Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Timmins

Family Health Team
Équipe de Santé Familiale

3/31/2016

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Ontario

Overview

The Timmins FHT is an organization that values quality care and has worked diligently over the past year to build an organizational culture that values continuous improvement. The TFHT has a clearly defined Strategic Plan endorsed by our Board of Directors with Strategic Directions that require outcome measure data tracking, planning, implementation and evaluation for continuous improvement across our primary care organization. Our QIP supports organizational compliance with our strategic plan and we are accountable to our Board through our Quality Management Committee and progress reports.

The availability of data has been our most useful tool as the data demonstrates our performance with regard to the outcome targets we set, our peer FHTs in the province and the overall provincial averages. Hosting a QIDSS position on behalf of 5 FHTs in NE Ontario, participation in AFHTO's D2D 3.0, and involvement in quality improvement in other provincial initiatives, the TFHT is contributing to the spread of quality improvement across the primary care sector.

Through leading the Timmins Health Link, on behalf of our Timmins healthcare partners, the Timmins FHT has led a patient engagement initiative based on a primary care model, that has demonstrated how engagement of the patient and focused care coordination can better meet the needs of complex patients and as a result, decreases their use of the emergency department and reduces hospital admissions. Based on the capacity of existing members of our primary care team, the TFHT is transitioning a Health Link philosophy to care of our complex patients.

In recognizing significant gains this year in the implementation of our quality improvement initiatives, the Timmins FHT is committed to maintaining this momentum within our primary care team and to expanding efforts where impact on patient health status can be demonstrated.

QI Achievements From the Past Year

The most significant achievement experienced by the Timmins FHT this year has been our ability to access consistent data on which to evaluate our performance with quality indicators. The availability of data has been transformational and has allowed our primary care team to identify trends in our patient's health status, to evaluate patient feedback, to assess workflow efficiencies and to initiate dialogue with providers on needed changes to the delivery of programs and services.

The Quality Management Committee, chaired by our Lead Physician has been instrumental in reviewing our performance through assessing our successes and challenges with achieving our performance targets. This information when shared with our primary care providers, engaged the group in meaningful clinical discussion which has led to improvements across the TFHT. Some of our primary care providers have consequently registered to receive data about their own practice through EMRALD, ICES and Cancer Care Ontario.

In addition, the Timmins FHT was a contributor to AFTHO's D2D 2.0 and 3.0 and now receives Practice Reports for the Timmins FHT. The Quality Management Team, Lead Physician and Executive Director are accountable to the Board of Directors. Based on the Strategic Directions endorsed by the Board in the Strategic Plan, the board receives reports at each of 7 meetings per year that outline our quality improvement efforts. An annual report, also based on progress with the Strategic Plan is presented to all Corporate Members of the FHT at the Annual General Meeting. At each of these levels Board Directors and Corporate Members have the opportunity to evaluate our performance and to challenge our FHT leaders on action plans.

Integration & Continuity of Care

The Timmins FHT is working to actively integrate care on two levels, a) integration within our diverse primary care team, across six clinical sites and b) integration of primary care within the health care system in Timmins and the Cochrane District. Commitment has been demonstrated to embed the services of our Integrated Health Professionals within primary care provider offices to enhance equal access to these services for patients across the TFHT. The focus of quality improvement efforts have been to harmonize programs and services rather than standardize.

In encouraging a quality culture within the TFHT, emphasis has been placed on achieving favourable outcomes through care delivery models that can vary from site to site, based on what is required to meet the needs of patients served by that site.

Facilitating a full scope of practice for our IHP roles, the responsibilities of each member of our primary care team is identified and plays an important role in the continuity of care for our patients. Documentation is integrated in a common EMR and the EMR is networked between all sites allowing everyone who cares for a patient to have access to a complete medical record.

The TFHT is engaged in working with most health service providers in Timmins. In collaboration with the VON for Diabetes care and the CCAC for Palliative care the TFHT has facilitated interagency agreements for access of partner agencies to access and document in the patient's EMR. In collaboration with the Timmins & District Hospital, the NE LHIN and North Eastern Specialized Geriatric Services, the TFHT was a significant participant in the submission of funding proposals for enhanced geriatric services, hospice beds and a Palliative Shared Care Team.

