McMaster Family Health Team
2020/21 Quality Improvement Plan for Ontario Primary Care

"Improvement Targets and Initiatives"

	QUALITY DIMENSION	MEASURE / INDICATOR	TYPE	UNIT / POPULATION	SOURCE / PERIOD	CURRENT PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFICATION	PLANNED IMPROVEMENT INITIATIVES (CHANGE IDEAS)	METHODS	PROCESS MEASURES	TARGET FOR PROCESS MEASURE	COMMENTS
						THEME I: TIMELY AND EFFICIENT TRANSITIONS							
1	**Efficient**	Percentage of those hospital discharges (any condition) where timely notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.	C	% / Discharged patients	EMR/Chart Review / 2020-2021	34	55	Performance in last year and logistics of obtaining information	#1) Continue to dedicate resources to contact all patients following discharge to ensure there is a plan in place and to arrange follow up appointment if needed	Dedicated resources retrieve hospital discharge data from Clinical Connect and make phone calls to non-obstetric patients based on recent hospital discharges. We will	% of patients who receive follow-up within 7 days of hospital discharge	55% of patients discharged from hospitals will receive follow-up within 7 days of discharge	Current process involves manually pulling discharge lists weekly and contacting all patients. Thus, if a patient was discharged earlier in the week and are one of the last patients to be called, the call would take place after the 7 days
						THEME II: SERVICE EXCELLENCE							
2	**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 2019 - March 2020	97.37	98	We are already at our target set for previous year. We will aim to surpass our target this year D2D - 89.9%"	#1) Surveys conducted semi-annually. Continue to ask this question for all appointment types	Ensure this question is asked with each survey	% of patients responding positively to question	>97% of patients will respond positively to the survey question	We continue to receive consistently high results for patient feedback
						THEME III: SAFE AND EFFECTIVE CARE							
3	**Effective**	Number of patients requiring palliative services who are supported by our FHT	C	Count / Palliative patients	EMR/Chart Review / 2020-2021	214	225	Currently tracking home visits associated with palliative care patients on Schedule A; Target is at least 200 pts/year and already at 214. We believe we can increase by at least 5% in the coming year	#1) Support patients at end-of-life, including those who previously lacked a primary care provider	Provide team-based support to patients in their homes	Home visits associated with palliative care patients	5% increase during the year	Currently tracking home visits associated with palliative care patients on Schedule A; Target is at least 200 pts/year
4	**Safe**	Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system within a 6-month reporting period.	P	% / Patients	CAPE, CIHI, OHIP, RPDB, NMS / 6 month period ending Mar 31, 2019	3.5	3.5	LHIN percentage - 4.2% Provincial percentage - 3.8% Maintain or better current performance	#1) Continue best practices when prescribing opioids to patients within our FHT	Pharmacists and FPs track and monitor patients dispensed an opioid	% of non-palliative patients newly dispensed an opioid within a 6-month reporting period prescribed by their physician within the MFHT (data obtained from MPR)	<= 3.5 of non-palliative patients newly dispensed an opioid within a 6-month reporting period prescribed by their physician within the MFHT (data obtained from MPR)	All of our FPs are currently signed up for the MPR however, data from the MPR is not timely and difficult to use to inform clinical practice; Our pharmacists continue to use EMR data to identify patients and track/follow-up with FP help/guidance As of March 31, 2019 - 3.5% of FHT patients have been dispensed an opioid o 7.9% of those opioids were prescribed by the patients' physician within the FHT o 92.1% were prescribed by other providers (e.g., other family physicians, dentists, surgeons) within or outside of the FHT LHIN percentage - 4.2% Provincial percentage - 3.8%"
						EQUITY							
5	**Equitable**	Patients with Diabetes <65 who receive DM care internally and have had an HbA1c test in past 12 months	C	% / Patients with diabetes less than 65 years old	EMR/Chart Review / 2020-2021	79	80	Annual HbA1c test is a measure of patient engagement with their diabetes care. We believe that we can improve our current performance	#1) Provide individualized feedback to MRPs related to their patients with Diabetes	Create scorecard with diabetes-specific indicators, including comparison to clinic average. Measures include bp measurement, hypoglycemic episodes, appointment history, continuity of provider. Distribute to clinicians	% of MRPs receiving scorecards	100% of MRPs will receive scorecards	We supported physicians by providing scorecards with individualized feedback about diabetic patients who are less than 65 years old and who are receiving care internally. Our initial focus with the scorecards was to help identify patients who were not well-engaged in their diabetes care and who had not had a HBA1c test in the past year. Our chosen intervention was to contact patients, offering a clinic appointment with preliminary lab work-up
									#2) Contact patients to encourage HbA1c testing	Clinical staff to contact patients requiring testing. Lab requisition to be provided and follow up appointment in clinic to be scheduled	% of patients contacted receiving a follow-up appointment	30% % of patients will be contacted for a follow-up appointment	We supported physicians by providing scorecards with individualized feedback about diabetic patients who are less than 65 years old and who are receiving care internally. Our initial focus with the scorecards was to help identify patients who were not well-engaged in their diabetes care and who had not had a HBA1c test in the past year. Our chosen intervention was to contact patients, offering a clinic appointment with preliminary lab work-up