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

West Elgin CHC 153 Main Street

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 patients who have had a 7-day post hospital discharge follow up for selected conditions. (CHCs, AHACs,NPLCs)	P	% / Discharged patients	See Tech Specs / Last consecutive 12-month period.	92245*	X		Denominator = 19; Data suppressed as per CIHI and MOHLTC guidelines. Partnership has been established with Four Counties Health Services (FHCS), Middlesex Hospital Alliance, for follow-up appointments to be arranged at discharge when indicated.	Four Counties Health Services Corporation, Four Counties FHT	1)The Elgin Health Links IDEAS project is working with local hospitals to improve the discharge planning process for inpatients with COPD or CHF. This is a pilot project and the Centre is exploring how we can be involved.	Confirm process with Health Links IDEAS team to be followed once one of our clients is identified as a participant in the pilot.	Number of clients with COPD or CHF who have had follow up appointments following hospital discharge	As this is a pilot, we will just be collecting baseline data	Our centre would be happy to join other nearby health centres (e.g. CKHA, STEGH) in forming agreements, similar to the one in place with FCHS, to facilitate improved post-discharge follow up. Leadership will continue to network and indicate our willingness to collaborate with local partners.
	Timely	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 2018 - March 2019	92245*	61.9	72.00	Target remains unchanged from previous year's. As mentioned in last year's QIP we are concerned 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. (During this year's survey we continued to ask the 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? The response was 75.6% YES - which represents a 2.0% increase from last year). Our Primary Care Team's current focus is to strike a balance between same-next-day and pre-booked appointments that meets our client's needs. The change ideas and process measures presented identify our plan to do so.		1)Continue to implement & evaluate recent change to appointment scheduling system that will allow clients to book appointments up to 5 days in advance.	Implement 5-day booking system for set period of time. Re-evaluate by asking representative sample of clients 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?". (Current performance is 75% - as per client satisfaction survey.)	% of clients who answered 'yes' (indicating that they received an appointment on the day they wanted).	80%	Continue to implement a method of data collection to measure this.
											2)Improve primary care provider availability by reducing wait-times for mental health counseling and system's navigation. (We expect that this will free-up primary-care provider's appointments that are being utilized to monitor clients with high needs).	Implement identified process changes to improve efficiency of counseling and system's navigation services.	Wait-times (in weeks) for MH counseling or system's navigation	<4wks.	In the past year wait-times for MH counseling have fluctuated between 8-18 weeks.

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											3)Continue to track ability to meet cleint's appointment requests at reception/admin on a quarterly basis. Review reports with reception and PHC Team to identify areas for improvement.	Identify 1 week/quarter where Admin will track type of appointment requested by client and type of appointment offered by centre. Report will be generated and reviewed with teams.	Number of reports generated & reviewed with teams.	4 reports generated & reviewed.	We have found this to be a helpful process in past year - as it has helped to identify process changes that can be made to improve our ability to meet client needs. (e.g. Nursing to follow-up with clients to develop care plan if no same-day available when request for appointment is received).
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 care and treatment?	P	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	92245*	95.03	95.03	We are happy with current performance and hope to maintain this level of excellence through transition to new EMR and undergoing accreditation.		1)Satisfied with results. No planned improvement; however, will continue to monitor.	Reach a representative sample of clients to ask question previously stated on client satisfaction survey.	Number of clients who responded to questions	95.00%	
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	92245*	CB		Will have PHC Team review technical specifications and see if a system for collecting baseline can be devised once new EMR (PMS Suites) has been adopted.		1)				The intent is to wait until after we migrate to our new EMR before we start to collect baseline data for this indicator.

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	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	92245*	4.4		Coming from practice profile.		1)				Baseline data is being pulled from the SW Practice profile report. Technical Spec: % of non-palliative care patients newly dispensed an opioid (excluding opioid agonist therapy) within a 6-month reporting period. *Identifies best performance in LHIN. Continuing to monitor performance & explore ways to use EMR to support low % new opioid starts.
Equity	Equitable	Cervical cancer screening rate stratified by income and stratified by racial/ ethnic group	C	% / Clients	RDSS semi annual report / Apr i 2019 - Mar 31 2020	92245*	CB	CB	BIRT/External Report is expected		1)New clients will be asked to complete the sociodemographic questions when they register. Existing clients will be asked to validate their socidemographic data if they have not done so within the past three years	Existing processes in place to monitor the cervical cancer screening rate will continue.	% of recommended clients who received or were offered a pap smear in the most recent 3-year period, stratified by income and stratified by racial/ ethnic group	Collecting baseline	As the questions are voluntary, clients can refuse to respond to some or all of the questions.
		Completion of sociodemographic data collection	C	% / Clients	BIRT Data repository / Apr 1 2019 - Mar 31 2020	92245*	CB				1)New clients will be asked to complete the sociodemographic questions when they register. Existing clients will be asked to validate their sociodemographic data if they have not done so within the past three years	An initial baseline value will be calculated at the start of the fiscal year and compared with a similar calculation at the end of the fiscal year.	% of active individual clients who had a face-face encounter within the most recent 1-year period and who responded to at least one of the four sociodemographic data questions: racial/ ethnic group, disability, gender identity, or sexual orientation.	Collecting baseline	As the questions are voluntary, client can refuse to respond to some or all of the questions.