Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	71.00	75.00	Current performance: FY19-20: 71% (Source: EMR search); History: D2D 6.0 TC LHIN: 84%, ON 66% (2018) D2D 5.0 TC LHIN: 64%, ON 57% (2017) Health Data Branch (MOH) % Rostered Pts seen within 7 days of disch. for selected conditions F18-19: 25% F17-18: 30%	

Change Ideas

Change Idea #1 Conduct malnutrition screening as part of the post-discharge follow-up intervention and monitor the use of a new 3-question malnutrition screening tool (imbedded into the 7-day Post Hosp Disch. F/U EA)

Methods	Process measures	Target for process measure	Comments
1) Use a validated screening instrument (SCREEN III) to assess nutritional status of patients recently discharged from hospitals	1) % of patients who recently discharged from hospital (excluding transfers to other institutions) with malnutrition screening completed	Collecting baseline.	

Change Idea #2 Continue to monitor current internal process and remind PCPs to use a single standardized method (i.e. 7-day Post Hosp Disch. F/U Encounter Assistant [EA])to doument f/u

Methods	Process measures	Target for process measure	Comments
1) Present at Fall Clinical Meeting 2) Audit to ensure complaince (i.e. look back on discharges found and correlate with using EA 3) Email reminders to PCPs not in compliance	1) Present at Fall Clinical Mtg 2) # audits 3) # emails sent	1) 1 Clinical Mtg 2) Quarterly 3) Quarterly	

Measure

Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	P	% / PC organization population (surveyed sample)	In-house survey / April 2019 - March 2020	77.08	80.00	Current performance: 77% [Source: FY2019-20 (PES)] History: FY 2018-19 (PES): 77% FY2017-18 (PES): 83% FY2016-17(PES): 82% FY2015-16 (PES): 82% FY2014-15(PES): 78% Provincial average: FY2017-2018: 40.4% (HQO System Performance) FY2016-17: 39.9% (HQO Measuring Up) FY2015-16: 43% (HQO Measuring Up) FY2014-15: 44% (HQO Measuring Up)	

Change Ideas

Change Idea #1 Continue to utilize online patient portal (Health Myself) to administer survey more efficiently and ask survey 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 NP to when you actually saw him/her or someone else in their office?"

Methods	Process measures	Target for process measure	Comments
1) Administer survey using patient portal (Health Myself) 2) Pose question on annual survey	1) Survey administered via patient portal (Health Myself) 2) Question posed on annual survey	1) Fall 2020 2) Fall 2020	Total Surveys Initiated: 1453

Change Idea #2 Continue to collect third next available (TNA)

Methods	Process measures	Target for process measure	Comments
1) Review all 19 physicians/nurse practitioners (NP) appointment books and determine TNA 2) Enter number of days to TNA into a spreadsheet for each physician/NP 3) At the end of quarter, calculate % of months with a TNA <=1 day for all 19 physicians/NPs 4) Present TNA to Board	1) All physician/NP appt books reviewed 2) TNA entered into spreadsheet 3) % of months with TNA <=1 day calculated 4) TNA presented to Board	1) 100% 2) Monthly 3) Quarterly 4) x2 year	

Change Idea #3 Go live with eBooking for the remaining 6 (out of 19) physicians/NPs to Health Myself portal

Methods	Process measures	Target for process measure	Comments
1) Set a Go Live date when we return post COVID-19 2) Review configuration document and schedule templates with HealthMyself before the Go Live date 3) Distribute a broadcast message via Health Myself patient portal	1) % of physicians/NPs offering e-booking via Health Myself Portal	1) 100% (by end of F20-21 to be 19/19 MDs/NPs)	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	96.88	97.00	Current performance: 97% [Source: FY2019-20 (PES)] History: FY2018-19 (PES): 96% FY2017-18 (PES): 96% FY2016-17 (PES): 96% FY2015-16 (PES): 96% FY2014-15 (PES): 95% Provincial Average: FY2017-2018: 86.4% FY2016-2017: 85.3% (HQO System Performance) FY2015-16: 82.9% (HQO System Performance) FY2014-15: 86.2% (HQO Measuring Up)	

Change Ideas

Change Idea #1 Continue to utilize online patient portal (Health Myself) to administer survey more efficiently and ask survey question "When you see your doctor, nurse practitioner or someone else, how often do they involve you as much as you want to be in decision about your care and treatment?"

Methods	Process measures	Target for process measure	Comments
1) Administer survey using patient portal (Health Myself) 2) Pose question on annual survey	1) Survey administered via patient portal (Health Myself) 2) Question posed on annual survey	1) Fall 2020 2) Fall 2020	Total Surveys Initiated: 1448

Theme III: Safe and Effective Care

Measure

Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	3.30	3.00	Current Performance: FY2018-2019 [Mar 2019] (PCPR): 3.3 History: FY2018-2019 [Sep 2018] (PCPR): 3.3 FY2017-2018 [Mar 2018] (PCPR): 3.6 FY2017-2018 [Sep 2017] (PCPR): 3.6	

Change Ideas

Change Idea #1 Ensure all patients with newly prescribed opioids (by TC FHT providers) or first renewal of opioids (by TC FHT providers) when prescribed by external healthcare providers, have a signed opioid contract in eMR

Methods	Process measures	Target for process measure	Comments
1) Using list of opioids from HQO, develop and run a quarterly eMR search 2) Pharmacists to audit/confirm that newly dispensed or renewed opioids (Denominator) 3) Pharmacists to audit whether signed contract in the eMR (Numerator)	1) % of patients with newly dispensed or renewed opioids with signed opioid contract in eMR	Collecting baseline	

Measure

Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients who receive a medication reconciliation, within 7 days, after discharge from hospital	C	% / Discharged patients	EMR/Chart Review / Apr 2020 - Mar 2021	21.30	25.00	Current performance: FY19-20: 21% (Source: EMR search)	

Change Ideas

Change Idea #1 Develop a Medical Directive that allows an interdisciplinary approach MedRec

Methods	Process measures	Target for process measure	Comments
1) Create QIC sub group to write medical directive	1) Medical Directive developed.	1) Mar 2021	This would eventually expand the MedRec initiative to other patient sub-populations (i.e. complex pts and frail elderly).

