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

Country Roads CHC 4319 Cove Road

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 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.	92228*	58	75.00	Use of SHIIP notification process, continue to improve this indicator with timely contact of clients		1)Collaborate with Hospital partners for improved notification and shared care collaboration for primary care and home supports	Participate in PSFDH quarterly meetings to develop improved linkages with patient flow coordinators (discharge planners) All CRCHC admin staff will actively utilize and maintain the data tracking form.	% of hospital discharges follow up visits completed within 7 days All visits not scheduled have documentation of reasons e.g. f/up with specialists, transfer of care etc.	improved from previous year from 51% to 70%	Continue to use the SHIIP notification system daily to identify timely
											2)With transition to new electronic health record software, PSS, we will develop a best practice custom form for hospital	CQI team will lead the development of a draft of best practice discharge visit template/ custom form after reviewing other samples. The custom form will be shared with provider and primary care team for PDSA trial.	% of discharge visits who have utilized the best practice template	50% of discharge visits will have utilized the custom template	
											3)The Primary Care Pharmacist will participate in hospital discharge follow up visits where medication reconciliation is indicated	Medication reconciliations will be completed as part of hospital discharge visit, with collaboration between PC pharmacist and Primary Care Provider.	Number of Medication Reconciliations completed at post discharge visits Number of Pharmacist interactions at post hospital client visits	Have been unable to effectively pull this data from our prior electronic health record	
											4)The primary care team will utilize Connecting Ontario Clinical Viewer for hospital discharge visits as needed to assist with more timely	Go live with Connecting Ontario Clinical viewer for start of fiscal. Ensure providers are trained on use, privacy and security requirements regarding the Connecting Ontario Portal. In-house LRA will credential and arrange training for additional primary care team members as	Number of primary care provider and other team members who actively utilize Connecting Ontario Clinical Viewer for hospital discharge visit preparation.	Collecting baseline for determining effective utilization this year.	
	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	92228*	51.04	70.00	Sustain the open access scheduling model and continue to make improvements in supply and demand capacity for		1)Ensure that advanced access scheduling strategies are fully integrated across the scheduling team and primary care team with	Ensure an adequate Sample size for client experience surveys using post visit methods at least 3 times year. monitor the number of days that clients are waiting outside of the same day or next day range by adjusting the response questions on the client experience survey.	% of clients each quarter who complete post visit surveys % of clients who report they can get an appointment when they wanted one % of clients who report they received an appointment same day or next day when needed. number of days to 3NA for each	improve same day or next day from 52% rate to 70% maintain 90-95% range of clients	
											2)track individual provider client experience surveys related to timely access	Analyze provider specific post visit client experience surveys at least 3 times this year Share with individual providers at performance feedback meetings	% of clients across an individual provider practice who report same day or next day appointments when needed. Number of days to Third Next Available Appointment (3NA) for individual provider each quarter	Improve from current performance of 52% to 70% Maintain 3NA at 1	
		% of Clients (over 65 years) who are supported with making challenging life decisions	C	% / PC organization population aged 65 and older	In house data collection / April 1,2019 to March 31, 2020	92228*	CB	CB	We will integrate practice improvements from the Senior Friendly Care		1)Spread Advance Care Planning Discussions with Clients over 65 years (Seniors) across the primary care team. Effectively utilize	Integrate Advanced Care Planning and Brain Health Best Practices into 2 team planning meetings this year. Build a "Senior Friendly" custom form into PSS including self management and advanced care planning.	Number of completed advanced care plans with clients over 65 years. Number of Senior Friendly Custom Templates utilized with clients over 65 years. Number of interprofessional team discussions related to Senior Friendly Care as evidenced in Team minutes.	Collecting baseline for the first year	
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	92228*	93	93.00	As we continue to track this indicator with a larger sample size we aim to maintain this service excellence standard.		1)Collect post visit client experience survey at least 3 times / year to ensure adequate survey numbers and provider specific	utilize email method for post visit client experience surveys	% of clients who state that a NP or MD or someone else in the office involves them as much as they want to be in decision about their care and treatment % of provider specific panel who indicate they were involved in care and treatment	Maintain current 90-95% range of service excellence on Client experience	