In addition, the TFHT works with a wide range of health partners through leading the Timmins Health Links. As an early adopter in Ontario, the Timmins Health Link has had success with piloting a primary care model of care coordination. Through the partnerships established with the Health Link, examples of improvements include the ongoing identification of acute care high use patients, more consistent flow to primary care providers of patient admission, discharge and ED visits information, and the identification of access barriers and gaps in service barriers.

Engagement of Leadership, Clinicians and Staff

TFHT leadership is engaged through reports to the Board of Director on activities that support the approved Strategic Directions in the Strategic Plan. This report includes information that demonstrates accountability through the provision of performance data based on specific outcome measures. Progress with the Quality Improvement Plan is monitored by the Quality Management Committee, responsible to the Board of Directors and chaired by the Lead Physician.

Formal mechanisms have been established to share our progress with outcome measures with clinicians and staff through monthly meetings with our primary care providers, IHPs and staff. The TFHT Lead Physician is actively engaged in the management of the TFHT, making decisions about its programs & services and in promoting a quality culture among clinical team members. The Lead Site Physicians and IHP representative on the management and quality management committees are responsible to implement improvements at each of their clinical sites and to engage their teams.

The TFHT is the host for a QIDSS position and provides services to 4 other FHTs in NE Ontario. All FHTs benefit from the work done by the QIDSS person and sharing of methodologies for data collection is encouraged.

Patient/Resident/Client Engagement

Patient feedback has been collected through patient feedback surveys. The number of patient surveys completed by TFHT patients has increased significantly in the past year through particularly the efforts of clerical staff who invite patients to provide feedback on a regular basis. Patients have the opportunity to complete surveys in English or French, by paper version, through our website and by tablet (pilot project launched at Administration site). The results of the surveys are provided to the Lead Site Physicians every 6 months with an expectation that these results will be shared with their site team members. Feedback results are entered into the TFHT Data Dashboard for tracking purposes and are reviewed by the Quality Management Committee.

Our QIP will be posted to our website, once approved by the Board for 2016-2017 and will be available to the general public. To more directly engage patients, the TFHT will investigate methods to increase patient engagement in organizational decisions that may include the facilitation of patient focus group discussions in 2016-2017. In addition, best practices for involving patients in care decisions will be reviewed.

Through our Health Link initiative, a Patient Discovery Interview has begun to be utilized with high user patients that assists with identifying what the patient feels is most important related to their plan of care. Experience gained through the implementation of the Health Link primary care model demonstrated that patients feel more involved in their care when the Patient Discovery Interview process is utilized.

Other

It is only through engaging the efforts of each member of our primary care team and engaging our patients in actively managing their own care that quality improvement efforts will have a direct impact on patient health status. The Timmins FHT is well positioned to move this work forward over the next year.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair Clark MacFarlane
Quality Committee Chair or delegate Dr. Yves Raymond
Executive Director / Administrative Lead Jennifer McLeod
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2015/16 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
1	{Percent of eligible patients/clients who are up-to-date in screening for breast cancer.} (%; PC organization population eligible for screening; n/a; EMR/Chart Review)	91447	68.00	70.00	75.30	Target met

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2015/16)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Evaluate patient health status, screen for risk factors and disease; provide preventive counselling intervention in an age-appropriate manner.	Yes	While our target was met, there is still opportunity for improvement by engaging the primary care team that works with the providers in reaching out to patients who are eligible for screening. Efforts will continue into the next fiscal year to review office flow and processes to facilitate improvement. Opportunity is available through implementing a consistent focus on preventative care that includes FOBT, Mammogram and Pap test screening.

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
2	{Percent of eligible patients/clients who are up-to-date in screening for cervical cancer.} (%; PC organization population eligible for screening; n/a; EMR/Chart Review)	91447	50.00	60.00	69.80	Target met.

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Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Ensure all eligible female patients/clients between 18 and 69 years have had pap test screening.	Yes	While our FHT target was met, there is still opportunity for improvement by engaging the primary care team that work with the providers and particularly the PC nurses in reaching out to patients who are eligible for screening. Efforts will continue into the next fiscal year to review office flow, processes and program delivery to facilitate improvement. Opportunity is available through implementing a consistent focus on preventative care that includes FOBT, Mammogram and Pap test screening.

