2015/16 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

Prince Edward Family Health Team

AIM		Measure						Change				
ity dime	Objective	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
ACCESS	Access to primary care when needed	Percent of patients/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 1 2014 - March 31 2015	62.84	75	Previous years did not include all office, we plan to include as many as possible in 2015/2016 survey.	1)Monitor Third Next Available appointment time, report as a range - highest, lowest and average. If provider is known to be away, we will use the lowest # from POD providers.	Once monthly review of all PCP office appointment schedules	# of days (high, low and average); % offices with 3rd next available < 2 days	Maintain an average less than 2 days on monthly reviews; 60% of offices with 3rd next available < 2 days	This is the same change idea, but we find this valuable to continue to track.
								2)Improve access to primary care during vacation or holiday periods through coverage within pods	Improve patient knowledge of cross coverage and POD system	Survey subset of patients regarding knowledge of cross-coverage; repeat staff survey regarding volume of calls after holiday.	75% of patients aware; followup on comments from staff survey	Previous goal of 90% was unrealistic
								3)Ensure new patients are being enrolled in a timely manner.	Run EMR inquiry monthly on # new pts (palliative, rostered)	# new patients enrolled	collecting baseline (compare with historical data)	Obtaining information from Health Care Connect was not possible.
								4)identify patients who may have more barriers to access or need consistent access (elderly, newborns, COPD)	open-ended questions, group discussion,	gather baseline, criteria	set a goal for next year	Fast track COPD appointments, reduce hospital use
	Reduce ED use by increasing access to primary care	Percent of patients/clients who visited the ED for conditions best managed elsewhere (BME).	% / PC org population visiting ED (for conditions BME)	Ministry of Health Portal / April 1 2013 - March 31 2014	0	0	No plans to set a target for this measure as our ED is used outside of office hours per our FHO agreement	1)nil	nil	nil	nil	No plans to set a target for this measure as our ED is used outside of office hours per our FHO agreement
INTEGRATED	Timely access to primary care appointments post-discharge through coordination with hospital(s).	Percent of patients/clients who saw their primary care provider within 7 days after discharge from hospital for selected conditions (based on CMGs).	% / PC org population discharged from hospital	Ministry of Health Portal / April 1 2013 - March 31 2014	70.12	70.12	Maintain target with change to new EMR in the spring/summer 2015	1)Continue to track # patients with a primary care visit within 7 days of acute discharge from QHC Picton	EMR inquiry/manual search	patients with a primary care visit within 7 days of acute discharge from QHC-Picton/patients discharged from QHC-Picton	Maintain with change to new EMR in the spring/summer 2015	
								2)Continue to improve use of appointment type for post-discharge visits to allow tracking through EMR	Continue to review all discharges for appropriate appointment type	% of visits with correct appointment type used	Maintain with change to new EMR in the spring/summer 2015	
								3)Increase # patients with Medication Reconciliation done on discharge	Set criteria and collect baseline. Define level of reconciliation to be done. Use Hospital @ Home experience to establish process. Choose set of patents for pilot reconciliation	% done = # of patients complete/ total # of patients in set	75%	This is an important patient safety issue.

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								4)Track # patients with a visit within 7 days of acute discharge to nursing home for selected conditions	EMR Inquiry/manual search	patients with a visit within 7 days of acute discharge to nursing home for selected conditions/patients discharged to nursing home for selected	50%	Gather baseline to see if there is room for improvement and a need to continue tracking for this subset.
								5)Track # HF patients with a visit within 7 days of acute discharge for selected conditions	EMR inquiry/manual review	HF patients with a visit within 7 days of acute discharge to nursing home for selected conditions/HF patients discharged for selected conditions	75%	Gather baseline to see if there is room for improvement and a need to continue tracking for this subset.
	Reduce unnecessary hospital readmissions	Percentage of acute hospital inpatients discharged with selected CMGs that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission, by primary care practice model.	% / PC org population discharged from hospital	Ministry of Health Portal / April 1 2013 - March 31 2014	22.66	22.66	Maintain target with change to new EMR in the spring/summer 2015	1)Track patients who are readmitted to QHC Picton (all conditions)	EMR inquiry and manual chart review	total # readmitted QHC Picton/# total admissions QHC Picton	Maintain with change to new EMR in the spring/summer 2015	We are still trying to define criteria for collaborative care plan, frequent admissions may help with defining this population.
								2)Readmissions for patients discharged from Hospital at Home program	EMR inquiry & manual chart review	# H@H patients readmitted to hospital/total # H@H patients	Maintain with change to new EMR in the spring/summer 2015	
								3)Readmissions for patients with a Collaborative Care Plan	EMR inquiry and manual chart review	# patients with CCP readmitted / # of patients with CCP	Maintain with change to new EMR in the spring/summer 2015	
								4)Continue to track patients readmitted to hospital within 30 days of acute discharge for selected conditions for QHC Picton.	EMR Inquiry	# patients readmitted to QHC Picton within 30 days of acute discharge for selected conditions / # patients admitted QHC Picton	Maintain with change to new EMR in the spring/summer 2015	
								5)Reduce hospital readmissions for patients with primary diagnosis of COPD	EMR inquiry/manual search	Patients readmitted with primary diagnosis of COPD/Patients readmitted	Collect baseline	
PATIENT-CENTRED	Receiving and utilizing feedback regarding patient/client experience with the primary health care	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) give them an opportunity to ask	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	92.68	92.68	Maintain	1)Conduct the survey in all PCP offices during the 15-16 year	survey	% of offices participating	100%	

