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

Carefirst FHT 27-420 Hwy 7 East, Richmond Hill, ON L4B 3K2

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	% of complex patients in the INTEGRATE program who have a MAPLe score documented in the EMR	C	% / Patients with complex conditions	In house data collection / Year to Date	91400*	CB	90.00	Patient roster fluctuates so we may not have 100% of patients with a documented MAPLe score by the end of the fiscal year.	1)Create an EMR tool for documenting and tracking MAPLe scores	QIDSS will develop the form in consultation with team	% of INTEGRATE patients with a document MAPLe score using this tool	90%	
										2)Set up accounts for Carefirst social workers to access InterRAI CHA data from the LHIN Home and Community Care organization for INTEGRATE patients.	Accounts will be created for Carefirst social workers	% of Carefirst social workers with an account	100%	
		Percent of INTEGRATE patients who have had at least 2 home visits in the past year by any provider.	C	% / Patients with complex conditions	In house data collection / Visits by end of fiscal year	91400*	CB	70.00	We are aiming to conduct two home visits for each of the INTEGRATE patients who consents to receiving home visit services.	1)INTEGRATE patients will be assigned to a specific nurse or NP who will be in charge providing home visits to these patients.	Assign patients to a nurse or NP by language	Percent of INTEGRATE patients assigned to a nurse or NP	100%	were not assigned to a specific INTEGRATE patient which affected continuity of care for these patients. New change idea would be to ensure each INTEGRATE patient will be assigned to a nurse/NP, for improved continuity of care.
	Effective transitions	Percentage of patients who have had a 7-day post hospital discharge follow up. (CHCs, AHACs,NPLCs)	P	% / Discharged patients	See Tech Specs / Last consecutive 12 month period	91400*	CB	CB	We are tracking the alternative 7-day post discharge indicator this year because it better reflects our teams	1)N/A	N/A	N/A	N/A	We are currently tracking the alternative 7-day post hospital discharge indicator.
		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	91400*	95.2	96.00	We plan to maintain our high performance in hospital follow-ups for notifications we receive in a timely manner. We are not	1)Educate patients about the importance of following-up with the FHT following a hospital discharge.	Add education material to our welcome package and waiting room TV program.	Number of welcome packages distributed to patients.	100	We are basing our target measure on the number of new patients we expect to have after we add this new education material.
Equitable	Population health - diabetes	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C)	A	% / patients with diabetes, aged 40 or over	ODD, OHIP-CHDB,RPDB / Annually	91400*	57.8	60.00	With our new diabetic encounter template we are better able to track patients	1)Use our diabetic encounter template and diabetic registry to recall patients overdue for testing.	IT/QIDSS will generate the report every 6 months and provide the lists to the physicians for recall. Patients in need of recall will be provided to the front desk with a requisition and front desk will call the patients asking them to pick it up.	Number of reports generated and provided to the doctors in 2018-19	2	
		Percentage of diabetic patients aged 40 or over who are at their individualized Hb A1C	C	% / patients with diabetes, aged 40 or over	In house data collection / Q4	91400*	62	65.00	This is our first year tracking individualized A1C targets so only 49.7% of	1)Improve tracking of patients over target so that we can follow-up with them more frequently.	Use our diabetic registry and diabetic recall reports to identify these patients and provide reports to our physicians.	Number of reports provided to our physicians	2	

		targets.							our diabetic patients over the age 40 have an individual target set. Our current performance is based on the	2)Continue to document individual A1C targets for all of our diabetic patients	Our existing diabetic flowsheet has the option to set an A1C target <= 7% or between 7.1-8.5%.	% of diabetic patients with an individual A1C target recorded	60%	We currently have 46.7% of patients over the age of 40 with an individual A1C target recorded.
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	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	91400*	83	85.00	All FHT physicians will be given their individual results in comparison to other FHT doctors which we hope can	1)Share survey results with individual physicians so they can compare their performance to the rest of the team.	Survey results will be analyzed on a per-physician basis and provided as a graph for easy comparison.	Number of survey reports created	1	We only intend to do this once this year to understand how useful the physicians find this information.
Timely	**Timely access to care/services**	Percentage of patients and clients able to see a doctor or nurse practitioner	P	% / PC organization population (surveyed	In-house survey / April 2017 - March 2018	91400*	50.7	52.00	With an increase in the number of after hours shifts offered by FHT	1)Increase the number of after-hours shifts offered by our physicians across both our sites	Recruit new physician who will offer after-hours care.	Number of after-hour shifts offered per week by our FHT physicians.	2 additional shifts	