Quality Improvement Plan Scorecard 2015-2016

CENTRAL HASTINGS FAMILY HEALTH TEAM

Progress Legend	Continue to Monitor	Review Required	Action Required

Quality Dimension: ACCESS									
Objective	**Indicator**	**Reporting Frequency**	**2014-15 Performance**	**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**Action / Commentary**
Access to primary care when needed.	From survey: Percentage of patients/clients able to see a doctor or nurse practitioner on "the same day or next day, when needed".	Quarterly	75.09%	80%	77%	78.3%	71.3%	74.25%	Q1-Based on 80 surveys, 69 respondents Q2 - Based 221 respondents Q3 - Based on 540 respondents Q4 - Based on 644 respondents Since the FHT has evening clinics five nights a week and 100% access within three days, there is little more that can be done to improve patient access.
Reduce ED use by increasing access to primary care	Percentage of patients/clients who visited the ED for conditions best managed elsewhere (BME).	Quarterly	2.04%	1.65%	N/A	N/A	N/A	2.04%	This is administrative data from the Health Data Branch Web Portal. It is always one fiscal year out of date. At this time this indicator is difficult to track. Funding for the Health Links embedded staff has been cut and fewer service hours were provided, which has impacted tracking for this indicator.

Quality Dimension: INTEGRATED									
Objective	**Indicator**	**Reporting Frequency**	**2014-15 Performance**	**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**Action / Commentary**
Timely access to primary care appointments post-discharge through coordination with hospital(s).	Percentage of patients/clients who saw their primary care provider within 7 days after discharge from hospital for selected conditions (based on HIGs).	Quarterly	42%	50%	N/A	N/A	N/A	32%	This is administrative data from the Health Data Branch Portal. It is always one fiscal year out of date. There has been a change in the indicator to include patients admitted for heart attacks and some other conditions not previously included, which has increased the denominator. The indicator also does not count post-discharge visits to Nurse Practitioners and Specialists. We will liaise with local hospitals to develop a process for receiving discharge notifications in a more timely fashion.
Reduce unnecessary hospital readmissions	Percentage of a primary care organization's patients/clients who are readmitted to hospital after they have been discharged with a specific condition (based on HIGs)	Quarterly	17% (for 2013-14)	15%	N/A	N/A	N/A	18%	This is administrative data from the Health Data Branch Portal. It is always one fiscal year out of date. There has been a change in the indicator to include patients admitted for heart attacks and some other conditions not previously included, which has increased the denominator.

Quality Dimension: PATIENT-CENTRED									
Objective	**Indicator**	**Reporting Frequency**	**2014-15 Performance**	**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**Action / Commentary**
Receiving and utilizing feedback regarding patient/client experience with the primary health care organization.	Percentage of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) give them an opportunity to ask questions about recommended treatment.	Quarterly	92.08%	96%	91%	86.3%	86.9%	87.85%	Q1 - Based on 80 surveys, 77 respondents Q2 - Based on 219 respondents Q3 - Based on 553 respondents Q4 - Based on 733 respondents This exceeds the average for Ontario (83.3%), as reported in the HQO Health Care Experience Survey ('Measuring Up 2014')

	Percentage 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.	Quarterly	93.16%	95%	95%	94.5%	94.6%	94.71%	Q1 - Based on 80 surveys, 78 respondents Q2 - Based on 219 respondents Q3 - Based on 552 respondents Q4 - Based on 724 respondents This exceeds the D2D 3.0 overall average of 89.6%, the D2D 3.0 peer group average of 89.6%, the 90.1% average reported for SELHIN ('Measuring up 2014') and the 86.2% average reported for Ontario in the HQO Health Care Experience Survey ('Measuring Up 2015').
	Percentage 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.	Quarterly	92.36%	95%	89%	90.8%	92.5%	91.61%	Q1 - Based on 80 surveys, 79 respondents Q2 - Based on 228 respondents Q3 - Based on 564 respondents Q4 - Based on 721 respondents Our performance exceeds the 82% reported for Ontario and the 87.5% reported for SELHIN ('Measuring up 2014').

