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

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AIM		Measure						Change				
Quality dimension	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	54.62	60	TCLHIN average is 50.3% for 2013. Since we have already exceeded the TCLHIN's average, we are benchmarking against ourselves (current performance).	1)Survey (continuation from year 1 QIP)	Survey already designed but some questions added this year; 100 clients targeted to complete survey per team.	# of clients given/completed survey	5% increase in positive responses re Access	Survey to start some time after April 1, 2015 and stop after 10% of client/team done.
								2)Give new and existing clients a hand out that clarifies clinic hours and duty nurse.	Hand out made that has clinic hours and how to access clinic on same day if sick on one side, and a specific provider's hours on the other side.	# of clients given hand out	90% of new clients given hand out and 75% of existing clients given hand out.	
								3)Schedule template changes by standardizing schedules across the teams.	1. Adding set # of clinical spots 2. Control # of non-clinical spots by standardizing admin	1. # of clients seen per provider - Primary care team 2. % of clinical vs. non-clinical average per week per provider 3. 3rd open and 3rd PBA - Primary care team 4. % no shows of booked clients 5. % of unused vs. used - primary care	1. 60% clinical vs. 40% non-clinical 2. keep 3rd PBA < 7 days 3. To date we have not compared % of used spots vs. % of unused spots because out templates have not been standardized. Now we hope to gather baseline.	Currently our clinical % is 54 and non-clinical work is 46.
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	0	0	MOHLTC did not provide Sherbourne with this data, so we cannot measure it.	1)Using the METHL criteria for what makes a complex client, we have decided to focus our quality initiatives on a smaller cohort of "complex" clients from the Urban Health Team.	1. Identify the most complex Urban Health Team (UHT) clients by using the Health Links (METHL) criteria of complexity. 2. Providers on UHT are given the list of who is deemed most complicated for them to review. 3. Outreach coordinators for Health Bus will also get this list of clients so they can act as "case managers" and point of contact for clients if they are admitted to hospital, etc.	1. # of complex urban clients identified using METHL criteria 2. % of these clients who have been admitted to hospital in the year 3. % of these clients who returned to see their primary care providers within 7 days of discharge from hospital 4. # of ED visits for this client group in the year	1. 75% of these clients will be informed to come back to see their provider if they are admitted to hospital within 7 days of discharge. 2. Collect baseline data on remaining process measures	We are trying to focus our Quality Improvement Initiatives on a a cohort of our most complex urban clients. The goal is for these clients to benefit from a wrap around model of care. Previously only 35% of clients in the entire organization knew to come back and see their providers within 7 days of discharge. The literature shows that by targeting the more complex clients we may improve coordination of care/system integration. Concentrating on a smaller group of people will allow us to track data in internally.
Patient-centred	**Receiving and utilizing feedback regarding patient/client experience with the primary health care organization.**	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 questions about recommended treatment?	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	91.29	92	We feel maintaining a marginal increase in target is reasonable since our base-line was so high last year thus allowing us to work on the priorities.	1)Feedback to organization re results of last year's survey. Survey clients again with same questions.	1. Minutes of meeting(s) to verify results given 2. Website updated with results before second survey done 3. Survey clients across all teams 4. Results analyzed broken down by team instead of global	1. # of surveys completed 2. # of meetings with feedback re survey results	1. 100% of meetings targeted for feedback done 2. 10% clients surveyed from each team	
		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	87.54	90	See above.	1)See above indicator	See above indicator	See above indicator	See above indicator	
								2)Provide tools for Advance Care Planning (ACP) and education. Focus getting ACP done for the complex cohort identified as a start.	1. Provide ACP tool and implementation 2. Medical Director to connect with TEGH for the speaker for a talk on ACP 3. Schedule complex clients an appointment with provider to start the ACP discussion	1. # of templates filled out ACP (% of complex clients have ACP completed) 2. Survey providers before and post the ACP lunch & learns session of their comfort level on doing ACP with clients	1. 50% of complex clients have ACP templates started 2. Increase providers' comfort level around ACP with their clients.	
		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	90.57	91	See above	1)See above indicator	See above indicator	See above indicator	See above indicator	
Population health	**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	37.76	55	According to CCO website, the breast cancer screening rate for TCLHIN is 55.9%. We would like to match our community screening rates as a target goal.	1)Letter campaign by medical secretary to remind clients they are due for screening.	One medical secretary given list of clients due for screening and time to send letters at beginning of each quarter.	# of letters sent.	All eligible clients due for screening get a letter reminding them to get screened.	
