Quality Improvement Plan Scorecard 2016-2017 Q4

CENTRAL HASTINGS FAMILY HEALTH TEAM

Progress Legend	Continue to Monitor	Review Required	Action Required

Quality Dimension: TIMELY

Objective	Indicator	Reporting Frequency	2015-16 Performance	Target	Q1	Q2	Q3	Q4	Action / Commentary
Access to primary care when needed	Percentage of patients/clients who responded positively to the question: "The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her?"	Quarterly	74.3	80	62.6	62.4	57.2	54.3	An additional 14.9% of patients could see their PCP within 3 days. Based on 1,118 answers this fiscal year. The survey results include data on only one physician and two NPs. Four physicians have withdrawn from the survey. 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 patients' access. Our performance still exceeds the D2D 3.0 peer group average of 51.2%, as well as the 44.3% reported for Ontario and 39.5% reported for SELHIN in the HQO Health Care Experience Survey ('Measuring Up 2015').
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	32 (2014-2015)	35	N/A	N/A	N/A	43 (2015-2016)	Data source: Health Data Branch Web Portal. (Data are always one fiscal year old). Our 2015-2016 performance exceeded our target and the comparative performance values for this indicator even though visits to NPs within seven days of discharge are not counted: Fiscal year 2015-2016 SELHIN 41/100, Ontario 37/100 (from the Health Data Branch Web Portal). Fiscal year 2013-2014 rural Ontario 24.9/100. http://www.hqontario.ca/Public-Reporting/Primary-Care/Quality-Indicators/Seven-day-follow-up-after-leaving-hospital

Improve timely contact with patient referred to the Mental Health Program	Percentage of new referrals triaged and contacted within 10 working days (2 weeks)/new referrals to the In-House Mental Health Program [not mandatory]	Quarterly	Baseline	60	90	62.5	94.7	93.5	Out of the cases where date triaged was provided, 93.5% were triaged within 10 working days and only five (6.5%) were triaged late. There was an ongoing problem with the "date triaged" field being left blank, though. Of all referrals, 76.6% were triaged within 10 days, 5.3% were triaged late and 18.1% were left blank. Nevertheless, there was considerable improvement in documentation by the end of the fiscal year.

Quality Dimension: EQUITABLE

Objective	Indicator	Reporting Frequency	2015-16 Performance	Target	Q1	Q2	Q3	Q4	Action / Commentary
Reduce barriers to clinic access for remote rural patients	Number of clinics per year at the Gilmour site	Quarterly	Baseline	48 planned days	92.3	100	100	91.7	Until the end of Q3, the clinic was open 97.1% of the days that it should have been, but winter storms in Q4 resulted in the clinic being closed for three of the thirteen planned days. Year to date, of the 48 planned clinic days only 4 were missed, for an overall opening rate of 91.7%. We are pleased that our efforts in reducing transportation barriers to rural Gilmour residents accessing primary care and our smoking cessation program have been successful.

Quality Dimension: PATIENT EXPERIENCE

Objective	Indicator	Reporting Frequency	2015-16 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	87.9	95.00	90.4	89.9	91.1	89.4	Based on 1,224 answers this fiscal year. This exceeds the average for Ontario (83.3%), as reported in the HQO Health Care Experience Survey ('Measuring Up 2014'). Although we had excellent performance on this indicator, some patients who said that they were included in decision making felt that they did not have an opportunity to ask questions about recommended treatment. We will attempt to encourage patients to ask questions through the use of educational posters, since patient understanding of any treatment changes is vital to positive health outcomes.
	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	94.7	95.00	95.3	94.8	96.9	94.8	Based on 1,242 answers this fiscal year. 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'), the 86.2% average reported for Ontario in the HQO Health Care Experience Survey ('Measuring Up 2015') and the 85.9% average reported for Ontario in 2016. Our performance is one of the highest in the province. This illustrates our practitioners' patient-centred approach to the care they provide.
	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	91.6	95.00	90.7	92.0	96.3	93.9	Based on 1,255 answers this fiscal year. Our performance far exceeds the 82% reported for Ontario and the 87.5% reported for SELHIN ('Measuring up 2014'). The FAQ document that was produced by the Communications Committee appears to have been successful in informing patients about the time constraints faced by our physicians and NPs.

Quality Dimension: EFFECTIVE

Objective	Indicator	Reporting Frequency	2015-16 Performance	Target	Q1	Q2	Q3	Q4	Action / Commentary
Diabetes: Provide education and assist patients for better self-management, control and understanding	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months	Quarterly	92	95	92.5	93.1	93.7	91.8	Our performance greatly exceeds the Ontario rate of 46.2% (March 2015 data from HQO's Primary Care Practice Report). We will be continuing our existing processes, which have resulted in one of the highest HbA1C tracking rates in the province.
Reduce the incidence of cancer through regular screening –colorectal and cervical cancer	Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years	Quarterly	66	70	63.2	63.0	63.6	64.4	Our performance exceeds the Ontario rate of 58.9% (March 2015 data from HQO's Primary Care Practice Report). We will continue efforts to educate patients in the target group on the importance of completing the FOBT screening kit. Patients who were overdue for screening were called by one of our staff.
	Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years	Quarterly	72	75	66.4	70.8	70.8	71.7	Our performance far exceeds the Ontario rate of 58.9% (March 2015 data from HQO's Primary Care Practice Report) We will continue efforts to educate patients in the target group on the importance of Pap tests. Patients who were overdue for screening were called by one of our staff.

Improve Seasonal Immunization Rates	Percentage of patients aged 12+ who report having a seasonal flu shot in the past year/patients aged 12+ eligible for a flu shot	Quarterly	15.6	33	16.5	16.3	21.0	22.4	Statistics Canada reports that 35.4% of the Ontario population aged 12 and over received influenza immunization in 2013-2014, so our documented rate of immunization is well below average. The addition of a flu shot question to the tablet appears to have resulted in a 5.9% increase in flu shot documentation. We suspect that the rate we have documented is far lower than the actual immunization rate because flu shots received at pharmacies and at public health clinics are not being recorded in the EMR.
Improve documentation of Substitute Decision Maker	Percentage of patients 65 and over who have documentation of Substitute Decision Maker [includes POA]	Quarterly	Baseline	65	35.7	37.2	38.0	39.7	Since the Personal History field is used for pharmacy information (such as SDM for Shopper's Drug Mart), we found that a colon needed to be added if providers were using "SDM" in the context of Substitute Decision Maker. Without a colon, other "false positive" results arose when the following types of entries were made, "Patient does not want to name an SDM" or "Patient is working on identifying an SDM". Going forward we will use a stamp to identify SDMs. As well, there needs to be a means for practitioners to indicate if patients have been asked whether they have an SDM.