											2)Improve client messaging surrounding self management and involvement in their care.	Offer Self management programs to clients: including Getting the Most out of your Health Care Appointment and Living Well with Chronic Pain Programs. Ensure that all new client orientation sessions include a self management discussion to encourage and welcome	Number of self management programs delivered in 2019 2020 year Number of client attendances for self management programs in 2019 2020 year Number of social media messages related to self management messages posted in 2019 2020 year	Offer at least 3 self management programs/ year Post 6 self management	
											3)Embed self management learning strategies and tools within our primary care team	provide at least 1 workshop for Health Providers	Number of team members who attended self management training sessions during the year Number of on site workshops for health providers offered during the year	50% of team members will attend or participate in onsite learning	
		% of Primary Care Clients (over 65 years) who indicate they are involved in their own care as	C	% / PC organization population aged 65 and older	In-house survey / April 1, 2019 to March 31, 2020	92228*	CB	CB	Integrate the Senior Friendly care framework into our QIP		1)Collect post visit client experience surveys at least 3 intervals/year to ensure adequate survey numbers. Analyze for provider specific	Analysis of age specific Client experience surveys post visit collected at least 3 times/ year.	% of primary care clients over 65 years who indicate they are involved as much as they want to be in their own care	At least 50% of primary care clients over 65 years will indicate they are involved	This is a Senior Friendly Framework QI indicator identified by our

		much as they wish to be									2)Build this self management question into Memory Clinic Surveys to learn more from this specific population	Administer updated Memory Clinic Experience surveys to all memory clinic participants. Review this data at least annually and share with Memory Clinic team members to learn more about responses within this specific population group.	% of Memory Clinic participants who indicate they are involved in their own care as much as they wish to be	Collect baseline for this question from all Memory Clinic Participants	
		% of primary care clients who are offered and supported with social prescribing options to improve their health and well being.	C	% / Clients	In house data collection / April 1, 2019 to March 31, 2020	92228*	CB	CB	We are participating in a provincial pilot with Alliance for Healthier Communities in collaboration with 9 other CHC's and 2 UK partner agencies. Since the start of the Pilot, our primary care team have	Alliance for Healthier Communities	1)Track social prescribing referrals made from the primary care team	Develop and utilize a customized template within PSS for tracking of social prescribing referrals made from the primary care team.	Number of social prescribing referrals made from primary care team. Number of linkages made to community services	Establsh baseline	
											2)Establish a clear work flow across the interprofessional team within the electronic health record.	Primary Care Team will utilize the Social prescribing referral template and PSS task box to connect clients with the Social Prescribing Team. The Social Prescribing team will utilize the PSS task box to improve communication and coordination of care for clients.	Number of referrals received from Primary Care each quarter. Number of collaborative meetings conducted by the Social Prescribing team.	Establish Baseline	In collaboration with the Social Prescribing Provincial Pilot led by Alliance for
											3)Clients indicate increased knowledge and awareness of social prescribing benefits on health and well being.	Administer an annual Client experience survey Specific to this indicator Conduct at least 1 focus group with clients to learn more about client perspective on improvements in health outcomes from social prescribing linkages	% of survey respondents who report that social prescribing had an impact on their health and well being.	At least 50% of survey respondents indicate a benefit of social	
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	92228*	CB	CB	We will work with the Ontario Palliative Care Network (specifically our SE partners) to learn more about best practices for screening for this		1)Increase staff awareness of oncology and non oncology conditions related to Palliative Care This increased awareness will	Review Palliative Care definitions with team. Collaborate with OPCN (Ontario Palliative Care Network) to increase knowledge of screening tools and consideration for adoption of the gold standard screening tool. Participate in Annual Palliative Care Network in LLG	Number of identified palliative care (oncology and non-oncology) clients identified per provider caseload Number of staff who attend the annual Palliative Care Learning day November 2019	Collect baseline	
											2)Develop a customized template within PSS for earlier screening and needs identification of Palliative Care Clients	Invite OPCN to a CQI meeting to learn more about LLG Coordination of Care Project-Early Identification for Palliative Care including the Gold Standard Screening tool. Research PSS templates developed by OPCN and e health Centre of Excellence in Waterloo. Explore HQO	Presentation by Ontario Palliative Care Network to CQI team and the Full staff team. Establishment of a CQI Palliative Care Work Group to review utilization of the Palliative Care Toolkit	2 Palliative Care Working Group Meetings 2x year. A customized tool for TELUS PSS will	