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
3	{Percent of eligible patients/clients who are up-to-date in screening for colorectal cancer.} (%; PC organization population eligible for screening; n/a; EMR/Chart Review)	91447	48.00	50.00	69.90	Target exceeded.

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Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Identify patients/clients between 50 and 74 who are eligible for FOBT testing; Identify patients/clients who are eligible who have not had testing within past 24 months or have not had a colonoscopy/sigmoidoscopy in the past 10 years.	Yes	While our target was exceeded, there is still opportunity for improvement through the review of office flow, processes and programs to facilitate improvement. Opportunity is available through

implementing a consistent focus on preventative care that includes FOBT, Mammogram and Pap test screening.

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
4	{Percent of patient/client population over age 65 that received influenza immunizations.} (%; PC organization population aged 65 and older; na; EMR/Chart Review)	91447	63.50	80.00	59.20	Target not met due to incomplete patient immunization data documented in the EMR.

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Collaborate with local health unit and pharmacies in order to ensure that documentation of immunization history is current in EMR	Yes	Process implemented successfully with health unit; not all pharmacies participated in forwarded immunization data to patient's primary care provider. Vaccination available at many other health sites. In future years, consideration will be given to gathering data through patient self-report to improve the accuracy of the immunization data in the EMR.
Offer influenza clinics at all clinical sites, targeting patients/clients over 65 years.	Yes	Flu clinics offered at all sites targeting patients over 65 and patients with multiple health conditions.
Improve access to influenza vaccine for patients/clients over 65 years during all encounters with TFHT care providers.	Yes	Flu vaccine offered at every opportunity at all sites during clinical visits. This was effective in reaching additional patients who did not go to flu clinics.

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
5	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); April 1 2014 - March 31 2015; In-house survey)	91447	80.37	85.00	82.98	Will continue to work towards improvement in patient's involvement in decisions about their care. Measure slightly below FHT target and provincial average (AFHTO D2D 3.0).

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Coordinate efforts with the primary care providers in order to improve patient/client satisfaction with involvement in decisions related to their care and treatment.	Yes	While patient satisfaction is good, further improvements are possible through focusing efforts on engaging patients in their own care. Change ideas for the next fiscal year will include strategies to further address this with the primary care team related to clinical practice.
Provide information through patient newsletter and website about how to get the most out of your primary care provider visit and to be involved in making decisions about their care and treatment during appointments.	Yes	Patient information was provided verbally by the clinical members of the team. Further communication strategies are needed and will be developed to educate patients about how they can be as engaged as they wish to be in decisions about their own care.
Ensure that all sites are collecting patient feedback through the Patient Feedback Questionnaire on a regular basis.	Yes	All patients have the opportunity to provide feedback by a number of means - paper version, website submission and electronically by tablet (currently in pilot stage). This feedback is reviewed by the management team and is incorporated into quality management initiatives.

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
6	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) spend enough time with them? (%; PC organization population (surveyed sample); April 1 2014 - March 31 2015; In-house survey)	91447	90.21	90.00	90.80	Target met and provincial average (AFTHO D2D 3.0) met.

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Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Coordinate efforts with the primary care providers and health care team in order to improve patient/client satisfaction with enough time spent during office visits.	Yes	Time allocated for patient visits in clinical schedule adequate to address most patient's concerns; Care provided is client centred and addresses patient care needs as perceived by the patient.
Educate patients/clients through patient newsletter and website about the full scope of services provided by their Family Health Team.	Yes	Information has been provided verbally to patients. Further communication strategies will be developed to facilitate the ability of patients to engage in their own care and to ensure that their care concerns have been addressed.
Ensure that all sites are collecting patient feedback through the Patient Feedback Questionnaire on a regular basis.	Yes	All patients have the opportunity to provide feedback by a number of means - paper version, website submission and electronically by tablet (currently in pilot stage). This feedback is reviewed by the management team and is incorporated into quality management initiatives.

