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

The Four Villages Community Health Centre 3446 Dundas Street West, Toronto, ON M6S 2S1

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	Coordinating care	Improve care transitions for clients discharged from a hospital (Part of the "Improve Post-	C	% / Clients with complex needs who are discharged from a hospital who	Manual tracking / April 2018-March 2019	91445*	CB	CB	Currently we have to manually track performance on this indicator, as	1)Incorporate coordinated care as part of post-discharge care to prevent re-admissions and reduce unnecessary MD/NP visits	Primary Care Coordinator (PCC) and RNs keep track of all clients post-discharge referred for care coordination or who are found to need care coordination once follow-up has been completed	1) # of coordinated care plans developed as a result of the follow-up process 2) # of IMPACT assessments for clients post-discharge	Better understanding of the extent of need for care plans for individuals	
	Effective transitions	Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification	P	% / Discharged patients	EMR/Chart Review / Last consecutive 12 month period	91445*	CB	CB	Data collection is challenging because it has to be done manually. Four	1)Develop a centre-wide process for following up on discharge notifications that is timely and consistent with best practices	1) Analyze the learning from piloting the project in 2017/18 with one test physician. 2) Follow-up four providers for one month to have a better understanding of the volumes of discharges. Analze findings. 3) Develop a process map for following up on all hospital	1) Analysis conducted and shared with the appropriate stakeholders at FV 2) Process map developed for following-up with all hospital discharge notifications 3) Literature and best practices on follow up with hospital discharges reviewed 4) Standards of care for clients	1) Understand resource requirements to follow up on all the hospital discharge	Four Villages cannot get data from the EMR or Hospital Report Manager on the
	Wound Care	Percentage of patients with diabetes, age 18 or over, who have had a diabetic foot ulcer	A	% / patients with diabetes, aged 18 or older	EMR/Chart Review / Last consecutive 12 month period	91445*	CB	CB	To understand levels of screening by all relevant providers (foot	1)Ensure standardized foot ulcer risk assessment is conducted regularly by all the relevant providers (foot care and primary care)	1) Review how foot exam is documented and standardize documentation 2) Develop a process for ensuring that individuals with diabetes get the foot exam annually (based on HQO quality standard of care) 3) Develop a benchmark for targets for assessments	1) Review documentation of foot exams at FV and ensure consistent and standardized documentation 2) Review HQO quality standard of care with primary care providers and foot care team 3) Collect performance information from other CHCs to assist with setting FV	Improved screening for foot ulcers for targeted clients with diabetes	
Equitable	Population health - cervical cancer screening	Equitable access to cancer screening (cervical, colon and breast cancer screening)	C	% / On-going primary care clients	Analysis of data pulled from NOD (EMR) & BIRT / For the Quarter. ending Sept. 30, 2017	91445*	CB	CB	FV will identify equity factors that correlate to cancer screening and create baseline information about which populations experience the most significant barriers to screening. Based on this	1)Share the analysis of the intersectional Socio-Demographic factors for cancer screening with the whole primary care team to	Hold a primary care team's meeting to share the analysis	Improvement in the rate of never screened clients by equity population	To screen never screened clients per equity population	
										2)Identify approaches based on results and the CHC's context (at the team/provider or organization level)	Identify projects or interventions, for the identified populations that do not receive equitable screening, to increase cancer screening rates	Improvement in the rate of never screened clients by equity population	To screen never screened clients per equity population	
										3)Evaluate the effectiveness of the approaches to see if the identified client group has been screened (based this CHC's decision to focus	To evaluate whether targeting the clients who did not receive equitable screening led to more effective screening.	Improvement in the rate of never screened clients by equity population	To screen never screened clients per equity population	
	Population Health	Improved Collection of Socio-Demographic Data Percentage of clients who have complete	C	% / Clients age 13+ with an encounter in the last fiscal year	EMR / 2018-2019	91445*	65.73	75.00	Target for the Health Service Providers (HSIPs) in the TC LHIN	1)Improve collection of health equity data to increase capacity for health equity initiatives	Continue with the process created last fiscal year to collect Health Equity (HE) data: a) Designated staff adds an alert into client's chart that HE data needs to be collected. b) At appointment, information is requested by front desk staff	Collection process continues	Target for collection of Health Equity data achieved (75% of clients SEEN in a	While TCLHIN goal targets clients seen in the past year, in future years
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	91445*	91.1	94.00	94% was Four Villages' goal for 2017/18. Four Villages will monitor performance.	1)n/a	m/a	n/a	m/a	Four Villages will monitor performance. Currently a client experience survey has been launched as of mid March 2018. Results will be reviewed and an improvement plan developed if warranted.
Safe	Medication safety	Improve medication safety for clients discharged from hospital (Part of the "Improve Post-	C	% / Roster of the test Primary Care Providers with medication reconciliation	Manual logs / 2018-2019	91445*	CB	CB	Four Villages needs better understanding of the resource requirements to	1)Determine the most appropriate client population who will benefit from medication reconciliation post	1) Continue with monitoring medication reconciliations following discharges 2) Seek out a pharmacist who can partner with FV and do medication reconciliations on site for our clients (community pharmacist or pharmacy residency program) 3) Develop criteria for when	1)Secure a community-based pharmacist who will partner with FV and provide medication reconciliations for clients discharged 2) With the pharmacist, develop criteria and process for conducting medication reconciliations for clients discharged from hospital	Partnership with pharmacist developed Criteria and process for medication	
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	91445*	34.62	45.00	Maintaining last year's target	1)Add a second Primary Care Provider (PCP) the Access to Care QI team	Have the second provider collect data about their practice for analysis	# of additional staff who have been given QI training	To increase staff's QI capacity in by end of March 2019	The question that is being asked to measure this indicator, as per HQO
										2)Collect and understand the second provider's supply and demand data	a) Apply supply and demand tool that had been created the previous year in order to analyze and understand where to focus our improvement efforts for the second provider. b) Manually collect supply and demand data for the second provider on the QI team for a period of	Collect Supply and Demand data for the second provider	Depending on the the needs and findings, based on collected supply and demand data,	Each CHC in the WE QI Collaborative will use HR, NOD, and financial data in
										3)a) Continue to monitor Third Next Available Appointment data (TNAA) for the first provider b) Collect TNAA data and	For both change ideas a) and b): - Apply the TNAA template for both providers - Continue with adding data to the run chart for the first provider and start a run chart for the new provider in order to interpret TNAA data and determine best possible target for the second	The number of days to TNAA	To improve the number of days to TNAA for each participating provider	NB. Not every client needs or wants to have an appointment on the same or next