								2)One seminar/panel/education session to primary care providers working with street involved sex trade workers to provide quality/client-centred well women care.	Mid April 2015 CIBC is sponsoring an educational event. Guest speakers knowledgeable working with street involved women (ie. paps on the bus providers) will lead a lunch and learns to community providers. The idea is to also have peers with lived experience to be on the panel and provide their input.	1. # of attendees. 2. Post survey to measure knowledge transfer.	1. Goal is to have 30 participants. 2. Goal is for providers to feel comfortable providing well women care (ie. paps, STI testing, mammogram referrals) to street involved sex trade workers.	

		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	24.16	25	We recognize how challenging it is for our homeless/underhoused clients to perform this test on their own since access to clean washroom is often a barrier. We are hoping that by helping a small part of our homeless population (those admitted to Infirmary) with their FOBT, it will have a small impact on overall target in addition to the letter campaign. In addition, the TCLHIN most recent screening data from 2011 on the CCO website is 23% for eligible FOBT screens completed. and therefore would like to be closer to reaching community standard as a goal.	1)Homeless clients who are admitted to Infirmary making sure their FOBT screen is up-to-date and if not, to have FOBT done during Infirmary stay.	1. Educate staff when referring primary care homeless client to infirmary, should print out FOBT requisition to give to Infirmary staff for completion during stay. 2. Compare # of primary care clients (eligible for FOBT screen) with FOBT lab results done this year.	1. # of requisitions/kits given to primary care Infirmary clients. 2. # of primary care FOBT eligible clients admitted to Infirmary	10 FOBT kits done during 2015/16 in Infirmary	54.4% of eligible clients had given/done FOBT during their stay in Infirmary in 2014/15. One of the results came back positive. Homeless clients who often live in Shelter or no the street, have understandable difficulty completing FOBT screens as access to a private/clean toilet is a barrier. The idea behind this initiative is that clients in the Infirmary with private and clean bathrooms and care providers to assist, will have an opportunity to follow through on this preventative health screen.
		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	41.74	50	The Ontario average screening rate is 64.9% from CCO website, and therefore we will try to match Ontario average.	1)Letter campaign by medical secretary to remind clients they are due for screening.	One medical secretary given list of clients due for screening and time to send letters at beginning of each quarter.	1. # of letter sent 2. # of letter returned	Increase cancer screening target by 5%	We have done both letter/phone campaign for the past two years in order to increase cancer screening compliance. We have found that only the letter campaign proved effective since so many of our clients do not have working phones.
	Reduce incident of adverse events due to medication errors for the cohort of "Complex Clients"	# adverse events due to medication errors for this cohort of clients	% / All acute patients	EMR/Chart Review / April 1, 2015 to March 31, 2016	CB	0	First time initiative so starting with a reasonable target.	1)Best Possible Medication History (BPMH)for clients in this group. Pharmacy.ca willing to see these clients and do a medication reconciliation at their site which is next door to Sherbourne.	Identifying the clients that qualify for the medication reconciliation and refer them to pharmacy.ca for a medication reconciliation appointment.	1. % of clients who get BPMH done at pharmacy.ca 2. # of discrepancies discovered for each client 3. # of adverse events in this cohort	New initiative so 50% is a first time goal for the process measures #1 (% of clients who get BPMH done at pharmacy.ca	
	Reduce infection rates in communty through increase in hand hygiene compliance	% of primary care providers who used hand rubs during client visits	Counts / Health providers in the entire facility	Audit / April 1, 2015 to March 31, 2016	66.25	67	To move the centre to a higher level of hand hygiene compliance.	1)Audit providers to see if using hand rub pre and post client encounter	1. Someone from the team doing audit in the exam room and provide feedback to the provider. 2. Each team will audit their own providers.	Audit quarterly	50% compliance for moment one (before initial patient/patient environment contact)and 50% compliance for moment four (after patient/patient environment contact).	Continuing quarterly
								2)Educate staff on hand hygiene	1. Presentation at clinicians meetings with quiz/prizes given quarterly 2. TV overhead with hand hygiene info slide deck 3. Wellness volunteers recruited to dispense hand rub to people entering and exiting the centre.	% of meetings that include hand hygiene education	5% increase of providers using hand rubs during office visits.	Infection Prevention and Control (IPAC) committee will be in charge of this audit. **OHA education modules have been incorporated in to new staff orientation and a follow-up mechanism will be implemented to ensure the compliancy. Therefore we are no longer tracking % of staff completing these modules.