Change Idea #2 Assess % of pts with med rec after being recently discharged from hospital

Methods	Process measures	Target for process measure	Comments
1) eMR searches to determine # pts with 7 day Post Hospital Discharge F/U EA with 'yes' to Med Rec (Numerator), # pts with 7-day Post Hosp Disch. F/U Encounter Assistant (Denominator)	1) % of pts with med rec after being recently discharged from hospital.	1) 25%	

Equity

Measure

Dimension: Equitable

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of patients, >=18yrs, screened for poverty	C	% / PC organization population (surveyed sample)	In-house survey / Apr 2020 -Mar 2021	CB	CB	F20/21 = CB to calculate prevalence of poverty in our population using 2020 Pt Care Survey F19/20 = 1.6% (Apr 1 - Aug 21, 2019) F18/19 = 2.6% (Apr 1 - Oct 1, 2018) Numerator: Socioeconomic Status Screen, Senior Care, Diabetes Intake CF Denominator: % / All patients >18 yrs with at least one clinic visit (Note: Most from Diabetes Intake Form)	

Change Ideas

Change Idea #1 1) Calculate prevalence of poverty in our population, using our Pt Care Survey

Methods	Process measures	Target for process measure	Comments
1) Add 2 screening questions to pt care survey, 2) Analyze survey data collected	1) % of pt who responded “Affirmative” to the question of "Do you ever have difficulty making ends meet at the end of the months?" and "Have you filled out & send in your tax forms?", 2) Fall 2020	Collecting baseline	

Change Idea #2 2) On the Pt Care Suvey, also direct pts to the FHT's website for additional resources, pt handouts and appointment booking information for our Single Session Counselling

Methods	Process measures	Target for process measure	Comments
1) Include URL of additional resources and PDF version of pt handouts on the specific page on the FHT's website, 2) include appointment booking information with respect to the single-session counselling clinic on the specific page on the FHT's website	1) Enhance the Program/Service Mental Health web page.	1) Sep 2020	

Measure

Dimension: Equitable

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1c) tests within the past 12 months	C	% / Other	EMR/Chart Review / Apr 2020 - Mar 2021	56.00	60.00	Current performance: 56% Source: FY2019-20 Q1-Q3 (EMR search) History: FY2018-19 Q1-Q3 (EMR Search): 59% FY2017-18 Q1-Q3 (EMR Search):63% FY2016-17 Q1-Q3 (EMR search):52% FY2015-16 Q1-Q3 (EMR search): 48% FY2018-19 (HQO Practice Profile Report) 45% FY2017-18 (HQO Practice Profile Report): 42% FY2016-17 (HQO Practice Profile Report): 38% FY2014-15 (HQO Practice Profile Report): 38%	

Change Ideas

Change Idea #1 Notify PCPs by providing reports of patients who have not had two or more HbA1C tests in the past 12 months

Methods	Process measures	Target for process measure	Comments
1) Prepare/distribute 'Non Compliance Reports'	1) 'Non Compliance Reports' provided to PCPs.	1) Fall 2020	Oct 4, 2019 - Total no. of rostered pts with diabetes seen in the last 2 years = 765, Pts having 2 HbA1C in last 12 months = 427, % of pts with 2 HbA1C in last 12 months = 56%, No. of pts NOT having 2 HbA1C test in last 12 months = 338

Change Idea #2 Notifying DEP (Diabetes Education Program) of FHT pts previously seen by DEP but not having two or more HbA1c tests within the past 12 months

Methods	Process measures	Target for process measure	Comments
1) QIDSS to prepare report of pts not in compliance (add column for last time DEP Custom Form completed) 2) DEP to audit list of pts not seen in 12 months 3) DEP to contact pts (via tele, HM) to discuss importance of ongoing care	1) Prepare/distribute report of pts not in compliance 2) DEP Audit Complete 3) % of pts contacted	1) Fall 2020 2) Jan 2021 3) 100%	Oct 4, 2019 search run showed 141 FHT DEP pts who did not have 2 HbA1C tests in last 12 months and not seen by DEP in last 12 months. DEP reviewed and/or contacted 0% of these pts, although it was requested.

Measure

Dimension: Equitable

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of pts, turning 50, who complete fecal immunochemical test (FIT)	C	% / PC organization population eligible for screening	Other / Apr 2020 - Mar 2021	15.00	33.00	Post introduction of FIT & No Turning 50 QI Initiative Jul - Aug 2019 = 14.6% Sep - Feb 2020 = 15.3% Using FOBT & Using Turning 50 QI Initiative Mar - Apr 2019 = 33%	

Change Ideas

Change Idea #1 Re-launch a revised "Turning 50 Initiative" for FIT using the Preventative Care Summary Report in our eMR

Methods	Process measures	Target for process measure	Comments
1) RNs to review Preventative Care Summary Report in eMR and notify PCP of screen-eligible patients who are turning 50 years-old 2) Provide list to PCPs to generate LifeLabs lab req 3) RNs to F/U 4 months later to determine if FIT is done 4) If not done, RNs to call pt once to F/U	1) % of pts turning 50 with the a FIT test done.	1) 33	Mar 18, 2020 Ontario Health suspended routine CA screening due to COVID-19 pandemic. Timeline of this QI initiative may be adjusted as screening activities resume.