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
7	Percent of patients/clients who saw their primary care provider within 7 days after discharge from hospital for selected conditions (based on CMGs). (%; PC org population discharged from hospital; April 1 2013 - March 31 2014; Ministry of Health Portal)	91447 X		50.00	50.00	FHT Target met.

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Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Ensure that all patients discharged from hospital will have follow-up assessment within by IHP within 72 hours of discharge.	Yes	88% of patients discharged from hospital were assessed by an IHP within 72 hours of discharge (Q3)
Appointments will be made for all patients discharged from hospital with selected conditions with primary care provider.	Yes	Based on anecdotal information from IHPs and TFHT procedure. Unable to track data at this time.
Evaluate flow of information from acute care to community care, in addition to the clinical information received by the hospital.	Yes	Evaluation identified that discharge notices were not received by the FHT in a timely manner. Meetings held with acute care services and provision of discharge information has improved significantly.

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
8	Percent of patients/clients who responded positively to the question: "The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone else in their office?" (%; PC organization population (surveyed sample); April 1 2014 - March 31 2015; In-house survey)	91447	29.81	50.00	30.54	Performance currently below target and below provincial average of 54% (AFHTO D2D 3.0). Improvement will be achieved through the implementation of new change ideas.

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Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Assess patients/client satisfaction with access to primary care services through patient feedback survey	Yes	Poor performance with this indicator to be reviewed with Quality Management team and new change ideas to be incorporated into workplan for next fiscal year.
Implement advanced access principles for care providers who do not have same day or next day access	Yes	All primary care providers offer same day access when they are in the office. Most providers work part-time in their primary care practice.
Offer Multidisciplinary services through after hours clinic.	Yes	Counselling services have been offered by the Social Workers as well as OTN Specialist's appointments and have worked well. Additional services will be explored in collaboration with the After Hours Clinic.
Assess patient/client usage of after hours clinic and consider in strategies for providing timely, convenient access to care.	Yes	Utilization data has been reviewed. More appointments are in place currently than are utilized by patients.
Assess office client interactions for	Yes	Phone visits and home visits done by more

alternate service delivery models; Implement phone appointments for care providers where appropriate; Implement home visits where appropriate.		providers and IHPs. Group models have been implemented in the Mental Health program and Health Promotion.
Ensure that all sites are collecting patient feedback through the Patient Feedback Questionnaire on a regular basis	Yes	All patients have the opportunity to provide feedback by a number of means - paper version, website submission and electronically by tablet (currently in pilot stage). This feedback is reviewed by the management team and is incorporated into quality management initiatives.

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
9	Percent of patients/clients who visited the ED for conditions best managed elsewhere (BME). (%; PC org population visiting ED (for conditions BME); April 1 2013 - March 31 2014; Ministry of Health Portal)	91447	CB	30.00	5.76	Data from Health Data Branch released in Jan. 2016 for FY 2014-15. New target for next fiscal year will be aligned with actual performance.

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Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Complete case review of all high users of emergency department for patients/clients rostered with the Timmins FHT to determine if more of their health needs can be met through the primary care/community care environment	Yes	Patient Discovery interviews and case review of Health Link patients by primary care provider and team.
Provide in-depth Health Link assessment for patients who have had 15 or more visits to the ED and have been identified as high users; Provide care coordination through the primary care RN for these patients.	Yes	This process has begun through primary care providers and team. Health Links patients will increase as process improves at FHT.

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
10	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?" (%; PC organization population (surveyed sample); April 2015 - March 2016 ; In-house survey)	91447	75.94	75.00	68.05	Currently performance is below FHT target and below provincial average of 88.8% (AFHTO D2D 3.0). Improvement plan will be addressed through change ideas.

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Coordinate efforts with the primary care providers in order to raise their awareness of patient's satisfaction with the knowledge they have gained about their health condition and treatments.	Yes	Data reviewed with PCPs. More emphasis to be placed on action towards improvement in the next fiscal year.
Provide information through patient newsletter and website about how to get the most out of your primary care provider visit, to encourage patients to ask any questions they may have through patient appointments.	Yes	Information provided verbally to patients. Additional communication methods to be developed for patient education.
Ensure that all sites are collecting patient feedback through the Patient Feedback Questionnaire on a regular basis	Yes	All patients have the opportunity to provide feedback by a number of means - paper version, website submission and electronically by tablet (currently in pilot stage). This feedback is reviewed by the management team and is incorporated into quality management initiatives.