Quality Dimension: POPULATION HEALTH

Objective	Indicator	Reporting Frequency	2014-15 Performance	Target	Q1	Q2	Q3	Q4	Action / Commentary
Reduce influenza rates in older adults by increasing access to the influenza vaccine.	Percentage of eligible patient/client population over age 65 that received influenza immunizations.	Quarterly	57%	65%	N/A	N/A	34%	37%	Data are not available before flu season. Flu shots were offered to all patients 65 and over; however there was a shortage of vaccine provided by PHU. As well, it was difficult to determine how many patients had been vaccinated outside the FHT. For the 2016.2017 QIP, the age range has been changed to 12 and over.
Reduce the incidence of cancer through regular screening	Percentage of eligible patients/clients who are up-to-date in screening for breast cancer.	Quarterly	61%	75%	63%	62%	62%	64%	This indicator is no longer required in the 2016.2017 QIP.

for BREAST, COLORECTAL, and CERVICAL CANCER	Percentage of eligible patients/clients who are up-to-date in screening for colorectal cancer.	Quarterly	42%	60%	43%	43%	44%	66%	Q1-Q3 reports FOBT, whereas Q4 includes both FOBT and screening with colonoscopy/sigmoidoscopy, allowing for better representation of screening levels. CCO reports are now received and being compared with EMR data.
	Percentage of eligible patients/clients who are up-to-date in screening for cervical cancer.	Quarterly	73%	75%	73%	72%	69%	72%	Reminders are placed in the EMR. Our performance exceeds the D2D 3.0 overall average of 69.2%, the D2D 3.0 peer group average of 67.6% and the Cancer Quality Council of Ontario rate of 62% (2011-2013 data).

Quality Dimension: POPULATION HEALTH (not mandatory indicators)

Objective	Indicator	Reporting Frequency	2014-15 Performance	Target	Q1	Q2	Q3	Q4	Action / Commentary
Diabetes-Able to identify specific populations, monitor those patients' progress and intervene in their care earlier	Percentage of diabetic patients in program with A1C to target.	Quarterly	57%	60%	59%	57%	57%	61%	787 DM patients. Our patients are given individual targets 0.065, 0.070 or 0.085. When individualized, our 3 groups meet our stated targets.
	Percentage of diabetic patients with LDL to target.	Quarterly	57%	65%	66%	68%	65%	70%	787 DM patients. Patients who are not on medication, but who should be, are being identified.
COPD-Able to identify specific populations, monitor those patients' progress and intervene in their care earlier	Percentage of eligible patients who received Level 1 COPD Screen	Quarterly	74%	95%	92%	95%	91%	92%	Reminders are placed in the EMR.
	Percentage of patients with a positive Level 1 Screen receiving in-house Level 2 Screen	Quarterly	38%	45%	28%	45%	-	52%	Spirometry clinics have worked well, allowing for spirometry to be set up and for several patients to be tested on the same day.

Smoking-Able to identify specific populations, monitor those patients' progress and intervene in their care earlier	Percentage of non-smokers in those patients/clients 12+ years	Quarterly	43.3%	45%	64%	65%	66.5%	66.5%	91 % of patients have smoking status documented. Patient enrollment in STOP will be continued. The percentage of STOP patients with "Quit" status at the 3-month follow-up is being tracked.
LTC Patients-Able to identify specific populations, monitor those patients' progress and intervene in their care earlier	Reduction in number of glucometer tests in our LTC resident population	Quarterly	270	170	186	168	111		Q4 - This was a LTC initiative, so it is part of the LTC home's QIP. There was no other direct action by the FHT.
LTC Patients-Able to identify specific populations, monitor those patients' progress and intervene in their care earlier	Reduction in number of drugs individual LTC residents are prescribed (monitor polypharmacy)	Quarterly	12	11	13.0	12.75	12.83		Q4 - This was a LTC initiative, so it is part of the LTC home's QIP. There was no other direct action by the FHT.
Gain insight into antipsychotic medication use and decrease use in the LTC facility	Percentage of patients on antipsychotic medication for agitation with no psychotic symptoms	Quarterly	CB	33	36	28	27		Q4 - This was a LTC initiative, so it is part of the LTC home's QIP. There was no other direct action by the FHT.
Advance care planning	Percentage of patients with an Advance Care Plan in place	Quarterly	CB	10	3	5	10		Q1 - Piloting this indicator based on one physician Q2 - YTD based on one physician Q3 - YTD based on one physician Q4 - It was decided that to scale back the scope of this initiative to focus on ensuring patients' substitute decision makers or Powers of Attorney are on file.