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


| AIM | | Measure | | | | | | | Change | | | | |
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| 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 | 91956* | CB | CB | The Oxford Health Link program is currently in the initial stages of development. | 1)The Ingersoll NPLC providers will work collaboratively with the Oxford Health Link project manager and community | Ingersoll NPLC providers will receive training specific to Health Link care coordination. Ingersoll NPLC providers will Identify patients and clients who meet Health Link criteria. Ingersoll NPLC providers will participate in Health Link coordinated care plans involving our | # of training sessions attended by Ingersoll NPLC providers. # of patients/clients referred to Oxford Health Link. # of coordinated care plans that involve Ingersoll NPLC providers and their patients. | 1 Health Link training session attended by Ingersoll NPLC providers Collect | The offices for the Project Manager and Community Engagement |
| | | | | | | | | | 2)The Ingersoll NPLC will provide support to Oxford Health Link. | The Ingersoll NPLC Clinical Administrator will attend Health Link Advisory committee meetings. The Ingersoll NPLC Clinical Administrator will attend Primary Care Engagement Committee meetings. The Ingersoll NPLC Community Coordinator/Situation Table Facilitator will | # of Health Link Advisory Committee meetings attended by the Clinical Administrator. # of Health Link Primary Care Engagement Committee meetings attended by the Clinical Administrator. Number of meetings between the Ingersoll NPLC Community Coordinator/Situation | The Clinical Administrator will attend 3 Health Link Advisory Committee | The NPLC's Community Coordinator facilitates the Oxford Situation |
| | Effective transitions | Percentage of acute hospital inpatients discharged with selected HIGs that are readmitted to any | % / Discharged patients with selected HIG conditions | CIHI DAD / April 2015 - March 2016 | 91956* | CB | CB | The Ingersoll NPLC inconsistently receives notice of hospital | 1)Connect patients with selected HIG's at risk for readmission to hospital with the Oxford Health Link and local care coordinators. | The Ingersoll NPLC will increase communication with the Oxford Health Link Coordinator as well as local care coordinators. | # of onsite meetings with Oxford Health Link Community Engagement Coordinator. # of referrals made to the Oxford Health Link. # of Ingersoll NPLC patients with selected HIG's accepted for care coordination. | CB | The Ingersoll NPLC will work with community case managers who are assigned |
| | | 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. | 91956* | CB | 50.00 | It is projected that the Ingersoll NPLC will receive 50% of our patient's discharge summaries within 7 days of discharge and will therefore be able to connect with patients within that time frame. | 1)Implement a team approach for follow up post discharge, ensuring that the most appropriate provider is in contact with patient by | Following receipt of a discharge summary, the NP will faciliate follow up by phone or in person by the NP, the RPN or a counsellor. | # of phone calls made to patients within 7 days of discharge. # of in-person visits with patients within 7 days of discharge. | CB | Many patients are advised on discharge to follow up with their health care |
| | | | | | | | | | 2)Educate patients to follow up with their primary health care provider within 7 days of discharge from hospital | Develop and display poster for waiting room and exam rooms encouraging patients to contact the Ingersoll NPLC within 7 days of discharge from hospital. | # of posters developed. # of posters displayed. | 1 poster developed. 8 posters displayed. | By encouraging patients to contact the NPLC on their own, follow up within |
| | | | | | | | | | 3)Work with local hospital providers to advice patients to follow up with their health care provider within 7 days of discharge | The Clinical Administrators will table a discussion regarding discharge instructions at the Oxford area provider table (APT) meeting. | # of discussions at the Oxford APT meeting | 2 discussions | Not all of the local hospitals are represented consistently at the APT meetings |
| | Population health - cervical cancer screening | Percentage of screen-eligible women, 21-69 years old, who completed at least one Pap test in a 42- | % / PC organization population eligible for screening | EMR/Chart Review / April 1 2017-March 31 2018 | 91956* | CB | 75.00 | The Ingersoll NPLC will adjust our parameters for calculating this indicated | 1)Create a notification system to communicate with women who are due for their Pap test. | Prepare quarterly report of screen-eligible women, 21-69 years old, who have not had a Pap test done in the past 42 month period. Receptionists will contact patients by phone to book an appointment for their Pap test on a quarterly basis | # of notification systems created and carried out | 1 | Cancer Care Ontario informs patients directly when needing a Pap Test. With |
| | Population health - colorectal cancer screening | % of Ontario screen-eligible individuals, 50-74 years old, who were overdue for colorectal screening | % / PC organization population eligible for screening | EMR/Chart Review / April1 2017-March 31-2018 | 91956* | CB | 60.00 | The Ingersoll NPLC has adopted Cancer Care Ontario's new indicators | 1)Inform patients about Cancer Care Ontario's new guidelines for colorectal screening | Develop a health promotion package for patients regarding Cancer Care Ontario's new colorectal screening guidelines that includes an FOBT every 2 years or a signmoid/colonoscopy every 10 years. | # of colorectal cancer screening health promotion packages produced. # of colorectal cancer screening health promotion packages distributed. | 1/100 | The Ingersoll NPLC will update our EMR reminders to reflect the CCO's |

