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

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AIM		Measure								Change				
Quality dimension	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
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	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	92240*	CB	CB	Data is currently unavailable to us, therefore we are still collecting baseline data.	1)Quest will continue to focus on decreasing our response time to see individuals who have recently been discharged from hospital. Our planned improvement initiatives include: a) Increasing probability of Quest receiving discharge summaries by asking to attend discharge planning meetings with NHS and b) informing hospital of individuals who are Quest clients, but for whom Quest has not received a discharge summary after they have been released from hospital.	1) Continue to monitor reports from the hospital when available. 2) Bring information to interdisciplinary team huddles for review, 3) Connect with the client and book back when necessary, 4) Continue to educate clients about the importance of connecting with Quest after having attended the Emergency Department or being admitted to hospital 5) Monitor gaps between Information Decision Support Data (IDS)and discharge summaries and notify hospital of any client for whom we have not received a discharge summary 6) Attend a discharge planning staff meeting and inform them of Quest CHC's interest and availability to attend discharge planning meetings for shared clients.	1) Continue to monitor discharge summaries quarterly. Identify client lists and bring to Quest interdisciplinary teams to ensure timely follow-up within 7 days post discharge 2) Attend one discharge planning meetings every 6 months 3) Complete the gap analysis by monitoring IDS data and discharge summaries received, on a quarterly basis.	1) Quarterly review of IDS data 2) Attend two discharge planning staff meetings annually 3) Conduct gap analysis of IDS data compared to our received discharge summaries, quarterly.	Quest has not received updated data on performance of this measure, therefore, we cannot set a target.
		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	92240*								
		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	92240*								Quest has completed the previous indicator i.e. Percentage of patients who have had seven day post hospital discharge followup (CHC's, AHACs,NPLCs) which was specific to CHC's.

	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	92240*	100	100.00	Based on previous performance.	1)Offering the Integrated Community Lead Health Link framework to 100% of clients identified and referred by hospital as individuals frequenting the ED experiencing MH&A issues.	Quest participates in the Health Link planning table in Niagara. As the identified Health Link Lead for MH&A Quest is currently offering the Health Link approach (Integrated Community Lead Framework) to 100% of referred clients, and Quest reports to the three Health Link Leads in Niagara once client is connected and Coordinated Care Plans (ICL) are developed.	Continue to receive and track referrals. Provide care to every client who consents to services and develop a Coordinated Care Plan with the client, client's care team and community (using the ICL Care Plan model).	100% of identified clients who consent to service have Coordinated Care Plans.	Quest has been identified as a Health Link Lead for MH&A in Niagara and promotes the Health Links framework. Additionally, Quest is the Chair of the Niagara MH&A Complex Care Planning Table where many of the complex clients in need of care planning and coordination are identified.
	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	92240*	75	85.00	based on current performance.	1)Quest interdisciplinary care teams continue monitoring quarterly data regarding individuals who have been diagnosed with diabetes who require a foot assessment annually. Quest will follow-up with notifications in Electronic Medical Record indicating the client is eligible but has not received a foot assessment. In addition, Quest will raise awareness via health promotion messaging on the importance of foot assessment for diabetic clients, as well as schedule two foot care classes annually.	1) Continue to monitor quarterly data with Quest interdisciplinary teams for individuals who are eligible and have not received a foot exam, and enter notifications into client's EMR 2) Develop health promotion messaging to increase diabetes education and awareness around foot care 3) Foot exam is incorporated into the Quest refresh intake process when appropriate 4) Develop and conduct two foot classes annually, incorporating a foot assessment, self assessment teaching, as well as offering professional pedicure services through partnership with Niagara College.	1) Continue to monitor screening data quarterly 2) Conduct two health promotion initiatives related to diabetic foot exams 3) Offer refresh intakes to 100% of eligible clients and offer foot exam where appropriate 4) Partner with Niagara College to conduct two foot classes annually.	85.00% Of Eligible clients receive foot exam.	

