2019/20 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

Timmins FHT 300-123 Third Avenue

	Measure									Change				
Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned Improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
lls must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Efficient	Percentage of patients who have had a 7-day post hospital discharge follow up for selected	P	% / Discharged patients	See Tech Specs / Last consecutive 12-month period.	91447*	74				1)				This indicator is not required for FHTs.
	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.	91447*	47.6	65.00	The TFHT will focus on this indicator as a primary indicator for this year. With the improvement in receipt of discharge Information through HRM, it is expected that there will be significant improvement. Therefore, the improvement is even more ambitious than the target suggests since the baseline will increase significantly.	Timmins & District Hospital - Medical Core Committee	1)Ensure that all primary care providers have registered to receive e-notification.	Facilitate signing of registration forms; Submit registration forms to Ontario MD; Provide education to primary care providers to promote the benefits of receiving e-notification	Number of primary care providers who have registered for receipt of e-notification.	39 of 40 primary care providers will receive discharge information through e-notification	This will facilitate the smooth transition from POI to HRM.
										2)Continue to work with Timmins & District Hospital to achieve consistent e-notification for all discharged TFHT patients.	Collaborate with Timmins & District Hospital to ensure the consistent delivery of discharge e-notifications. Reconcile the fax notifications with the e-notifications.	Number of faxes received for which no e-notification was received.	It would be expected that the number of missing e-notifications would be zero as of Q4, 2019-2020 so that the fax notification can be discontinued.	Receipt of e-notification upon discharge is not received consistently for all TFHT patients discharged from Timmins & District Hospital by those primary care providers who are enrolled in HRM. Some discharge notifications continue to be received by fax only.
										3)Develop standardized discharge follow-up process.	Identify TFHT-wide current practice for discharge follow-up through QI Clinical Site Lead involvement. Standardize nursing assessment and elements to be included in comprehensive discharge follow-up. Identify how a comprehensive discharge assessment is completed at each site and by which primary care team member.	Number of key clinical measures standardized within the discharge assessment.	3 clinical measures will be standardized within the discharge assessment.	

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	Timely	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	P	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	91447*	29.75	35.00	While target represents an ambitious improvement, our ambition this year is to optimize the existing unused same day appointments to better match patients to available same day services. We expect that this will result in a 5% absolute increase in this indicator.		1)Provide training to staff on the principles of good customer service.	Train staff members on providing excellent patient experience by determining the nature of the patient's need for the appointment and facilitating rapid access when appropriate. Encourage staff to book same day/next day appointments and to provide good customer service during phone communication with patients.	Improve patient experience with reception encounters when patients contacting primary care provider offices.	Increase patient satisfaction by 5% on patient experience survey (very good or excellent) answers specifically on the question related to patient's contact with reception staff.	
											2)Educate patients about how they can access same day/next day appointments when needed.	Develop patient education campaign through website, social media, public announcements and printed materials, to distribute information about how to access same day/next day appointments.	Number of people from the community reached through each media of campaign.	10,000 people will access campaign information through one of the multiple media options.	
											3)Improve patient satisfaction with access to appointments.	Offer same day or next day booking opportunities in all offices, provided by a member of the primary care team. Monitor use of appointment slots to determine if number available meets patient demand.	Percentage of unused same day/next day appointment slots.	Decrease the number of unused same day appointment slots by 20% compared to a reference period (to be selected early in fiscal year before training).	Monitor progress through quarterly patient survey stats.
Theme II: Service Excellence	Patient-centred	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?	P	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	91447*	94.26				1)				Performance is excellent with this indicator. An organizational culture that values patient involvement in decisions about the care and treatment will continue to be promoted.

