AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Access	**Access to primary care when needed**	Percent of patients/clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	91444*	77.85	80	Team believed in F14-15 they could reach 80% falling short by 2%. Team wishes to aim for 80% again.	1)TNA Board review/discuss quarterly	1) On last business day a month review all 15 physicians appointment books and determine TNA 2) Enter number of days to TNA into a spreadsheet for each physician 3) At the end of quarter calculate % of months with a TNA <=1 day for all 15 physicians and present to Board quarterly	% of months with a TNA <1 day for all 15 physicians	97% of the time patients will wait <=1 day for TNA appointment.	F14-15 TNA = 95% F13-14 TNA = 98%
									2)Explore e-Booking	1) Review 2 key papers on e-booking and synthesize 2) Present findings at a Clinical Meeting 3) Explore/compare options for adoption (vendors to present to physicians) 4) Poll physicians on desire to implement	# of physicians indicating desire to implement	5/15 physicians indicate desire to pilot	If cost exorbitant this may be delayed
		No. of home visits done by any clinician (PC @ Home physicians, other physicians and IHPs)	Counts / Home Care Clients	EMR/Chart Review / FY 2015-16	91444*	966	1000	4% increase in visits (34 more visits) allows team to take on 2 more housebound	1)Provide ++ support/coverage for PC@Home Team	1) Discuss need at Board for shared coverage 2) Build rotational schedule for shared coverage equally amongst 15 physicians 3) Ensure PC@ Home Physician Assistant (PA) discusses 'red flag' patients with PC@Home Physician prior to PC@Home physician's leave and can succinctly brief	# physicians who agree to be part of rotational schedule # of successful leaves during year (measured by PA & PC@Home Physician and covering physician)	80% of leaves covered successfully 80% of physicians agree to be part of rotational schedule	
	Reduce ED use by increasing access to primary care	Percent of patients/clients who visited the ED for conditions best managed elsewhere (BME).	% / PC org population visiting ED (for conditions BME)	Ministry of Health Portal / April 1 2013 - March 31 2014	91444*	0.5	0.45	Performance Hx F12/13 = 0.54%	1)Article Re: Why Visiting EDs for Conditions BME May Not Be Recommended & How to Manage at Home until your TC FHT Appt	1) Executive Director to seek clinical writer/editors at various internal meetings 2) Author to utilize 'Up-To-Date' as clinical source 3) Post on website, in suites and distribute via Wellx (secure email) to patients	1) Author/editors found 2) Article written 3) Article posted/distributed	Article written/posted/distributed by Mar 2016	
									2)Inform patients of After Hour Clinic option by distributing wallet size cards Re: Accessing After Hour Clinic	1) Create wallet size card advertising where to find information Re: TC FHT After Hour Clinic 2) Audit once a month making sure cards available for all patients, at all times, in all 7 suites	Number of wallet size cards taken by patients	Aug 2015, wallet size cards available Sep-Mar 2016, 100% of the time wallet size cards were	
									3)Perform a prospective After Hour Clinic audit to determine % occupancy, time appts booked and reason for visit in order to develop booking	1) QIDSS/Executive Director to develop audit 2) Collect data (May-Jul 2015) analyze & discuss booking protocols with Operations Committee (Sep 2015) 3) Executive Director to draft internal booking protocols for Board Approval (Fall 2015) 4) Disseminate booking protocols to	After Hour Clinic Occupancy Rate Physician/Medical Secretary adherence to booking protocols	80% After Hours Clinic occupancy, Evidence of booking protocol adherence	
Integrated	**Timely access to primary care appointments post-discharge through coordination with hospital(s).**	Percent of patients/clients who saw their primary care provider within 7 days after discharge from hospital for selected conditions (based on CMGs).	% / PC org population discharged from hospital	Ministry of Health Portal / April 1 2013 - March 31 2014	91444*	17	25	Based on MOHLTC Portal History: F13-14 & F14/15 Interim Data: 17% F12/13 = 27% & F11/12 = 26% Based on internal process for F14-15: Q1= 38%, Q2= 23%, Q3= 37% and b/c TCFHT enabled Hospital Report Manager (HRM) in FY 2014-15 we	1)Medical Secretaries to request pts inform us when discharged & make appt	During Medical Secretary meeting Executive Director to emphasize indicator importance and outline selected conditions then request they upon hearing a pt is being admitted or has been admitted that they 1) inform pts of importance of being seen by their PCP post discharge 2)	# pts who call to inform medical secretary they have been discharged and need to be seen	25% (or approximately 38 pts) contact medical secretary to inform them they have	F13/14 - 96 TC FHT pts discharged with selected conditions
									2)As part of internal process of searching for discharge summaries also send eMR message to PCP & Medical Secretary that pt needs to be	Revise process	% pts who see their primary care physician w/i 7 days after d/c from hospital for selected condition	25% of patients see their primary care physician w/i 7 days after d/c from hospital for selected	
									3)Exec. Dir./Lead Physician to participate in MWTHL Regional Steering Committee focused on addressing hospital gaps in notifying	1) Exec. Dir./Lead Physician attend MWTHL Regional Steering Committee 2) Advocate for implementation of MWTHL Regional Steering Committee's recommendations to the TC LHIN	% MWTHL Regional Steering Committee mtgs attended by either Exec. Dir. or Lead Physician % MWTHL Regional Steering Committee recommendations to the TC LHIN implemented	Exec. Dir. or Lead Physician attend 100% of MWTHL Regional Steering Committee Mtgs	