Efficient	**Access to right level of care**	Add other measure by clicking on "Add New Measure"	A	Other / Other	Other / Other	92240*								
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	92240*	77	80.00	Based on current performance.	1) Quest interdisciplinary care teams continue monitoring monthly data regarding individuals eligible, but yet to receive preventive cancer screening 2) Quest to continue "refresh intake" process where clients are invited to participate in an appointment to review preventive care screening, update health record, medication review/reconciliation and review client goals 3) Quest will continue to host/work with cancer screening coach to increase rates for those under-screened and never screened in Niagara.	1) Data pulled quarterly identifying clients who have not been screened and distributing to teams for review 2) Meet with clients who have been with Quest for 3+ years to conduct refresh intakes (e.g. updating socio-demographic information, health history, preventive screening rates, medication review/reconciliation, client current and future goals, addressing any barriers to care, and review Quest services; ensure client is knowledgeable of all programs and services at Quest 3) Quest continues to host and promote attendance to cancer screening coach in Niagara 2x monthly. Ensuring client have access to prompt barrier free cancer screening on cancer coach and at Quest.	1) Continue to monitor screening data quarterly 2) Quest to conduct 25 refresh intakes in the upcoming fiscal year 2) Quest continues to support the cancer coach coming to two St Catharines locations monthly.	80% of clients age 21-69 years have been offered pap screening. 100% of target refresh intakes completed. Cancer screening coach operational in St Catharines offering cancer screening, including pap.	
	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	92240*	39.6	35.00	less than 35% of individuals will not have received screening, based on current performance.	1)Quest interdisciplinary care teams continue monitoring monthly data regarding individuals eligible but yet to receive preventive cancer screening 2) Quest to continue refresh intake process where clients are invited to participate in an appointment to review preventive care screening, update health record, and review client health goals 3) Quest will continue to host and promote cancer screening coach, thus increasing rate of screening for under-screened and never screened 4) Quest to continue birthday card initiative to send out 50th birthday cards, identifying new qualification for cancer screening for clients turning 50.	1) Data pulled quarterly identifying clients who have not been screened and distributing to teams for review 2) Meet with clients who have been with Quest for 3+ years to conduct refresh intakes (e.g. updating socio-demographic information, health history, preventive screening rates, medication review, client current and future goals, addressing any barriers to care, and review Quest services) 3) Quest continues to host and promote cancer screening coach in Niagara 4) Identify clients who are 49 years of age as of this fiscal year (2018/2019) who would benefit from screening reminders as they turn 50 years old-Birthday card initiative.	1) Continue to monitor screening data quarterly 2) Quest to conduct 25 refresh intakes in the upcoming fiscal year 2) Quest continues to support the cancer coach coming to two St Catharines locations monthly 3) Sending out birthday cards to 100% of clients turning 50 years old (who have a valid address) reminding them to come in to talk about all eligible cancer screenings (including receiving a gift when the client comes in for services).	65% of clients receive 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	92240*	44	50.00	Based on current performance.	1) Quest interdisciplinary care teams continue monitoring quarterly data regarding individuals who have been diagnosed with diabetes who are in need of two HbA1C tests per year. Quest will follow-up on notifications in Electronic Medical Record indicating the client is eligible but has not received two HbA1C tests per year. Lastly, Quest will maximize client access for point-of-care testing at Quest for those who experience barriers accessing community labs.	1) Continue to monitor quarterly data with Quest interdisciplinary teams for individuals who are eligible and have not received two HbA1C screening annually 2) Reduce barriers by faxing requisitions to community labs 3) Continue to enter notifications into client's EMR who are eligible for testing 4) Conduct training for staff regarding point-of-care testing and ensure all staff are routinely trained, along with messaging to clients regarding the importance of testing 5) Develop two strategies to increase diabetes education and awareness around HbA1C testing.	1) Continue to monitor screening data quarterly 2) Staff training will happen annually and all new primary care staff will be trained during orientation 3) Create template in EMR to ensure HbA1C testing is captured consistently.	50	HbA1C testing will also be included in Quest's Refresh Intake Process.
	Ensuring Equitable Access to initiatives that focus on the Social Determinants of Health	The number of community capacity building and health promotion initiatives that address each of the social determinants of health.	C	Number / Clients	In-house survey / 2018/2019	92240*	CB	2.00	This is the first year Quest is setting a target as last year we were collecting data.	1) Review all group, health promotion and community capacity initiatives that address the social determinants of health (SDoH, organized by Quest Priority Populations , 2) Conduct a Gap analysis that includes what Quest has available and what is being done in community, 3) Work internally and with community partners to develop initiatives in Gap areas.	1) Review current EMR data, review environmental scan to identify gap areas. 2) Identify two new initiatives to implement.	1) Identify two new initiatives to address gap areas.	100% of planned initiatives completed.	
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	92240*	90	90.00	Based on current performance being high.	1)Current performance continues to be high, however, we did see a slight reduction. Quest will strive to maintain performance over the next year.	1) Continue to conduct bi-annual survey blitz 2) Implement new survey methodology to capture client experience (e.g. QUESTion of the week that engages clients in non-tradition survey methods) 3) Develop staff training around questions that increase clients opportunity to check in about how they feel about their treatment plan e.g. 'Is there anything else we can help you to reach your health goal?'.	1) Continue to promote and implement client experience survey by marketing survey through posters, providers wearing pins, distribution of survey by provider before and after appointment, and advertisement through our wait room PowerPoint 2)Continue to implement QUESTion of the week 3) Provide and encourage staff to utilize menu of client involvement questions and ask them to self assess their utilization rates.	90	Continue to monitor and be aware of trends.
Safe	**Medication safety**	Percentage of patients with medication reconciliation in the past year	A	% / All patients	EMR/Chart Review / Most recent 12 month period	92240*	100	100.00	Based on achieving our target of 25 refresh intakes annually.	1) Quest will meet with clients who have been with Quest for 3+ years to conduct refresh intakes (e.g. medication review/reconciliation, updating socio-demographic information, health history, preventive screening rates, client current and future goals, addressing any barriers to care, and review Quest services).	1) Quest to identify clients who have been to our CHC for 3+ years 2) Quest will invite these clients to a refresh intake 3) Conduct refresh intakes including: medication review/reconciliation, updating socio-demographic information, health history, preventive screening rates, review client current and future goals, addressing any barriers to care, and review Quest services.	Quest to conduct 25 refresh intakes in the upcoming fiscal year.	Complete 100% of targeted refresh intakes.	

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	92240*	51	55.00	Based on current target.	1) Continue with same day service access, including continuing to triage clients based on health concern and urgency, "The right care, the right provider, at the right time". 2) Continue to provide priority slots to ensure primary care providers can bring client back in a timely fashion when necessary 3) Continue to find ways to promote Same Day Access to Service at Quest CHC.	1) Continue providing triage and educate clients on managing urgent issues as well as highlighting the scope of practice of nursing staff 2) Identify and hold priority slots bookable by primary care for urgent care needs when there is a need to book back a client for follow-up quickly 3) Continue to raise awareness of the Same Day Service through PowerPoint playing in wait room and Same Day Access Brochure.	Continue to survey clients regarding their perception of timely access to care.	55% of clients state they perceive they have timely access to care.	