2018/19 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	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 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	92235*	9	5.00	We feel this is a achievable target.	1)Better inform clients about the importance of follow up after hospital discharge.	1. Add instruction to information cards for clients who are going to hospital to call the Health Centre after discharge from hospital. 2. Instruct medical secretaries to call clients that they know were in hospital to come in for follow up with triage nurse. 3. Inform clients at intake about the importance of follow up after discharge. 4. Add information bulletin to TV in reception 5. Target COPD clients and do group education days (how to use puffers, red flags)	Practice Profile	5%	
		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	92235*	36	45.00	We feel this is an achievable target.	1)We will to continue to implement strategies to better inform clients about the importance of follow up after hospital discharge.	1. Add instructions to information cards for clients who are going to the hospital to call the centre after discharge from hospital. 2. Instruct medical secretaries to call clients that they know were in the hospital to come in for a follow up with triage nurse. 3. Inform clients at intake about the importance of follow up after discharge. 4. Add information bulletin to TV in reception. 5. Add information to referral notification letter for clients.	Practice Profile	45%	

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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	92235*	67	75.00	We feel this is an achievable target.	1)1. Move towards 4 registered nurses trained to preform paps on a regular basis. 2. More focus on completing pap tests for our HIV positive clients. 3. Use Health Promoter to engage and educate clients about importance of pap test.	1. Create a new Women's Health Group through Integrated Programs 2. Design communications materials to encourage clients to book appointment for pap 3. More focused effort to have nurses will ask client to book appointment 4. Registered Nurses will be trained to preform paps by September	Number of paps recorded in NOD	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	A	% / PC organization population eligible for screening	See Tech Specs / Annually	92235*	68	72.00	We feel this is an achievable target.	1)We will continue to increase the number of FOBT's offered to clients.	1. Share QIP indicators trending and target numbers with clinical teams on a regular basis. 2. Dedicate RN focused on FOBT through updated client list. 3. Health Promoter will engage and education clients about FOBT and offer to book appointments.	EMR data number of clients called by dedicate staff per quarter number of tests completed.	72%	

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Equitable	**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	92235*	68	77.00	We feel this is an achievable target.	1)We will continue to increase the number of HbA1C's completed on clients with diabetes over the age of 40.	1. Present this indicator as a strategy to focus on QIP at clinical and diabetes team meetings. 2. Diabetes nurses alert physicians to order the HbA1C test. 3. Pull list of clients who haven't had a HbA1C test and book an appointment.	EMR	77%	
	Community Health	Help, Opportunity and Planning Education (HOPE program)	C	Number / All patients	EMR/Chart Review / 2018	92235*	CB	CB	This is a new QIP indicator.	1)To educate clients about opportunities to mitigate poverty and enhance access to education.	1. Enroll all eligible clients into the HOPE program. 2. Promote to and engage with clients throughout all Health Centre programs and services. 3. Promote awareness to all providers to refer their clients to this program through more standardize planning.	EMR- Identifier	CB	
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	92235*	83	90.00	We feel this is an achievable target.	1)We will continue to better inform providers, volunteers and clients.	1. Modify the provider chart audit so that this question is reflected. 2. Create cue cards for volunteers who help with the surveys so that this question is clearly understood.	Number of client surveys reflecting client had an opportunity to ask questions about their treatment. To be reviewed quarterly.	90%	

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Patient-centred	**Care Plan Tool**	A new care plan tool is developed and piloted. This tool will focus on the social determinants of health of each client. This care plan will be the result of a new process that will be standardized across the Health Centre using an integrated approach.	C	Development of Tool / All patients	EMR/Chart Review / 2018	92235*	CB	CB	This is a new QIP indicator.	1)Better manage client-centred care focused on the social determinants of health using an inter-professional team approach.	1. Develop a care plan tool with a staff working group, that can be used within the EMR by all providers. 2. Select timelines for piloting the tool. 3. Pilot tool. 4. Manual review of charts. 5. Gather feedback and make changes to tool if necessary.	1. Provider input 2. Manual chart review	CB	
Safe	**Harm Reduction Kits**	Number of kits distributed to clients who inject substances.	C	Count / All patients	EMR/Chart Review / most recent 12 month period	92235*	CB	CB	This is a new QIP indicator.	1)We will offer harm reduction kits to clients who inject substances.	1) Develop partnership and create MOU with RHAC 2) Increase awareness and knowledge of harm reduction policies and practices within our Centre 3) Train all staff in harm reduction 4) Train specific staff on kit distribution and outreach strategies 5) Develop referral system for kit distribution 6) Distribution of kits.	1) # of staff trained 2) # kits distributed	CB	

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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	92235*	48	50.00	We feel this is an achievable target.	1)We will continue to improve access to primary care.	1. 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 day/next day care when sick to be reviewed quarterly.	50%	