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

South Georgian Bay CHCs 202-14 Ramblewood Drive, Wasaga Beach, ON L9Z 0C4

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	Measure			
Issue	Measure/Indicator	Type	Unit / Population	Source / Period
; must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicato				
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
Population health - cervical cancer screening	Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month	A	% / PC organization population eligible for screening	CCO-SAR, EMR / Annually
Population health - colorectal cancer screening	Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for colorectal	A	% / PC organization population eligible for screening	See Tech Specs / Annually
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
Equity-Events Addressing Barriers Attended	Number of initiatives, events, advocacy opportunities, and committee meetings attended that address	C	Number / Initiatives,events, committee meetings, advocacy	In house data collection / Annually
Equity-Impact Assessments	Percentage of Health Equity Impact Assessments completed on new initiatives, policies and	C	% / PC organization population (surveyed sample)	In-house survey / Annually
Equity-Poverty Screening	Percentage of positive Poverty Screening Tool used that that result in a form completion or referral made	C	% / Tools Used that result in a referral	In house data collection / Annually
Equity-Target Population	Percentage of CHC target population reached in programs	C	% / PC organization population (surveyed sample)	In-house survey / Annually

	Population Health-Breast Cancer Care Screning	Percentage of eligible female clients, aged 50 and over, who completed a mammogram in the	C	% / PC organization population eligible for screening	In house data collection / Annually
Timely	**Timely access to care/services**	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018

				Change
Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)
›r) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (				
91570*	CB	CB	Current performance cannot be gauged due to lack of consistency in	1)1. Work with the local hospital to ensure they understand the role of SGBCHC including Nurse Practitioners 2. Develop a
91570*	88	95.00	Target decided based on prior year performance and corresponds with M-SAA	1)1.Increase the rate of cervical cancer screening in eligible women
91570*	11	10.00	Target is set based on prior year performance and corresponds with M-SAA target	1)Decrease the percentage of clients who are overdue for colorectal cancer screening
91570*	83	85.00	Target adjusted according to past performance	1)1.Maintain/slightly increase the percentage of clients with diabetes, aged 40 and over, with two or more A1c tests within the past 12 months
91570*	CB	CB	This is a new indicator for the SGBCHC and therefore baseline must be	1)To focus the team's advocacy work on the factors that impact clients' health inequities
91570*	CB	CB	This is a new indicator for SGBCHC and therefore baseline data must be	1)To begin using the Health Equity Impact Assessment
91570*	CB	CB	This is a new indicator for the SGBCHC therefore baseline data must be	1)To increase use of the Poverty Screening Tool and develop procedures for follow-up (filling out ODSP forms, referral to partner
91570*	CB	CB	This is a new indicator for the SGBCHC and therefore baseline must be	1)To begin using the standard program evaluation to track whether programs are reaching target population

91570*	76	85.00	Target based on past years performance and corresponds with M-SAA target	1)Increase the percentage of eligible female clients, aged 50 and over, who have completed a mammogram in the previous two year period
91570*	62	68.00	Target set based on percentage of improvement to be obtained in the upcoming	1)1. To improve office efficiencies by exploring available tools/strategies (eg: Advanced Access techniques) 2. Improve understanding of

Methods	Process measures
add any other indicators you are working on)	
1. The Clinical Manager will work with the hospital to review the role of the CHC and to ensure all providers are registered within the hospital database 2. All PHCP's will notify the clinical nurse when they receive a hospital admission report as well as discharge report 3. The Clinical	Number of hospital admissions/discharges compared to the number of clients who are seen within 7 days post-discharge
1. Create searches through the EMR to be automated and accurate 2. Create a recall system for clients overdue for screening 3. Maximize use of reminder system within EMR 4. Consider culture sensitivity training for staff in order to identify outreach strategies 5. Maximize every client visit by	Percentage of eligible women, aged 21-69 years old, who completed at least one Pap test in a 42 month period
1. Create searches through the EMR to be automated and accurate 2. Create a recall system for clients overdue for screening 3. Maximize use of reminder system within EMR 4. Consider cultural sensitivity training for staff to identify new outreach strategies 5. Maximize every client visit by	The percentage of eligible clients, aged 50-74 years old, who are overdue for colorectal screening in the calendar year
1. The diabetes team will work together to further develop the system for recalling and connecting with diabetic patients 2. The Data Management Coordinator will work with the diabetic team to ensure a reminder system is put in place when a clients's A1C test is due 3. The Diabetic	The percentage of clients with diabetes, aged 40 and over, with two or more HbA1c tests within the past 12 months
1. Data management coordinator will develop effective tracking method for recording attendances 2. Clinical manager to train staff on which advocacy, committee meetings, initiatives and events can be counted as 'addressing barriers that impact health equity' 3. Staff to	Total number of initiatives/committee meetings/advocacy opportunities attended or organized by any staff member, that address barriers that impact client health equity
1. The clinical manager will train all staff on the use of the Health Equity Impact Assessment 2. Policies and procedure will be developed to support staff to use HEIA on new initiatives, policies and programs 3. Support will be provided by clinical manager until staff feel comfortable	The number of new initiatives, policies and programs that complete an HEIA, over the total number of new initiatives, policies and programs.
1. Clinical manager to organize training to all staff on the Poverty Screening Tool, 2. Clinincal manager to organize in-depth training for appropriate staff (NPs, Clinical Nurse, Health Promoter, Patient Navigator) on Poverty Screening Tool and Benefits Screening Tool (see	Total number of forms completed/referrals over the total number of individuals with a positive result from the Poverty Screening Tool.
1. Data management coordinator will develop effective data analysis method for completed evaluations 2. Health promotion staff, supported by the Clinical Manager will develop a process and policy regarding using the standard evaluation 3. Staff will begin using the Standard Evaluation	The number of program participants that meet one of the target population boxes in the standard evaluation, over the total number of program participants that complete the evaluation.

1. Create searches through the EMR to be automated and accurate 2. Create a recall system for clients overdue for screening 3. Maximize use of reminder system within EMR 4. Consider cultural sensitivity training for staff to identify new outreach strategies 5. Maximize every client visit by	The percentage of eligible female clients, aged 50 and over, who have completed a mammogram in the previous two year period
Explore and implement aspects of advanced access, review/maximize provider schedules, examine complexities of client care, optimize use of entire care team, explore alternate care models, maximize use of the EMR, reduce backlog, promote continuity and explore/reduce no-show	Percentage of clients who report they are able to see a doctor or nurse practitioner on the same day or next day, when needed over a 12 month period

Target for process measure	Comments
Baseline rate of hospital discharges will be established by December 31, 2018	
95% of eligible women, aged 21-69 years old, will have completed at least one Pap test in a 42	
Ten percent or less of total eligible clients, aged 50-74 years, will be overdue for	
85% of clients with diabetes, aged 40 and over, will have two or more HbA1c tests completed in a	
Baseline data will be established to determine to total number of initiatives/committe	
Baseline data will be established of the number of new initiatives, policies and programs that	
Baseline data of the total number of forms completed/referrals made over the total	
Baseline data will be collected for the number of program participants that meet one of the	

85% of eligible female clients, aged 50 and over, will have completed a mammogram in the	
68% of clients surveyed will report that they are able to see a doctor or nurse practitioner	