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
11	Percentage of acute hospital inpatients discharged with selected CMGs 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. (%; PC org population discharged from hospital; April 1 2013 - March 31 2014; Ministry of Health Portal)	91447	CB	60.00	20.00	Data from Health Data Branch released in Jan. 2016 for FY 2014-15. New target will be aligned with actual performance.

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Improve capacity of IHPs to assist with primary care focused patient care coordination, care planning and health system navigation	Yes	Consistent discharge follow-up process implemented that assists in meeting the discharge needs of patients at high risk of readmission. Continued work needed with acute care facilities to coordinate care efforts.
Increase referral of clients eligible for Telehomecare monitoring.	No	Data not tracked. While referrals continue to occur, it is unknown with regard to any increase in referrals.

2016/17 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

Timmins FHT 300-123 Third Avenue, Timmins, ON P4N 1C6

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target Justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	Improve rate of cancer screening.	Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years	% / PC organization population eligible for screening	See Tech Specs / Annually	91447*	69.9	72.50	To continue to demonstrate realistic improvement with this measure and to continue achieving above average rates that demonstrate leadership with cancer screening.	1)Ensure that all patients eligible for colorectal cancer screening have been notified, provided with education and offered appropriate testing.	Identify eligible patients through EMR search; Notify patient of eligibility; Provide FOBT kits for test collection where appropriate and patient education; facilitate referral for colonoscopy/sigmoidoscopy where appropriate; Monitor progress through Quality Management Committee and data provided on the TFHT Primary Practice Report; Establish process for each TFHT site to review this data with site staff and primary care providers and to monitor process; Harmonization of processes throughout the sites based on both internal and external best practices.	Number of patients eligible for colorectal cancer screening; Number of eligible patients who have had testing; Number of contacts (e.g. calls made, letters sent) to eligible patients	72.5% of eligible patients will have been tested in 2016-17. This is an increase from previous year.	
		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	91447*	69.8	72.50	To continue to demonstrate improvement in this measure and to continue achieving above average rates based on the provincial average (AFHTO D2D 3.0) that demonstrate leadership with cancer screening.	1)Ensure that all patients eligible for Pap smear screening have been notified, provided with education and offered testing.	Identify eligible patients through EMR search; Notify patient of eligibility; Patient provided with education and appointment with IHP or PCP offering Pap smear ; Monitor progress through Quality Management Committee and data provided on the TFHT Primary Practice Report - Establish process for each TFHT site to review this data with site staff and primary care providers and to monitor process; Harmonization of processes throughout the sites based on internal and external best practices.	Number of patients eligible for cervical cancer screening; Number of eligible patients who have had Pap smears; Number of contacts (e.g. calls made, letters sent) to eligible patients.	72.5% of eligible patients will have been tested in 2016-17. This is an increase from previous year.	
	Improve rate of HbA1C testing for diabetics	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months	% / All patients with diabetes	Ontario Diabetes Database, OHIP / Annually	91447*	51	60.00	An increase to 60 % is realistic based on the most recent data from our EMR and goal to improve care for patients with diabetes; Maintain our	1)Develop an EMR tool consistent with accepted internal process and aligned with guidelines to standardize data to improve EMR search capability to identify patients with diabetes	Develop standardized EMR diabetes encounter assistant to facilitate accurate searching of diabetes care; Continue ICD 9 coding of diabetes in EMR.	Number of patients with diabetes who's EMR has not been coded with ICD 9 codes	To ensure that all EMR search data for diabetes is accurate.	