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Theme III: Safe and Effective Care	**Effective**	Proportion of primary care patients with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	91447*	0.9	0.70	This current performance of 90% shows that the Timmins Integrated Palliative Care Team does comprehensive assessment in a near-systematic way after referral. One issue is the lack of an identification process that is documented in a standardized way across the team and not tied to the referral process. At this stage, we would prefer if patients were labelled as "palliative" earlier and more often rather than necessarily focusing on the speed of the assessment	NE LHIN Home & Community Care, Victorian Order of Nurses - Pain & Symptom Management, Dr. Patrick Critchley - Family Physician - palliative lead, Timmins & District Hospital - Timmins Hospice Centre	1)Build capacity in decision making among primary care providers related to earlier identification of patients with life-threatening illness.	Provide education to primary care providers that supports decisions and referral to the integrated team for patients with life-threatening illness. The Timmins Integrated Palliative Care Team to provide consultation services to providers as needed.	Number of training events organized. Number of providers available for consultation.	1 event will be organized. 9 Providers will be available for palliative care consultation.	
										2)Identify patients with life-threatening illness earlier in the illness trajectory.	Identify patients with multiple co-morbidities including at least one life-threatening condition, through EMR search and chart review. Complete patient case review with patient's primary care provider and palliative team to determine if palliative identification is appropriate.	Increase in the number of patients referred to the palliative program with a PPS score over 60. Number of patients with a cancer diagnosis/other diagnosis.	60% of patients referred to the TIPC team will have a PPS score of 60 or higher at time of referral. 40% of patients identified have an other disease diagnosis vs. cancer diagnosis.	
										3)Standardize the method of documentation that identifies that a patient is palliative across the TFHT.	Develop documentation tool that allows for identification of patient without referral to palliative care program.	Number of new patients identified. Percentage of new patients identified relative to past fiscal year.	Increase in percentage of new patients identified by 30%.	

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								hence the lower target.		4)Complete comprehensive, holistic, multidisciplinary assessment through collaboration with and referral of patients with progressive life-threatening illness to the Timmins Integrated Palliative Care Team.	Collaborate with Timmins Palliative Care service providers through participation in the Timmins Palliative Care Resource Team. Complete the PPS & ESAS assessments at appropriate intervals.	Number of patients with a PPS & ESAS completed.	Increase the number of patients with a PPS & ESAS recorded by 30%.	The Timmins Integrated Palliative Care Team is an new initiative that promotes integrated services for patients. Collaborative partnerships exist between Home & Community Care, Palliative Physicians, Timmins FHT, Timmins & District Hospital (hospice), Horizon's Volunteer Visiting as well as others.
Safe	Percentage of non-palliative patients newly dispensed an opioid within a 6-month reporting period prescribed by any provider in the health care system within a 6-month reporting period.	P	% / Patients	CAPE, CIHI, OHIP, RPDB, NMS / Six months reporting period ending at the most recent data point	91447*	5.4	5.00	Only 20.4% of these Opioids were dispensed by PCPs within the FHT therefore, we would only have control for this indicator on a limited number of patients. The relatively modest target we want to achieve will reflect this fact as well as the efforts of the team to provide alternative treatments for non-cancer, non-palliative patients with chronic pain.		1)Explore the possibility of the development of a team based approach for chronic pain and opioid management that includes tapering.	Meet with primary care providers who have an interest in the development of a team approach to chronic pain management.	Number of formal conversations about the development of a team based approach.	2 meetings will be held to discuss the development of a team based approach.	The National Pain Centre recommends optimization of non-pharmacological therapy rather than a trial of opioids when considering therapy for patients with chronic non-cancer pain. It also recommends a formal multidisciplinary program for patients with chronic non-cancer pain who are using opioids and experiencing serious challenges in tapering.

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										2)Measure risk factors for opioid addiction, misuse and overdose.	Measure morphine equivalent (MEq) through EMR search as well as co-prescription of benzodiazapine and other medications know to increase risk. Utilize screening tools for opioid misuse non-compliance.	Number of patients who have a documented MEq in the EMR.	30% of patients on opioids will have an MEq documented.	
										3)Support primary care providers who wish to assist patients with tapering opioid use.	Continue development of Opioid toolbar and tools and encourage use by providers who wish to assist patients with tapering opioid use. Identification of patients who are at increased risk of developing opioid addiction.	Percentage of patients that have an opioid tapering schedule in their chart.	Tapering schedule will be in use for 10% of patients on opioids.	