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| **Efficient** | **Mental health care** | % of patients who seek out services for mental health issues at the Ingersoll NPLC. | % / Mental health patients | In house data collection / April 1, 2017 - March 31, 2018 | 91956* | CB | CB | This data will be used to inform further development of our mental health team and resources. | 1)Improve health care professionals capacity to identify and manage major depressive disorder using evidence based practice and | Mental health team and clinical team will receive training on the Health Quality Ontario's Quality Standards for Major Depression. Create a search within the EMR to determine the # of patients seeking support for mental health concerns. Create a search within the | # of training sessions. # of patients seeking support for mental health from the Nurse Practitioners. # of patients receiving support from mental health counselors for major depressive disorder. # of patients identified with a confirmed DSM V diagnosis of major | 8 mental health round meetings where this measure will be addressed. 2 | |
| | | | | | | | | | 2)Improve health care professionals capacity to identify and manage an Anxiety Disorder using evidence based practice, | Mental health team and clinical team will receive training on evidence based practice regarding General Anxiety Disorder (GAD). Create a search within the EMR to determine the patients seeking support for mental health concerns. Create a search within the EMR to | # of training sessions. # of patients seeking support for mental health from the Nurse Practitioners. # of patients receiving support from mental health counselors for anxiety. # of patients identified with a confirmed diagnosis of GAD using the DSM - V criteria. | 8 mental health round meetings where this measure will be addressed. 2 | Currently there is not a Quality Standard for GAD through Health Quality Ontario. |
| | | | | | | | | | 3)Improve health care professionals capacity to identify and manage all other DSM V diagnosed mental health issues using | Mental health team and clinical team will receive training on DSM - V criteria for mental health disorders. Create a search within the EMR to determine the patients seeking support for mental health concerns not specific to Major Depressive Disorder (MDD) or | # of training sessions. # of patients seeking support for mental health from the Nurse Practitioners. # of patients receiving support from mental health counselors for mental health concerns other than MDD or GAD. Number of patients identified with a confirmed | 8 mental health round meetings where this DSM - V diagnoses will be addressed. 2 | |
| | **Team-Based Care** | % of patients with a diagnosis of hypertension or diabetes who are referred to the | % / Complex continuing care patients | EMR/Chart Review / April 1 2017-March 31 2018 | 91956* | CB | 75.00 | The Chronic Disease Coordinator facilitates the Ontario | 1)Increase delegation of hypertension and diabetes management from the NPs to the Chronic Disease Coordinator (CDC) | Review data quarterly with the NPs that reflects the # of patients with hypertension and/or diabetes who are being managed by the CDC. Review data quarterly with the NPs that reflects the # of patients with hypertension and/or diabetes who are being managed | 1. % of patients with hypertension and/or diabetes who are managed by the CDC 2. % of patients with hypertension and/or diabetes who are managed by the NP 2. # of Chronic Disease Rounds per year | 1. 75% 2. 4 | When additional co-morbidities exist, the NP is the most appropriate |
| | **Timely Access to Care** | Number of months that the average Third Next Available (TNA) appointment is 5 business days or less | Months / All patients | EMR/Chart Review / April 12017 - March 31 2018 | 91956* | CB | 11.00 | TNA has previously been an indicator that was helpful in demonstrating efficiency within our clinic. | 1)Reception will collect weekly TNA stats for each NP | Monitor appointment availability for each NP | TNA appointments will be calculated weekly on the first day of the week that the NP is scheduled to work. | 10 | |
| | | | | | | | | | 2)NPs will review the TNA trends monthly at NP Team meetings | TNA will be added as standardized topic on the NP Team meeting agenda during the first meeting of the month. | # of NP meetings where TNA was discussed | 12 | |
| **Equitable** | **Mental health and Addiction** | Number of community engagement sessions provided about mental health and addictions services offered at or in collaboration with the Ingersoll NPLC. | Number / Mental health patients | In house data collection / April 1, 2017 - March 31, 2018 | 91956* | CB | 4.00 | The Ingersoll NPLC has worked collaboratively with 3 other agencies for the past 5 years to develop coordinated access and treatment | 1)Develop community engagement sessions to inform our community about mental health and addictions services that are | The mental health team will develop a presentation to be used in community engagement sessions. The Community Coordinator will seek out opportunities to hold community engagement sessions. | # of presentations developed # of community engagement sessions held | 1 presentation 4 community engagement sessions | Opportunities for displays at community events and presentations by |