	Safe	Percentage of non-palliative patients newly dispensed an opioid within a 6-month reporting	P	% / Patients	CAPE, CIHI, OHIP, RPDB, NMS / Six months reporting period ending at the most recent	92228*	5.3	5.00	Using My Practice Primary Care Data from HQO report June 2018, CRCHC has		1)Utilize the June 2018 as well as the next edition of My Practice: Primary Care Report to engage full primary provider team in	Review June 2018 edition with all primary care providers and monitor for any changes with next release. Engage Providers to access their own profiles. Utilize new electronic record software PSS as of April 1st to pull data regarding opioid prescribing at CRCHC.	% of non-palliative clients newly dispensed an opioid within a 6 month reporting period (internal and external.	Continue to monitor and aim for decrease. The June 2018 My Practice report	Due to some external issues in our community as well as supporting new
Equity	**Equitable**	Improve the updating and Completion of socio demographic data collection for active individual clients to determine breakdown of clients served(based on ethnicity, disability, gender identity or	C	% / Clients	BIRT / April 1 2019 to March 31 2020	92228*	12.9	25.00	CHC Practice Profile March 2018(April 1 2015 to March 31, 2017.	Performance Managment Committee in Community Health Centre Sector	1)Ensure all new clients registering for services are supported and assisted to complete the demographics form at registration. Provide	Engage our staff team (intake team) to understand the importance of socio demographic data collection with orientation of script and current status.	% of new clients will have completed socio demographic data for ethnicity , disability, gender identity or sexual orientation. % of clients who we contacted for needed support or follow up for completion	90% of all new client registrations will have completed socio demographic data	
											2)Utilize our new PSS electronic record software to update Sociodemographic Information as part of	Utilize improved functionality within PSS system to update sociodemographic data within counseling or primary care visit. Build this into our team work flow.	number of team members who are comfortable and active with updating Socio demographic information in health record. number of QI discussions related to this indicator	50% of our Primary Care Team will actively update SD information when received from a	
		Percentage of Clients who in response to the question " to what degree would you say that you feel welcome and comfortable at CRCHC	C	% / All patients	In-house survey / we will track this indicator quarterly	92228*	96	96.00	Track this indicator quarterly and review specific reasons for not meeting this target to better understand barriers to care.		1)Continue to monitor this indicator from our client experience surveys quarterly and track for trends in any negative	client experience surveys analyzed each quarter.	% of primary care clients who indicate they feel welcome and comfortable at CRCHC	Maintain current % in 90-95% range	
											2)Integrate this question into Group Program Experience survey and track on Program Report Card. Explore feedback from	Add to Community Group Program Experience Survey and Report Card reporting tool to better understand this indicator within our group programs. Review trends in learning at Community Team meetings.	% of Group Programs Survey Respondents who indicate to what degree they feel welcome and comfortable at CRCHC. % of negative responses indicated on the Group Program experience survey	75% of Program respondents will indicate they feel comfortable and welcome at CRCHC	
		The percentage of our clients with developmental and intellectual disabilities who meet best practice standards of care	C	% / PC organization population (surveyed sample)	POC/PCC Audits / We will complete one client record audit this year	92228*	CB	CB	The goal this year is to determine numbers of clients from this population and to initiate improved tracking in our electronic record		)Review best practices for this populations to identify gaps in care	work with local community service partners to learn more about resources available and collaboration in care opportunities. Research evidenced based best practices	number of partner meetings completed this year. number of best practice team discussion led by nursing or therapy student	2 partner meetings 2 Best practice team discussions	
											1)Determine actual caseload of clients with developmental and intellectual disabilities.	Identify encodes for chart entry. Support providers to more accurately track encodes for this population.	% of clients identified with intellectual or developmental disabilities	Determine Baseline	

									software		3)Work with community partners and PHD candidate to develop a customized template for standards of care for individuals with	Research Best practices in collaboration with community service agencies and research project PHD candidate. Work with PS Super User team to develop a customized template for this population Conduct a best practice client record review to determine gaps in care	% of client with a completed client record review. completion of a customized template for standards of care	Complete at least 10 client record audits Implementation of a best practice	