Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 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 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	Number of patients identified as meeting Health Link criteria who have a coordinated care plan documented in the EMR. (Number; Patients meeting Health Link criteria; Last consecutive 12 month period; In house data collection)	91447	178.00	260.00	137.00	Stats calculated on calendar year 2018. No benchmark. Target not met due to the devolution of the Health Link program during this fiscal year. With a change in provincial criteria for Health Link, the TFHT was unable to meet the requirements of the program as a different model had been adopted initially by the Timmins Health Link.

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Change Ideas from Last Years QIP (QIP 2018/19)	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?
Develop a process to populate the EMR when patients who meet the health link criteria are identified.	Yes	Health Link clients can be identified based on complex health conditions, palliative diagnosis, frailty, frequent ED visits or hospital readmission. Once identified, the patient can be tagged in the EMR as eligible for a health link approach to care. As a result, numbers of health link patients can be searched and patient lists can be acquired.

Collaborate with primary care team to develop a process to offer a health link approach to care for patients who meet the health link criteria and would benefit from a health link approach.	Yes	Health Link approach promoted with palliative and geriatric populations for patients who would be eligible according to the health link criteria.

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2	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 2017 - March 2018; In-house survey)	91447	93.80	94.00	94.26	Stats are calculated on calendar year 2018. Target met for this indicator and performance was above that of the NELHIN (88.6%), based on D2D 6.0.

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Support an organizational culture at the TFHT that values patient involvement in decisions about their care and treatment.	Yes	This is a practice in which our primary care team excels. Patients report on the patient surveys that they are satisfied with their involvement in decisions about their care and treatment. A culture of client care that involves patients is promoted within the TFHT as opportunity arises.

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3	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; Annually; See Tech Specs)	91447	23.90	22.00	24.20	Stats based on Q3 reporting - Schedule A (as complement of the percentage of patients screened). Performance was similar to previous year and target improvement was not achieved. However, the FHT continues to perform better than the NELHIN (28.7% based on D2D 6.0).

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Ensure that patients 50 to 74 years who are eligible for Colorectal cancer screening have been notified, provided with education and offered testing.	Yes	Change ideas resulted in performance improvement with this indicator. Therefore, strategy for change will be continued into 2019-2020 with a continued emphasis on increasing rates of colorectal screening through all methods available.

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4	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; Annually; CCO-SAR, EMR)	91447	80.20	82.00	80.90	Target was not reached for this indicator however, on a 36-month period, our performance is 9 percentage points over the NELHIN average based on D2D 6.0.

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Ensure that patients eligible for Pap smear screening have been notified, provided with education and offered testing.	Yes	Patients eligible for Pap smear can be easily identified through EMR search. While performance is higher than the NE LHIN average, improvement was not demonstrated with this indicator. A review of pap clinics offered will determine if FHT staff have offered the maximum clinics possible based on their clinical capacity.

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5	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); April 2018 - March 2019; In-house survey)	91447	28.70	31.00	29.75	Stats calculated on calendar year 2018. The NELHIN average is 41% based on D2D 6.0.

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Improve patient satisfaction with access to appointments with primary care providers and team when needed by patient.	Yes	Slight improvement has been shown in patient's access based on patient survey data. However, change ideas were not effective in facilitating significant improvement with this indicator. Additional efforts will be required in 2019-2020 to improve performance.

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6	Percentage of patients who have had a 7-day post hospital discharge follow up for selected conditions. (CHCs, AHACs,NPLCs) (%; Discharged patients ; Last consecutive 12 month period; See Tech Specs)	91447	72.00	72.00	74.00	Our performance of 74% is strong as it exceeds our target of 72% and is 20 percentage points higher than the NELHIN average of 54% based on the same source (Health Data Branch for FY 2017-18).