	Reduce unnecessary hospital readmissions	Percentage of acute hospital inpatients discharged with selected CMGs that are readmitted to any	% / PC org population discharged from hospital	Ministry of Health Portal / April 1 2013 - March 31 2014	91444*	11	10	Target is based on the internal FY 14-15 data Q1: 5%, Q2: 10%	1)Modify internal process - after physician visit, physician to send x1 delayed messages to RN or Pharm to f/u x1 within 30 days	1) Internal process to be modified so physician sends delayed message in eMR for either RN or Pharm to f/u (via phone) x1 within 30 days and bring to physician attention if need for visit	% pts discharged with selected condition, receive 1 f/u phone call	75% of pts, discharged with selected conditions, receive 1 f/u phone calls	Est. 150 discharges, with selected conditions, per year
	Increase co-ordinated care plans (CCP) for complex patients	No. of negotiated CCPs for complex patients	Counts / Complex patients	EMR/Chart Review / FY 2015-16	91444*	CB	50	F14/15 TC FHT completed 32 CCPs	1)Define & identify complex pts	1) Review MWTHL & WCH definition of complex pts 2) Operations Committee to decide on definition ensuring chosen definition can be built within eMR 3) Build eMR search to flag complex patients	# of complex patients in eMR	100% complex patients can be identified in eMR	
									2)Educate clinicians of value of CCPs	1) Present at 2 Clinical Meetings 2) Clinicians communicate CCP value via testimonials	# Clinicians that uptake completing CCPs for complex patients	50% clinicians complete at least on CCP	
									3)Pts presented at Complex Care Clinic to have a CCP (est. 10), PC@Home team to complete (est. 10 CCPs) & Physicians to complete 2 each	1) Lead physician organizing CCC to encourage provider presenting to complete CCP 2) PC@Home team to record on their indicator tracking sheet whether CCP completed 3) eMR to provide list of complex pts to physicians encouraging 3 CCPs within FY	# of CCP completed	65 completed CCPs by the end of FY 2015-16	
	Participate in RED (Referral from Emergency Department)	# of RED Referrals Accepted	Counts / All acute patients	EMR/Chart Review / F2015-16	91444*	CB	12	12 referrals amongst 6 physicians participating in RED HL Project by	1)6 physicians participate in the RED Health Link Project	Minimum of 6 TC FHT physicians will participate in the RED HL Project and accept 12 pts with a CTAS (Canadian Triage Accuity Score) of 2 - Emergent, from partner emergency departments	# pts accepted from RED HL Project	12	

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Patient-centred	Receiving and utilizing feedback regarding patient/client experience with the primary health care organization.	Percent 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	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	91444*	96.02	96.02	Maintain	1)Improve automation of Patient Care Experience Survey	1) Develop easy method to collect patient email addresses (pts complete contact card for later entry by Admin. Staff) 2) Exec. Director to encourage Medical Secretaries to ask patients to complete contact card 3) QIDSS to investigate best automated methods to distribute survey via email (i.e.	Response Rate	10% sample (approximately 1800 surveys) within 1 month	IPAD method used in F14-15 survey unsuccessful
									2)Create Patient Advisory Council	1) Review 2014 AFHTO Conference presentations on how other FHTs have created Patient Advisory Councils 2) Contact FHTs who have done this and request to observe one in action 3) Learn from MWTHL successes in incorporating pts on their Council and Working Groups	# Patient Advisory Council Meetings	1 Patient Advisory Council Meeting held within F14-15	
		Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	91444*	95.2	95.2	Maintain	1)See change idea for above indicator	See method for above indicator	See process measures for above indicator	See Goal for change idea for above indicator	
		Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	91444*	91.82	91.82	Maintain	1)See change idea for above indicator	See method for above indicator	See process measure for above indicator	See Goal for change idea for above indicator	
Population health	Reduce influenza rates in older adults by increasing access to the influenza vaccine.	Percent of patient/client population over age 65 that received influenza immunizations.	% / PC organization population aged 65 and older	EMR/Chart Review / na	91444*	55	57	Performance History: F13-14 = 50% F12-13 = 50%	1)Improve tracking of pts who have already rec'd flu shots elsewhere by ensuring Q130A tracking code entered	1) Internal patient signage: Advise clinician if you have already rec'd flu shot 2) Ensure all clinicians know how to input Q130A code if flu shot rec'd outside of FHT	% pts over age 65 receiving flu shot	57%	
									2)Track and contact pts without flu shots	1) Sep 2015 Clinical Meeting educate staff on how to record billing codes for flu shot 2) Run searches in Jan/Feb 2016 QIDSS_Influenza Numerator - rostered pts 65 and > who received the flu vaccine (G590, Q130 or documented in immunization section) & QIDSS_Influenza Denominator -	% pts over age 65 receiving flu shot	57%	
	Reduce Cancer mortality through regular screening.	Percent of eligible patients/clients who are up-to-date in screening for colorectal cancer.	% / PC organization population eligible for screening	EMR/Chart Review / n/a	91444*	36	40	Perf. History: F13-14 = 37% F12-13 = 35%	1)Co-ordinate/delegate access to CCO's SAR (Screening Activity Report) to assess if data can be used to monitor/create reminders in	1) Start by having one physician grant access to Executive Director 2) Executive Director and QIDSS to review CCO SAR information and determine how information could be used to increase % of pts up-to-date in screening for colorectal cancer (i.e. eMR reminders, sending FOBT kits in	% of eligible patients/clients who are up-to-date in screening for colorectal cancer.	40%	Continue with Turning 50 FOBT Project - Eligible patients turning 50 receive a birthday