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

Port Hope CHC 99 Toronto Road, Port Hope, ON L1A 3S5

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

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**	Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach	A	% / Patients meeting Health Link criteria	In house data collection / most recent 3 month period	91430*	CB	CB	Clinicians in the Primary Care Clinic are just getting trained and receiving access to the CHRIS HPG Health Links Portal for submission of	1)Train Primary Care staff (Providers and Allied Health) on the Health Links Framework. Train Primary Care staff in the use of the	Conduct Meetings with Primary Care Providers (PCPs) and Registered Practical Nurses (RPNs) to discuss the Health Links Framework for Primary Care Clinic clients. Conduct meetings with Geriatric Assessment and Intervention Team (GAIN) members to discuss Health
										2)Identify Primary Care clients meeting Health Link criteria and pilot 1 CCP per Primary Care Provider. Discuss Coordinated Care	Use the AOHC BIRT Primary Care Dash Board to identify clients with more than 4 chronic conditions who have attended for multiple appointments. Use NOD (to identify which clients in the above list are using multiple services) and could benefit from a health link approach.
	Effective transitions	Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification	P	% / Discharged patients	EMR/Chart Review / Last consecutive 12 month period	91430*	76	80.00	We feel that by better capturing data related to follow-up appointments	1)Contact all clients (for whom we receive a timely discharge notice) with-in 7 days and follow-up via the phone to determine the	Utilize the RPN's that work within the clinic to conduct follow-up phone calls, provide health teaching or advice, and book appointments when necessary.
Equitable	**Population health - colorectal cancer screening**	Percentage of Ontario low income screen-eligible individuals, 50-74 years old, who were overdue for colorectal screening in each calendar year	C	% / PC organization population eligible for screening who have a low income level	EMR/Chart Review / January 1, 2018 - December 31, 2018	91430*	CB	CB	Currently the Community Health Centre has insufficient data on income levels to adequately assess the current performance for	1)Increase the percentage of clients for whom income level is documented in the electronic medical record (EMR)	Use the "We Ask Because We Care" client sociodemographic form that is utilized by other Community Health Centres within Ontario to collect and update income information in the client record. Ask primary care clinicians to collect this information at
										2)Standardize the use of social en-codes (e.g. Poverty) used by providers to document on the assessment, treatment, and	Provide clinicians with direction and standard en-code designations to be used in circumstances where income level plays a role in the ability of the client to manage disease or improve well being. This will provide standardized information that can be collected from the
	Population health - diabetes	Number of Indigenous clients who receive one-on-one diabetes education and care in each calendar year.	C	Number / Clients	EMR/Chart Review / January 1, 2018 - December 31, 2018	91430*	17	30.00	The team member will visit the Alderville Community once per month. The first half of the previous year was spent in building rapport and trust and	1)Increase advertising (in partnership with Indigenous clients) of diabetes services being offered in the community.	Offer monthly groups and opportunities for individual to attend. Ask clients attending services to provide feedback regarding satisfaction with services. Ask clients for input on how to reach other members of the community who are in need of Diabetes education. Ask
										2)decrease barriers to access by conducting home visits	When transportation is reported as a barrier to access the team member will offer a home visit as an option
Patient-centred	**Person experience**	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	91430*	95	95.00	See change idea.	1)We have consistently performed well in this area and constantly receive positive feedback from clients about their	We have consistently performed well in this area and constantly receive positive feedback from clients about their satisfaction with being equal partners in their care. The CHC model and philosophy of care embraces this as a standard of practice and all providers working in this

Timely	**Timely access to care/services**	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	91430*	70	70.00	Please see change idea.	1)Please see comments.	Please see comments.
		Increase the primary care panel size (number of individuals currently without access to a primary care provider) by rostering new clients to Nurse Practitioners and Physicians at the Port	C	% / Clients	EMR/Chart Review / March 1/18 - February 28/19	91430*	91	96.00	Relative to no. of providers, support staff and improvements in workflow while considering limitations (such as no. of exam rooms per provider) this	1)Continue to optimize the use of allied health professionals to their full scope of practice in order to efficiently use nurse	Use nurses working in the clinic to conduct pap tests, do wound care, provide health education as much as possible
										2)Schedule appointment slots in each providers schedule for the monthly uptake of new clients.	Continue to use the Urgent Day Clinic (UDC) to see clients who need same day/next day access. By balancing the supply with demand for these appointments providers are able to allot time in their schedules for new clients to obtain timely access to a

Process measures	Target for process measure	Comments
)		
Number of staff who have received training by attending meetings, completing modules, and participating in process development	18 staff members will be trained and educated	
Measure the number of CCPs in place for Primary Care clients for each provider. Measure the number of CCPs in place for GAIN Team clients as a percentage of the number of GAIN identified clients meeting the criteria for a health link approach.	7 CCPs for Primary Care clients (during the Pilot Phase) 30 CCPs for GAIN clients	
Track the percentage of phone calls made by the RPN's to clients for whom a discharge notice was received within 48 hours. Track the percentage of clients who received a face-face encounter with a primary care provider within 7 days of receiving a timely hospital	90 % of those clients for whom we have received a timely discharge notice (48 hours)	
Percentage of clients who have completed the "We Ask Because We Care" form and this has been recorded in the EMR.	80% of all new clients will have income level recorded in their medical record	
Number of clients eligible for cancer screening who have identified poverty as a social issue that affects their health condition or ability to access necessary resources to access treatment/services.	100% of primary care providers will report that they have been actively using the	
Number of unique Indigenous individuals accessing diabetes services at Alderville.	30 Unique individuals	
Number of individuals receiving home visits and accessing service who would otherwise not have received service	CB	It is hard to predict the number of clients for whom this may be a feasible
We have consistently performed well in this area and constantly receive positive feedback from clients about their satisfaction with being equal partners in their care. The CHC model and philosophy of care embraces this as a standard of practice and all providers working in this	We have consistently performed well in this area and constantly receive	We have consistently performed well in this area and constantly receive

Please see comments.	Please see comments.	Clients who are sick and call into the CHC in need of an urgent appointment are
Number of new patients seen in primary care clinic	14 new clients (approximately 2 per provider) will be seen in the clinic each month. The	
Number of new clients seen by each provider on a monthly basis.	Minimum of 14 new clients brought into the clinic each month for a twelve month	