								standard of care above the provincial average.	2)Accurately identify all patients with diabetes in need of diabetes care; Develop recall process to ensure that patients with diabetes have been invited to receive care at 4 month intervals.	EMR search to identify patients aged 40 and over with diabetes; EMR search to identify patients not seen in diabetes clinic in past 4 months; contact patient to arrange labwork and appointment; IHP to provide education & support through diabetes clinic and to monitor all diabetes care recommended through CDA clinical practice guidelines.	Total number of patients on diabetes registry Total number of patients aged 40 and over on diabetes registry Number of patients 40 years and over who have had a HgA1C two or more times in the past 12 months.	Eligible patients will be identified accurately; 60% of patients 40 years and over with Diabetes will have had a HgA1C in the past 12 months.	
									3)Develop a process map for diabetes care to identify steps involved in diabetes care process, time frames, expectations of EMR notification system and to identify roles for each member of the primary care team.	Discuss process at each TFHT site, identify commonalities, identify best practices based on individual office performance with indicator, standardize process through the development of process map, educate staff about new process, implement process.	Completion of process map by March 2017	To standardize method for providing diabetes care across the TFHT to ensure the consistent implementation of CDA clinical practice guidelines.	
	Improve seasonal immunization rates	Percentage of people/patients who report having a seasonal flu shot in the past year	% / PC organization population eligible for screening	EMR/Chart Review / Annually	91447*	CB	CB	Data available for a specific target population. Baseline will be collected in 2016-17 for entire population.	1)Modify method of information collection to increase accuracy of EMR documentation related to seasonal immunization.	Collaborate with local health unit and pharmacies to improve documentation received of seasonal immunizations received by patients; Include patient self-report as a method to populate EMR on seasonal immunizations received; Develop survey mechanism to collect information on influenza immunization update.	Number of patients who have received seasonal immunizations. Number of patients eligible to receive seasonal immunizations.	To ensure that documentation of seasonal immunization is accurate.	
									2)Increase patient access to receipt of seasonal immunizations.	Offer influenza clinics at all clinical sites; Offer to provide immunization at all clinical visits during influenza season.	Number of patients who received seasonal immunization. Number of patients eligible to receive seasonal immunization. Percentage of patients who received seasonal immunization. Number of patients immunized in clinics, in clinical office setting, outside of FHT	To increase the number of patients who are protected against seasonal influenza and pneumonia.	
	Reduce hospital readmission rate for primary care patient population	Percentage of acute hospital inpatients discharged with selected HIGs that are readmitted to any acute inpatient hospital for non-elective patient care	% / PC org population discharged from hospital	DAD, CAPE, CPDB / April 2014 – March 2015	91447*	20	18.00	Improvement will be demonstrated in this measure through enhancing discharge follow-up and through	1)Collaborate with acute care facilities to flow patient discharge information to primary care providers office within 24 to 48 hours of discharge	Continue to meet with TADH to improve quality and timeliness of discharge information provided to primary care provider office; track patients for who no information was received; Implement e-notification, POI and any other electronic methods of notification and information sharing.	Number of patients discharged from acute care facilities Number of discharge notices received. Time elapsed between patient discharge and receipt of discharge notice.	To decrease the time between hospital discharge and Primary Care Provider notification.	

