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

De Dwa Da Dehs Nyes Aboriginal Health Centre 200-678 Main Street East

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 patients who have had a 7-day post hospital discharge follow up for selected conditions. (CHCs, AHACs,NPLCs)	P	% / Discharged patients	See Tech Specs / Last consecutive 12-month period.	92212*	45.2	47.00	The 2015-2017 Practice Profile Report (covering the period of April 1 2015 to March 31, 2018) is the source of data for this indicator. As we are using old data to report and build a target and based on the data have not achieved this target that the target remain the same for the 2019-20 fiscal year.		1)Empowering patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital.	When patients call to schedule an appointment, reception staff ask if the appointment is in follow up to a discharge from hospital. Clinicians remind patients that if they were in hospital that they should notify the health centre for follow up. In addition, a reminder will be added to the clinic voice mail for patients to inform reception staff if they have recently been discharged from hospital. Signage with reminders will also be placed around the clinic.	An increase in the number of patients seeing their primary care provider within 7 days after discharge from hospital for selected conditions.	Patients have access to primary care appointments post-discharge through coordination with hospitals.	
		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.	92212*	CB	CB	We do not report on this indicator.		1)At this time we do not report on this indicator, we report on a similar indicator.	At this time we do not report on this indicator, we report on a similar indicator.	At this time we do not report on this indicator, we report on a similar indicator.	At this time we do not report on this indicator, we report on a similar indicator.	At this time we do not report on this indicator, we report on a similar indicator.
	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	92212*	28.48	44.00	We are keeping the target in the 2019-20 fiscal year. With the additional of Same Day Access and Walk-in Clinics we find that the patients/participants are not necessary answering this question appropriately. We will review the question being asked to ensure it captures the data for this target		1)Keeping one appointment time open each day, at each site, to support patients when needed.	Filling the open appointment on a first come, first serve basis.	Measuring how many days the open appointment is through consistent coding across both sites in the EMR.	Patient satisfaction with access to same day and next day appointments.	
											2)Introduction of weekly evening walk-in clinics for rostered patients	Providing clients with walk in access to Primary Care services one evening per week to meet urgent episodic care.	Measure the utilization of the walk-in clinic appointments at each site to ensure it is being utilized to its fullest.	Patient satisfaction with access to same day and next day appointments.	
											3)Introduction of Same Day Access for Primary Care Patients	Currently the Brantford clinic offers one afternoon per week with Same Day Access appointments. In Hamilton there are three afternoons being offered for Same Day Access	Measure the utilization of the same day access appointments at each site to ensure it is being utilized to its fullest and promoting an efficient use of Clinician time.	Patient satisfaction with access to same day and next day appointments.	
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	92212*	91.86	100.00	We dropped a bit in this indicator in the 2018-19 year so we are keeping the target the same.		1)To make paper/electronic surveys available to our patients at each visit in the waiting rooms.	Paper/Electronic surveys available to our patients when they are in the waiting rooms.	Annual reporting on Patient Experience Satisfaction Survey.	Patient satisfaction with their involvement in decision making.	

