2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

London InterCommunity Health Centre 659 Dundas Street East, London, ON N5W 2Z1

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Coordinating care	Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach	% / Patients meeting Health Link criteria	In house data collection / Most recent 3 month period	92235*			The health centre is a member of London Middlesex Health Link steering committee and working groups. Coordinated care planning is led by the South West CCLC. We are committed to participating with identified clients but will not be setting a target.					
	Effective transitions	Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions.	% / Discharged patients with selected HIG conditions	CIHI DAD / April 2015 - March 2016	92235*	38	45.00	We saw an improvement in our performance this year and will continue to focus on this indicator	1)Better equip and inform clients about the importance of hospital follow up	Add instruction to information cards for clients who are going to hospital to call the centre after discharge from hospital. Instruct medical secretaries to call clients that they know were in hospital to come in for fup with triage nurse. Inform clients at intake about the importance of follow up after discharge. Add information bulletin to TV in reception Add information to referral notification letter for clients.	Practice Profile	45%	
		Percentage of acute hospital inpatients discharged with selected HIGs that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission, by primary care practice model.	% / Discharged patients with selected HIG conditions	CIHI DAD / April 2015 - March 2016	92235*	9	5.00	We continue educating clients about the importance of follow up after discharge but we prefer to focus on our other indicators	1)Better inform clients about the importance of fup after hospital discharge.	Add instruction to information cards for clients who are going to hospital to call the centre after discharge from hospital. Instruct medical secretaries to call clients that they know were in hospital to come in for fup with triage nurse. Inform clients at intake about the importance of follow up after discharge. Add information bulletin to TV in reception Target COPD clients and do group education days (how to use puffers, red flags)	Practice Profile	5%	

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Effective	Effective transitions	Percentage of patients for whom discharge notification was received who were followed up within 7 days of discharge, by phone or in-person visit, with any clinician.	% / Discharged patients	In house data collection / Last consecutive 12 month period.	92235*			We prefer to focus on the original 7 day follow up question (seen above)					
	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.	% / PC organization population eligible for screening	CCO-SAR, EMR / Annually	92235*			We prefer to focus on the 3 year PAP indicator which aligns with our MSAA reporting (see above)					
		Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years	% / PC organization population eligible for screening	See Tech Specs / Annually	92235*	71	75.00	We saw an improvement in our performance this year and will continue to focus on this indicator	1)Increase the number of women who have received a PAP	#1) 1. Dedicated RN focussed on tracking paps through updated patient lists 2. Implementing primary team approach with shared accountability for Pap targets 3. Identify shared clients between community programs and clinical services in order to increase knowledge and awareness around the importance of preventative cancer screening	EMR data number of clients called by dedicated staff per quarter number of tests completed	Continue to focus on reaching women who need to have a pap test and meet our target of 75%	
	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	% / PC organization population eligible for screening	See Tech Specs / Annually	92235*			We prefer to focus on the FOBT indicator that aligns with our MSAA requirements (see below)					
		Percentage of screen eligible patients aged 50 to 74 years who had a FOBT within the past two years, other investigations (i.e., flexible sigmoidoscopy) within the past 10 years or a colonoscopy within the past 10 years.	% / PC organization population eligible for screening	See Tech Specs / Annually	92235*	67	72.00	While we are meeting target, our performance slipped a bit this year so we will monitor this indicator closely over the year	1)Increase the number of FOBT's offered to clients	#1) 1. Dedicated RN focussed on tracking fecal occult blood tests through updated patient lists 2. Implementing primary team approach with shared accountability for FOBT targets 3. Identify shared clients between community programs and clinical services in order to increase knowledge and awareness around the importance of preventative cancer screening	EMR data number of clients called by dedicated staff per quarter number of tests completed	continue to maintain above target result of 72%	

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Effective	**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	% / patients with diabetes, aged 40 or over	ODD, OHIP-CHDB,RPDB / Annually	92235*	77	80.00		1) Increase the number of HbA1C's completed on clients with Diabetes over age 40	Develop medical directive so that nurses can order bloodwork in advance of a diabetes clinic Assign an RN to audit client HbA1c lists quarterly in terms of who needs fup, blood work, connection to DEP, self-management groups. RN will work closely with a single point of contact through the DEP.	EMR	80%	
Equitable	**Improve our provision of health care to government assisted refugees**	Increase our Early Health Assessments for all government assisted refugees in London.	Number / Clients	EMR/Chart Review / 2017	92235*	CB	CB	set up a Early Health Assessment schedule type and track shows vs no shows					
	Provide health centre programs and services to disengaged clients and potential new clients who live in subsidized housing	Offer people increased diversity and frequency of programming 2. Give people service options that are appropriate to a community health centre that are focused on supporting people to improve their health 3. Access different providers in a variety of settings 4. Engage people who might otherwise have slipped through the cracks (Number; Clients; 2016/17; EMR/Chart Review)	Number / Clients	EMR/Chart Review / 2017	92235*	126	190.00	190 HIHI clients in total. This allows for continued service to clients who are currently connected and for the addition of new clients.	1)1. Register people with the Health in Housing Initiative. 2. Link registered HIHI participants to LIHC programs and services 3. Expand area of service	EMR	number of new HIHI clients	190 HIHI clients in total	
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?	% / PC organization population (surveyed sample)	In-house survey / April 2016 - March 2017	92235*	76.83	90.00		1)Better inform providers, volunteers and clients	Modify the provider chart audit so that this question is reflected. Create cue cards for volunteers who help clients with the surveys so that this question is clearly understood.	Number of client surveys reflecting opportunity by clients to ask questions about treatment to be reviewed quarterly.	90%	

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Safe	Medication safety	Percentage of patients with medication reconciliation in the past year	% / All patients	In house data collection / Most recent 12 month period	92235*	CB	CB		1)Develop process internally to reconcile client medications	Assign a NP to work with DMC to develop a system for tracking medication reconciliations	EMR	Collecting Baseline Data	
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.	% / PC organization population (surveyed sample)	In-house survey / April 2016 - March 2017	92235*	44.16	50.00		1)Improve access to primary care	Set up a triage system to allow clients to be seen same/next day when sick	Number of client surveys reflecting client access to same/next day care when sick to be reviewed quarterly.	50%	