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

Brockton and Area FHT Box 1300, Walkerton, ON N0G 2V0

AIM		Measure									Change				
Issue	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
M = Mandatory (all cells 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)															
Theme I: Timely and Efficient Transitions	**Efficient**	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.	91953*	CB	CB	Collecting baseline as this is a new initiative for our FHT	South Bruce Grey Health Centre	1)Introduce post discharge follow up at two FHT sites: Chesley and Durham with plans to expand to all teams	Incorporate into existing FHT Medication Reconciliation Program. FHT RNs will follow up with patients using the appropriate mode. RNs may refer to other providers within the FHT/FHO based on patient needs (Respiratory Therapist, Social work, or Dietitian for example)	% of rostered patients who receive follow up after an SBGHC inpatient discharge	75% of our rostered patients from SBGHC will have received follow up by any provider by any mode	
											2)Partner with our local hospital pilot sites to identify best process/methods of sharing and communicating patient information in a timely efficient manner	Define the FHT information needs related to Discharge notification, CCP screening and Palliative care assessment Present a proposed communication process with hospital as a starting point to collaborate on best mutual solution Align EMR and other documentation tools to the defined process Trial the process at one hospital/FHT site and expand to others as feasible.	Development of a draft process to present to the hospital contacts Approval of a defined communication method/process for FHT patients admitted to hospital Completion of trial and alignment of documentation supports	Completion by March 31, 2020	
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	91953*	93.45	95.00	We are targeting a modest increase as we are performing well in this measure.		1)Expand our use of technology within the FHT to give patients more options of communicating and/or sharing information, with our team	Introduce email consent process as a pre-requisite to future patient communications at one FHT site, with a plan to expand to other sites. Explore expanding the use of tablet technology to capture patient-centric information and improve efficiencies within the FHT. Trial the use of electronic communications with patients such as a patient newsletter or appointment reminder.	Implementation of an email consent process. Completion of a review of potential tablet applications within the FHT. Completion of a patient electronic communication trial.	Email consent implementation at one team by September 2019. Completion of tablet and patient communication trial by March 2020.	
											2)Improve patient centred care by understanding the social determinants of health for our patient population.	Collect/develop local resource listings for our patients (one team) Investigate the use of an EMR tool and/or patient tablet to effectively collect patient social determinant information	Completion of resource list and review of electronic documentation options for one site.	Completion by March 31, 2020	
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	91953*	CB	CB	Collecting baseline for 19/20 as new measure/process for our FHT		1)Educate our providers on advance care planning and promote documentation of a patient's substitute decision maker	Offer education to all providers on Advance Care Planning at a team education session Demonstrate an EMR tool that can be used to document a patient's substitute decision maker	% of FHT providers who are offered Advance Care Planning education	100% of providers will be offered training/education resources on advance care planning	
											2)Assess the implementation and process of palliative care identification and screening for a targeted patient population	Trial the use and documentation of palliative care needs for our Healthlinks/CoordinatedCare patients at one FHT site. Assess the alignment of documentation and how to communicate palliative care status within our EMR and across care partners.	Complete the review and trial of palliative care identification and assessment for the targeted patient group	March 2020 completion of review and trial	
	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	91953*	4.2	4.10	We are targeting the provincial mean as we work on process improvements for our 19/20 QIP.		1)Incorporate the review of hospital discharge opioid prescriptions as part of our Medication Reconciliation program	RNs to review the opioid prescriptions of SBGHC patients discharged from hospital. The medication profile will be updated to reflect the hospital prescribed medications and new opioid prescriptions will be flagged for provider review	Implementation of documentation and communication process within the Medication Reconciliation program	Completion by March 2020	
											2)Provide education and tools on safe opioid prescribing to a target provider group	Review education and support resources available to providers. Promote education of one provider group and introduce trial of an opioid management EMR tool. Demonstrate tool/opioid resources to other providers upon trial completion	Completion of education and EMR tool trial	Completion of education by December 2019 Completion of EMR tool trial by February 2020	
											3)Promote patient awareness and education on safe opioid use	Use waiting room monitors, web site and other media to provide patient education	Implementation and update of patient education references	Completion of planned education by March 2020	