		Percent of patients who responded positively to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office spend enough time with you?"	C	% / PC organization population (surveyed sample)	In-house survey / 2018-19	92212*	100	100.00	To gauge patient's perception of the amount of time spent with clinicians.		1)Patients are satisfied with the amount of time that the clinician spends with them during their appointment.	To make paper surveys available to our patients.	To equip departments with satisfaction surveys.	To ensure patient satisfaction.	
		Percent of respondents who responded positively to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office give you an opportunity to ask questions about recommended treatment?"	C	% / PC organization population (surveyed sample)	In-house survey / 2018-19	92212*	99	100.00	We achieved 99% for this indicator in 2017/18 and 2018/19 we dropped slightly. We continue to strive for 100%.		1)To make paper/electronic surveys available to our patients at each visit in the waiting rooms.	Paper/Electronic surveys available to our patients when they are in the waiting rooms.	Annual Reporting on Patient Experience Survey	Patient understands their treatment options and treatment.	
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	92212*	CB	CB	At this time no target has been identified as we are collecting baseline data on this indicator and will report on once data is available		1)A review of the EMR data for this indicator will take place.	Reports will be generate by our EMR to ensure that we are pulling the data correctly and to identify base line performance.	Once a base line performance level is identified we will begin developing process measures for the indicator.	To identify palliative care needs early though a comprehensive and wholistic assessment.	
		Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period.	C	% / PC organization population eligible for screening	EMR/Chart Review / 2018-19	92212*	61.6	63.87	Although we did not meet this target we have kept this target the same for this year. Our current performance is taken from the results at the end of Q3 for the 2018-19 fiscal year.		1)Continue to utilize the data mining component of the new EMR to identify eligible patients and to offer to provide the service to them.	Through the utilization of our EMR we were able to identify patients who were eligible for the screening and were contacted to schedule the appointment.	Reports from our EMR will be utilized to identify patients eligible for the screening.	The incidence of cervical cancer is reduced in our patients through regular screening.	
		Percentage of patients with diabetes up-to-date with glycated hemoglobin (HbA1C) tests	C	% / patients with diabetes, aged 40 or over	ODD, OHIP-CHDB,RPDB / 2018-19	92212*	71.65	79.65	This is only the third year collecting this information. By the third quarter of 2017-18 we exceeded our initial target; therefore, we are increasing this indicator for 5% in 2019-20.		1)Continue to utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them.	Through the utilization of our EMR we were able to continue to identify patients who were eligible for the screening and were contacted to schedule the appointment.	Reports from our EMR will be utilized to identify patients eligible for the screening.	To identify and support patients who are at risk or have diabetes to control blood sugar levels. Decrease diabetes related complications.	
		Percentage of people/patients overe 65 who report having a seasonal flu shot in the past year	C	% / PC organization population eligible for screening	EMR/Chart Review / 2018-19	92212*	51.88	55.00	We exceeded the target for this indicator at the end of Q3 in 2018-19 therefore, we are projecting a 5% increase in this indicator for 2019-20.		1)Continue to utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them.	Through the utilization of our Electronic Medical Record (EMR) we were able to identify patients who were eligible for the vaccine and were contacted to schedule the appointment.	Reports from our EMR will be utilized to identify patients eligible for the vaccine.	To reduce the incidence of influenza in people/patients over the age of 65.	
											2)Discussions with patients at regular appointments to offer the flu shot or to identify if the flu shot has been received elsewhere.	Clinicians (Physicians and Nurse Practitioners) offer patients the flu shot at appointments during the flu season. If the patient has received a flu shot elsewhere it is noted in the EMR.	Conversations with patients regarding the benefits of flu shots and offering the vaccine at scheduled appointments.	To reduce the incidence of influenza in people/patients over the age of 65.	
		Percentage of screening eligible patients up-to-date with cervical cancer screening QIP	C	% / PC organization population eligible for screening	EMR/Chart Review / 2018-19	92212*	49.34	53.00	We have not met the target as of the end of the third quarter of the 2018-19 fiscal year. As a result, we		1)Continue to utilize the data mining component of the new EMR to identify eligible patients and to offer to provide the service to	Through the utilization of our EMR we were able to identify patients who were eligible for the screening and were contacted to schedule the appointment.	Reports from our EMR will be utilized to identify patients eligible for the screening.	The incidence of cervical cancer is reduced in our patients through regular screening.	
		Percentage of screening eligible patients up-to-date with colorectal cancer screening (Retired)	C	% / PC organization population eligible for screening	EMR/Chart Review / 2018-19	92212*	51.85	54.00	We did not meet this target for this indicator in 2018-19; therefore, we are keeping this indicator the same for 2019-20.		1)Continue to utilize the data mining component of the new EMR to identify eligible patients to offer to provide the screening to them.	Through the utilization of our EMR we were able to continue to identify patients who were eligible for the screening and were contacted to schedule the appointment.	Reports from our EMR will be utilized to identify patients eligible for the screening.	To reduce the incidence of cancer in eligible patients through regular screening.	

	Safe	Percentage of non-palliative patients newly dispensed an opioid within a 6-month reporting period prescribed by any provider in the health care system	P	% / Patients	CAPE, CIHI, OHIP, RPDB, NMS / Six months reporting period ending at the most recent data point	92212*	CB	CB	At this time we are collecting our base line data and will report on this indicator when data is available.		1)A review of the EMR data for this indicator will take place.	Reports will be generated by our EMR to ensure that we are pulling the data correctly and to identify base line performance.	Once baseline performance level is identifed we will begin developing process measures for this indicator.	to identify non-palliative patients newly dispensed an opioid within a 6 month report period.	
Equity	**Equitable**	Health equity allows people the opportunity to reach their full health potential and receive high quality care that is fair and appropriate to them and their needs, no matter where they live, what they have or who they are.	C	Count / All patients	In house data collection / 2017-18	92212*	6549	8500.00	Our target in 2018-19 is 8000 and we are on track to meet the target by the end of Q4. As a result, we have increased the target to 8,500 for the 2019-20 fiscal year.		1)In 2017-18 the Healthy Living Department engaged members of the community through programs and services such as camps, healthy living programs, and diabetes education sessions. All of the Health Promotions programming have cultural component to enrich the participants spirit as well as their physical health.	To have over 8,500 persons attending our wellness and healthy lifestyle programs.	Quarterly reporting on the number of program participants registered within the new EMR.	To increase access and attendance to Wellness and Healthy Lifestyle programs.	