	Reduce influenza rate in community by increasing staff/client vaccine rate	# of clients who received flu vaccine and % of staff who received flu vaccine.	Counts / All clients	EMR/Chart Review / April 1, 2015 to March 31, 2016	793	1200	Infection control; In past years (ie. during H1N1 pandemic)>1200 flu shots were given out. Over the past couple of years these numbers have started to dwindle.	1)Education	1. Emails sent reminding staff importance of flu vaccine 2. EMR with reminder in template for providers/clients 3. Posters in building, stickers given to those who got shot 4. Infection prevention and control committee to present at clinicians meeting at beginning of flu season	EMR to pull data	5% increase in number of staff and clients receiving vaccine	
								2)Flu shot clinics	1. Increasing the number of flu shot clinics during flu season for community (staff/clients and non registered clients), using St. James Town clinic and mobile health bus with emphasis on providing clinics that target vulnerable population (i.e. elderly, Hepatitis C,	1. # of clients who received flu shots (including received elsewhere) 2. % of staff (and whether declined or received elsewhere)	See above	
								3)High risk clients review/reminder	1. EMR specilist sends high risk clients list/tasks in August 2. Lists given to providers to keep and go through 3. Half way through season providers given list of clients who have come in for care but did not receive flu shot (and not marked "declined")	# of high risk tasks sent	See above	

Other - Efficiency	**Efficiency - Reduce overall # of "no shows" across the three primary care team; Improve client satisfaction with implementation of automated EMR appointment reminder.**	Time saved by Medical Secretary not requiring to complete appointment reminder	% / All Primary Care Patients	Time Study / October 2015 to March 2016	CB	50	Future target will be established to assess No Show rates of clients receiving EMR reminder calls vs. those that do not with the focus of reducing overall No-shows.	1)1. Implement new EMR client/patient appointment reminder system	1. Develop system implementation plan and train medical secretary staff on new system 2. Complete time study on process time required to complete client/patient appointment reminder phone calls by medical secretary vs. EMR appointment reminder system 3. Develop No Show rates for client/patient population contacted by EMR client reminder system.	1. Time saved in implementing EMR appointment reminder system 2. a) # of no shows of clients receiving automated EMR reminder; b) # of no shows of clients who do not receive automated EMR reminders 3. Provider satisfaction survey results.	1. Baseline for time saved per month from implementing appointment reminder system 2. # and % of client/patient contacted by reminder system vs. medical secretary 3. Client satisfaction survey results of 80-85% from system users.	
	Efficiency - Implementation of EMR integrated ECG/blood pressure devide will provide real time diagnostic information in the EMR system to support timely and accurate diagnosis, treatment, and improve overall quality of health care services	Time saved by clinical providers by the adoption of Accuro EMR integrated ECG/Blood pressure device vs. manual transcription of diagnostic information into EMR system (time study).	% / All Primary Care Patients	Time Study / October 2015 to March 2016	CB	50	Collecting baseline.	1. Implement new EMR integrated ECG/Blood Pressure diagnostic system 2. User satisfaction survey	1. Develop system implementation plan and train clinical providers on new device. 2. Complete time study on process time required to complete diagnostic procedures using integrated EMR device vs. manually transcribing information into the EMR system 3. Develop provider satisfaction survey on system ease of use, support, accuracy, and efficiency.	1. Time saved by Provider taking information; Time saved by EMR integrated device taking information. 2. # and % of client/patient ECG/Blood Pressure taken by EMR integrated device. 3. Provider satisfaction survey results.	1. Baseline for time saved per month from implementing EMR integrated ECG/Blood Pressure device. 2. Increase the # and % of client/patient ECG/Blood Pressure completed by integrated device 3. Provider satisfaction survey results of 80-85% from system users.	
	Efficiency - Increase efficiency in completing client/patient check-in process thus improving overall client experience.	Medical secretary time saved in completing client/patient check-in (time study);	% / All Primary Care Patients	Time Study / January 1, 2016 to March 31, 2016	CB	50	Collecting baseline data to establish a target (ie., % of clients/patients admitted by self check-in in kiosk vs. medical secretary).	1. Implement new EMR client/patient check-in/kiosk; 2. Client experience	1. Develop system implementation plan and train Medical Secretaries and security staff on new system. 2. Complete time study on process time required to check in client/patient by medical secretary vs. EMR self check-in system. 3. Develop client satisfaction survey on system ease of use, support, and efficiency.	1. Time saved in implementing self check-in kiosk: a) time to check-in client at front desk; b) time to check-in client at kiosk. 2. # and % of client/patient using self check-in kiosk 3. Client satisfaction survey results. 4. Results of client satisfaction survey for those that used the self check-in process/kiosk.	1. Collecting baseline data to establish target 2. # and % of client/patient using self check-in kiosk vs. medical secretary 3. Client satisfaction survey results of 80-85% from system users.	