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Collaborate with acute care facilities to improve quality (increased information) and timeliness of discharge information provided to primary care provider office.	No	We still have many Primary Care Providers that are not enrolled in HRM e-notifications which result in missing notifications from sending facilities including our local hospital. Even for providers enrolled to HRM, a number of discharge notifications are only received by fax which stresses the need for further collaboration.
Standardize process for discharge follow-up across TFHT to ensure that patients have been contacted and/or seen in clinic within 7 days post hospital discharge.	Yes	The process was standardized towards fiscal year end to use the eNotifications whenever the Provider is enrolled. This is going to increase the number of follow-up within 7 days. Some work still needs to be done to standardize clinical documentation i.e. the content of the follow-up depending on the reason for hospitalization.

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7	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. (%; Discharged patients with selected HIG conditions; April 2016 - March 2017; DAD, CAPE, CPDB)	91447	18.00	17.50	15.00	Our performance of 15% is good given that it went down by 3 percentage points and exceeds our target of 17.5% as well as the NELHIN average of 19% (both based on Health Data Branch FY 17/18). We will confirm this trend by looking at the overall readmission rate within 30 days and 1 year in the next MyPractice Report (regardless of the reason for hospitalization), as well as our internal measures with up-to-date data. In the meantime, we will improve our follow-up process as documented in this QIP workplan which could help further reduce our readmission rate.

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Identify TFHT patients with selected HIG conditions who were readmitted within 30 days of discharge.	Yes	Our new standardized template used across the sites include the identification of HIG as well as the patients that were readmitted within 30 days: this will allow us to collect and analyze more granular data in the coming years.

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8	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; Annually; ODD, OHIP-CHDB,RPDB)	91447	70.80	72.00	71.50	Stats based on Q3 reporting - Schedule A. The NELHIN and FHT averages are 44.9% and 59.2% respectively based on the PCP Report as of March 31, 2018. The FHT continues to perform well above the NELHIN average despite lack of service from the Diabetes Education Centre.

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Engage patients with diabetes in available diabetes programs through the primary care team and specialized diabetes care organizations, that includes close monitoring of HbA1C results.	Yes	Slight improvement was demonstrated with this indicator. A change in diabetes programming available in our community has impacted care of our patients with diabetes in 2018-2019. Most patient follow-up has been provided by our primary care team without the clinical capacity to increase services to compensate for those lost in the community.

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9	Percentage of patients with medication reconciliation in the past year (%; All patients; Most recent 12 month period; EMR/Chart Review)	91447	CB	CB	NA	Progress has been made with acquiring information about current practice for medication reconciliation across primary care team and with retail pharmacists.

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Develop routine processes for the completion of medication reconciliation by primary care team post discharge from hospital and on an annual basis.	No	Some progress was made on implementing this change idea this year with preparation completed for full implementation in 2019-2020. More information is available regarding current practice of each office for the completion of medication reconciliation by primary care team members. Practice varies from one office to another.
Develop standardized process that ensures that high risk patients (includes patients with multiple medications) will receive medication reconciliation at regular primary care visits/encounters.	Yes	Medication reconciliation is completed by primary care providers at most sites for patients on multiple medications and is increasing in frequency upon discharge. Referral for some patients made to retail pharmacies for medication reconciliation. More work to be done in standardization in 2019-2020 as this will require a multi-year effort to achieve significant improvement.

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10	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. (%; Discharged patients ; Last consecutive 12 month period; EMR/Chart Review)	91447	42.50	44.00	47.60	Target was exceeded for the follow-up done on the patients discharged from the local hospital. Next year's performance will be more reflective on actual follow-up on all patients since HRM notification will be included in the denominator.

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Continue to work with hospitals to achieve consistent receipt of discharge information (within 48 hours) for all patients discharged from hospital.	Yes	Number of electronic discharge notifications received for TFHT patients improving. Some discharges still received by fax. Receipt of discharge information still lagging however, patient status is assessed during discharge follow-up by nursing staff. Work will continue with this change idea into 2019-2020.