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	organization.	questions about recommended treatment?						2)Report the survey results back to all PEFHT staff, PCPs and office staff	collect and report	done or not done	100%	
		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?	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	92.64	92.64	Maintain	1)Conduct the survey in all PCP offices during the 15-16 year	survey	% of offices participating	100%	
								2)Report the survey results back to all PEFHT staff, PCPs and office staff	collect and report	done or not done	100%	
		Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) spend enough time with them?	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	93.29	93.29	Maintain	1)Conduct the survey in all PCP offices during the 15-16 year	survey	% of offices participating	100%	
								2)Report the survey results back to all PEFHT staff, PCPs and office staff	collect and report	done or not done	100%	
	Improve patient knowledge and confidence in managing complex health issues	Self-efficacy score improvement pre and post Chronic Disease and Collaborative Care Programs	% / Patients seen in Chronic Disease or Collaborative Care Program	EMR/Chart Review / Monthly	CB	10	This has taken longer than expected to establish baseline.	1)Plan education for primary care and allied health providers for consistent documentation of Patient Goals, ACP and Med Rec	test methods including: small group learning, office visits, staff day presentation	% of health care providers attending	40%	
								2)Engage providers for collaborative care planning	Continue education on collaborative care planning	primary care providers involved in CCP / total primary care providers = %	75%	
POPULATION HEALT	Reduce influenza rates in older adults by increasing access to the influenza vaccine.	Percent of patient/client population over age 65 that received influenza immunizations.	% / PC organization population aged 65 and older	EMR/Chart Review / na	50.8	50.8	Maintain target with change to new EMR in the spring/summer 2015	1)Improve communication and documentation for patients receiving flu shots outside of primary care offices (at community clinics and pharmacies)	(i)Display a poster at community clinics and pharmacies advising patients to let their PCP know of immunization (ii) Display a poster at office advising same (iii)provide wallet-sized cards to community clinics and pharmacies for patients to bring back to PCP	(i and ii) see if new EMR can capture # of immunizations entered but given elsewhere. (iii)# of cards returned to select PCP offices in 15/16 flu season.	collect baseline	
								2)Increase # patients (all ages) that received influenza immunizations.	EMR inquiry	# patients (all ages) that received influenza immunization / # all patients	25%	
								3)Maintain targets with change to new EMR	EMR inquiry	# patients tracked in new EMR/# patients tracked previously in BellEMR	100%	

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	Reduce Cancer mortality through regular screening.	Percent of eligible patients/clients who are up-to-date in screening for breast cancer.	% / PC organization population eligible for screening	EMR/Chart Review / n/a	51.6	51.6	Maintain target with change to new EMR in the spring/summer 2015	1)Maintain targets with change to new EMR	EMR Inquiry	# patients tracked in new EMR/ # patients tracked previously in BellEMR	100%	
		Percent of eligible patients/clients who are up-to-date in screening for colorectal cancer.	% / PC organization population eligible for screening	EMR/Chart Review / n/a	57.1	57.1	Maintain target with change to new EMR in the spring/summer 2015	1)Maintain targets with change to new EMR	EMR Inquiry	# patients tracked in new EMR/# patients track previously in BellEMR	100%	
								2)Continue to track patients with positive FOBT who have been referred to colonoscopy within 2 weeks	EMR inquiry as developed during QIIP	% referred	Maintain with change to new EMR in the spring/summer 2015	
		Percent of eligible patients/clients who are up-to-date in screening for cervical cancer.	% / PC organization population eligible for screening	EMR/Chart Review / n/a	58.7	58.7	Maintain target with change to new EMR in the spring/summer 2015	1)Maintain targets with change to new EMR	EMR inquiry	# patients tracked in new EMR/# patients tracked previously in BellEMR	100%	
	Improve compliance and outcomes with the 18 Month Enhanced Well Baby Visit according to Ministry	% patients with 18 Month Enhanced Well Baby Visit complete	% / Children 18 months of age	EMR/Chart Review / every 6 months	88.4	88.4	Maintain target with change to new EMR in the spring/summer 2015	1)Increase # patients 24m of age with immunizations complete	EMR inquiry	# patients 24m of age and immunizations complete / # patients 24m of age	70%	
								2)Continue to improve use of appointment type "18 Month Enhanced Well Baby Visit" to allow tracking through EMR	Continue to review 18m seen for approriate appt type "18 Month Enhanced Well Baby Visit"	% of appts with correct appt type used	50%	
	Increase the number of nonsmokers in our population	% nonsmokers	% / Patients = > 12 years of age	EMR/Chart Review / every 6 months	78	78	Maintain target with change to new EMR in the spring/summer 2015	1)Maintain target with change to new EMR	EMR Inquiry	# patients tracked in new EMR/# patients tracked previously in BellEMR	100%	
								2)Increase # patients with smoking status documented	EMR Inquiry	# patients with smoking status documented/# patients > 12 yrs of age	70%	

Underlined text cannot be changed.

Indicators with this colour background are mandatory.