| | | | | | | | | | 2)Improve use of media sources to educate community about collaborative services and pathways to service. | The Ingersoll NPLC, together with collaborative partners, will promote services through multi-media outlets. | # of television promotions. # of news outlet promotions. # of events promoted through social media. | 2 television promotion programs. 2 news outlet articles. 100% of | |
| | | Percentage of patients who stated that they felt they received care in a welcoming, inclusive, comfortable, and safe environment. | % / Mental health patients | In-house survey / April 1, 2017 - March 31, 2018 | 91956* | CB | 50.00 | The Ingersoll NPLC strives to make clients feel welcomed into an inclusive and comfortable, safe environment. Our own experience tells | 1)The Ingersoll NPLC will provide a positive, stigma reducing, and welcoming environment. | Health promotion campaign focused on reducing stigma associated with mental health and addiction. | # of health promotion campaigns. | 4 health promotion campaigns. | The Ingersoll NPLC waiting room is shared between or primary care, |
| | | | | | | | | | 2)Implementation of the Ontario Perception of Care (OPOC) Tool | Patients will be asked to complete the OPOC at session 6 and/or their last appointment. Group participants will be asked to complete the OPOC at their last session. Non-registered clients will be asked to complete the OPOC at their last session. | # of OPOC tools distributed. # of OPOC tools completed. | CB | An Ipad will be used to complete the OPOC tool with the exception being |
| **Patient-centred** | **Person experience** | Percent of patients who stated that when they see the doctor or nurse practitioner, they or | % / PC organization population (surveyed sample) | In-house survey / April 2016 - March 2017 | 91956* | 93.18 | 95.00 | The Ingersoll NPLC is dedicated to providing patient-centered care | 1)Increase clinical provider's competency in using a self-management model to involve patients in their care. | Provide self management training to clinicians. | # of training sessions provided | 2 | Two staff have been trained as Self-Management Facilitators through the |

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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 | 91956* | CB | CB | This is the initial year for this measure | 1)Collect the Best Possible Medication History (BPMH). | Review medications during complete physical exams, post hospital discharge and following visits to specialists | # of BPMH's completed. # of BPMH's completed during Cpx's. # of BPMH's completed following discharge from hospital. # of BPMH's completed after the patient has seen a specialist. | CB | This is a new measure that will be integrated into our prescription |
| | | | | | | | | | 2)Incorporate medication reconciliation into self management goals with patients living with chronic health conditions. | Develop educational resources that assist patients to provide the BPMH. | # of educational materials completed | 2 educational materials | The Ingersoll NPLC will build on existing resources to achieve this |
| | | % of patients prescribed long term controlled substances who have completed a Controlled | % / All patients | EMR/Chart Review / April 2016-March 2017 | 91956* | CB | CB | It is anticipated that NP's will be able to prescribe controlled substances in | 1)Increase the % of patients on long-term treatment with controlled substances who have completed a Controlled Substance | Collect data on patients who are prescribed controlled substances for a period of 30 days or more and compare that to the number of Controlled Substances Agreements that are completed and up to date | # of patients who are prescribed a controlled substance for a period of 30 days or longer. # of these patients who have an up to date (1 year old or less) Controlled Substance Agreement. | 80% | |
| **Timely** | **Timely access to care/services** | Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or | % / PC organization population (surveyed sample) | In-house survey / April 2016 - March 2017 | 91956* | CB | 95.00 | The Patient Experience Survey determines this data from the | 1)Maintain the current level of access for patients requiring same day or next day appointments | Adjust NP schedules according to seasonal fluctuations to reflect the # of same day and next day appointments needed by patients | # of patient requests for same day and next day appointments # of patients who receive a same day or next day appointments when needed | 95% | The Ingersoll NPLC would like to request this question be adjusted in the |
| | | % of patients who receive a same day or next day appointment with an NP or RPN for an | % / All patients | In house data collection / April 1 2016-March 2017 | 91956* | 95 | 95.00 | The Patient Experience Survey determines this data from the | 1)Maintain the current level of access for patients requiring same day or next day appointments | Adjust NP schedules according to seasonal fluctuations to reflect the # of same day and next day appointments needed by patients | # of patient requests for same day and next day appointments. # of patients who receive a same day or next day appointments when needed. | 95% | The Ingersoll NPLC would like to request this question be adjusted in the |