		within 30 days of the discharge for index admission, by primary care practice model.						more specific follow-up of Health Link patients; To be consistent with the provincial average of 16.83 (FY 2014/15) within 2 years.	2)Standardize discharge process across the TFHT; improve capacity of IHPs to provide care coordination and health system navigation for patients after discharge including facilitating connectivity to support services (ex. Home care, Telehomecare)	Investigate discharge planning process at each TFHT clinical site; Document procedure through process map; Provide staff education on community services; Contact patient within 24 hours of discharge or as soon as discharge notice is received; Provide appointment with PCP within 7 days of discharge; Track hospital readmissions within 30 days (all causes); Identify reason for readmission; Modify follow-up procedure based on the reasons and based on continuous improvement principles.	Number of patients who were contacted by IHP within 24 hours of discharge Number of patients for whom discharge information was not received within 24 hours of discharge. Number of patients who saw their PCP within 7 days of discharge. Number of TFHT patients identified as Health Link patients as a result of 4 or more hospital admissions in a 12 month period.	To ensure that patients discharged from acute care facilities receive the support they need to transition successfully home and to care provided in the community.	
Efficient	**Decrease Emergency Department visits for conditions best managed elsewhere (BME)**	Percentage of patients or clients who visited the emergency department (ED) for conditions "best managed elsewhere" (BME)	% / PC org population visiting ED (for conditions BME)	DAD, CAPE, CPDB / April 2014 – March 2015	91447*	5.76	4.50	Will demonstrate improvement in this outcome through tracking of ED visit data for FHT patients, Health Links initiatives and through ED diversion strategies; To be more consistent with the provincial average of 2.0% (FY 2014/15)within 3 years.	1)Evaluate ED use and reason for visit by TFHT patients to determine trends	Review all available data from EMR, TADH & provincial reports; Evaluate trends in ED use by TFHT patients; Evaluate access to appointment with primary care providers based on clinical schedules and appointments at the after hours clinic;	Number of TFHT patients who accessed the ED Number of TFHT patients who accessed the ED by type of diagnosis Number of TFHT patients who accessed the ED by CTAS level	To identify ED utilization patterns of TFHT patients and to determine possible available alternatives.	
									2)Provide enhanced assessment, care planning and care coordination for TFHT patients who are determined to be Health Link patients and high users of the ED.	Implementation of a Health Link philosophy and Health Link assessments through trained RNs; Development of HL assessment tools in EMR in searchable format; Development of coordinated care plan through EMR; Assist patient with care coordination and system navigation in order to link patient to services that will meet their needs.	Number of TFHT patients who are identified as Health Link patients by utilizing the ED more than 15 times in a 12 month period. Number of TFHT patients for whom HL assessments have been completed by the RNs. Number of HL patients who have decreased their use of the ED.	Decrease the number of TFHT patients who frequent the ED for conditions that could be managed in the primary care office.	
									3)Facilitate access to same day appointments with a primary care provider at all clinical sites and for all TFHT patients through the provision of cross coverage by all primary care providers.	Review data and collaborate with PCPs to review access to same day appointments for all TFHT patients; Collaborate with TADH ER to redirect patients back to PCP office where appropriate; Provide education to patients regarding same day service, the After-Hours clinic as well as appropriate use of ED.	Number of patients for whom same day appointments were provided Number of patients who were diverted from ED who received same day appointments in PCPs office. Number of patients seen in After-Hours clinic.	To provide TFHT patients with the opportunity to see a primary care provider within the TFHT for most conditions that can be addressed in a primary care setting.	

Equitable	**Other**	Add other measure by clicking on "Add New Measure"	Other / Other	Other / other	91447*	CB	CB	No data collected at this time.	1)Determine available methodologies to document patient data in the EMR related to situations in which patients may not have equitable access to health care.	Work with EMR vendor to develop fields in EMR to collect data on a patient's association with specific population groups and determinants of health (ex. income, housing); Assess and document demographic patient data in EMR based on patient self-report.	% of patient charts updated with one or more new demographic fields related to the social determinants of health % of patients with selected conditions who identify with one or more identified groups or determinants of health.	To ensure that patient information related to the identified groups or determinants of health is available in the EMR to include in care planning and the development of programs and services.	
	Access to Improved Health Status Equitable for all Patients	Percent of patients with selected conditions who self-identify association with one or more groups in which equitable access to health care may be a challenge.	% / All patients	EMR/Chart Review / April 1 to March 31	91447*	CB	CB	Collecting data through patient assessment and documentation in EMR	1)Determine available methodologies to document patient data in the EMR related to situations in which patients may not have equitable access to health care.	Work with EMR vendor to develop fields in EMR to collect data on a patient's association with specific population groups and determinants of health (ex. income, housing); Assess and document demographic patient data in EMR based on patient self-report.	% of patient charts updated with one or more new demographic fields related to the social determinants of health % of patients with selected conditions who identify with one or more identified groups or determinants of health.	To ensure that patient information related to the identified groups or determinants of health is available in the EMR to include in care planning and the development of programs and services.	
Patient Experience	**Improve Patient Experience: Opportunity to ask questions**	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?"	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91447*	68.05	75.00	To move towards the provincial benchmark for this indicator; Continue to demonstrate improvement in the patient's experience and improvement of the patient's understanding of their recommended treatment	1)Provide TFHT patients with the opportunity to have their questions answered regarding recommended treatment during their visit to their primary care provider and/or IHP.	Collaborate with PCPs and IHPs to ensure that TFHT patients are provided with the opportunity to ask questions and to discuss care & treatment until they are comfortable with their level of understanding; Patient education provided through all patient communication methods; Organize a formal feedback session in a format to be determined to better understand patient's priorities in terms of their expectations of our role in their health; Incorporate some of the top priorities in our QIP next year.	Number of TFHT patients who respond positively to the question on the patient satisfaction survey. Number of providers and IHPs who have altered appointment time slots to accommodate more discussion.	To ensure that patients are aware that they can ask questions about their treatment and that it is in their best interest to fully understand treatment options. Performance of the TFHT based on comparison of the TFHT survey results to the provincial average	