										4)Free up/increase the participating providers' supply of appointments	a) Monitor the progress of the first provider. b) Reduce bad backlog of the second provider. c) Test change ideas on the schedule of the second provider on the QI team d) Apply the learning to other MD/NP as appropriate	The TNAA for each participating provider is at target (based on best possible based on FTE and scheduling)	To improve TNAA appointment based on each provider's target.	The driving force behind year 3 WE QI Collaboration's common QIP is the focus on
										5)Appropriate use of both participating providers' time	a) Analyze and understand pressures from internal and external demand on the QI providers' schedules to determine changes for improvements b) Test change ideas for improvements c) Measure revisit rates for both providers based on client context	Revisit rate	To optimize the use of both providers' time	The driving force behind year 3 WE QI Collaboration's common QIP is the focus on
		Percent of clients who responded "yes" to the question: "the last time you were sick or were concerned you had a health problem… you got an appointment on the date you wanted?"	C	% / Client who had used MD/NP services	Client experience survey / 2018-2019	91445*	78.7	78.70	To maintain performance while continuing to measure this indicator, to compare FV performance with 5 CHC members of the the WE QI Collaborative and to identify a benchmark for	1)To have all participating CHCs within the Collaborative ask this question on the client survey for 2018-19	a) Ensure the question is identical in the participating CHCs b) Analyze the results of the this particular question for all participating CHCs to determine the project for the next year's QIP	The number of CHCs collecting the measure	a)To understand the percentage of clients who are getting an appointment with the primary care team when they want/need it b) To determine the baseline among participating CHCs in the Collaborative c) To	This question was chosen as a balancing measure to the "same day/next day" indicator on this QIP. It is more important that clients get an appointment on the day they want or need it and not