?") Possibly use simple EBD surveying strategy (e.g. pebble in a box that represents satisfaction).	We hope that increased avenues to access information on our primary care access system will help to improve awareness and understanding of processes and services. We hope that this communication strategy will assist us in communicating future improvements/changes to system and the effectiveness of our system.
										4)Identify opportunities to improve access community to service programs: Counseling and System's Navigation / Health Promotion (Smoking Cessation).	Evaluate supply and demand for 2 teams (mental health and HP/System Navigation) by collecting data at re: demand for services - data collection template to be developed in partnership with PHQ. Identify patterns in supply vs demand and identify recommendations to adjust appointments and intake process as needed.	# of requests enrollment into programs collected. # of appointment slots used, no-showed/cancelled appointments. # of recommendations to adjust appointments and intake process	Demand for community support team appointments collected on a weekly basis	Depending on the supply and demand,, investigate tool for the SW LHIN Rapid Assessment Model

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										5)Develop communication plan to gain awareness of the patient experience with access to mental health and systems-navigation/health promotion.	Engage client and family advisory council to solicit feedback / recommendations to improve referral, service model and/or booking system. Partner with PHQ to conduct representative focus groups to gain further feedback and explore recommendations to improve referral, service model and/or booking system. Meet as team and continue to explore ideas for improvement to referral, service model and/or booking system.. Work as team to incorporate feedback and develop proposal for improvement	i)Recommendations from meetings with family advisory council. ii) Recommendations from representative focus groups. iii) Provider based recommendations for change.	i) Ask for 3 minimum recommendations from all sources. ii) Minimum of 1 focus group that has met at least 2 times iii) Aim to identify 3 changes that can be made to improves access to CS programs. v) Aim to incorporate all recommendations & no less than 50% of client / provider recommendations.	Aim will be to recruit a broad range of individuals to focus groups. This will include clients who are currently pleased with current booking system and those who would like to see improvements. We expect that planning/proposal development stage will not happen until the end of the year. Additional communication work could include consulting clients in developing a strategy to inform clients about our booking system