	Improve Patient Experience: Patient involvement in decisions about care	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 2015 - March 2016	91447*	82.98	88.00	To meet the provincial benchmark for this indicator.	1)Support an organizational culture at the TFHT that values patient involvement in decisions about their care and treatment.	Collaborate with PCPs and IHPs to encourage consultation with the patient and their caregivers in decisions about the patients care and treatment; Provide professional development for staff; Provide clinical staff with the results of patient feedback surveys from their office; Provide patient education that encourages their involvement in decisions. Communicate to patients about the changes that result from their feedback.	Number of TFHT patients who respond positively to this question on the patient feedback survey. Performance of the TFHT based on comparison of the TFHT survey results to the provincial average	To promote self-care amongst TFHT patients	
	Improve Patient Experience: Primary care providers spending enough time with patients	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?"	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91447*	90.26	91.00	To maintain current performance with this indicator.	1)Ensure that the time spent with patients is enough for patients to have their questions answered and for them to be involved in decisions about their care and treatment.	Collaborate with PCPs and IHPs to ensure that they have provided the patient with the opportunity to be involved in discussion and decisions about their care and to ask any questions before ending the appointment; Monitor length of appointments to determine if appoint time slots needs to be altered; provide phone appointments and/or appointments with members of primary care team to increase patient contact for complex patients. Share results of patient feedback surveys with PCP and team.	Number of TFHT patients who respond positively to this question on the patient feedback survey. Performance of the TFHT based on comparison of the TFHT survey results to the provincial average	Improve patient comfort with the level of care and support provided to them by their primary care team related to their health concerns.	
Timely	**Improve 7 day post hospital discharge follow-up rate for selected conditions**	Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions.	% / PC org population discharged from hospital	DAD, CIHI / April 2014 – March 2015	91447*	50	51.00	To demonstrate improvement with this indicator through improved discharge follow-up by primary care team; Maintain target and performance above the provincial average of 28.30% (FY 2014/15).	1)Collaborate with acute care facilities to flow patient discharge information to primary care providers office within 24 to 48 hours of discharge; Develop process map of discharge follow-up process to standardize across the TFHT.	Continue to meet with TADH to improve quality and timeliness of discharge information provided to primary care provider office; track patients for whom no discharge information was received; Implement e-notification, POI and any other electronic methods of notification and information sharing; Implement discharge follow-up by IHPs.	Number of patients discharged from acute care facilities Number of discharge notices received. Time elapsed between patient discharge and receipt of discharge notice. Number of patients who saw their PCP within 7 days of discharge.	To ensure that all patients with selected conditions will see their primary care provider and team within 7 days of discharge to assess/determine that treatment and community services arranged post acute care admission are meeting their health needs.	

	Improve timely access to primary care when needed	Percent of patients/clients who responded positively to the question: "The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone else in their office?"	% / PC organization population (surveyed sample)	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period available)	91447*	30.54	40.00	To improve patient access to timely appointments with their primary care provider or someone else in the office when needed.	1)Same day appointments will be available at all clinical sites through cross coverage by PCP and team and will be offered to patients with acute illness or who request these appointments due to a health concern.	Availability at each site will be assessed; Available data collected through clinic schedules to be reviewed to determine how many same day appointments were filled; Opportunities for cross coverage to be discussed with each site; Patient education to be provided informing patients that this opportunity is available to them; Communicate to patients about all existing services; Patient feedback survey results will be shared with PCPs, IHPs and team.	Number of same day appointments filled at each site. Number of patients who respond positively to this survey question. Number of patients seen in After-Hours clinic.	To provide all TFHT patients with appointments to see their PCP or IHP on the same day if this is needed or requested by the patient.	