Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Peterborough FAMILY HEALTH TEAM

2/22/2017

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

The Peterborough Family Health Team (PFHT) is committed to putting patients first and engaging in Quality Improvement in Primary Care.

Our vision: A leader in the delivery of collaborative family medicine serving the residents of Peterborough County.

Our mission: As a provincial health care leader and community partner, the Peterborough Family Health Team coordinates and empowers family practice-centred multidisciplinary teams to provide high quality, evidence-based, primary care to meet the needs of all residents of Peterborough County.

Through our Quality Improvement Plan, we continue to demonstrate our commitment to quality while fulfilling our vision and mission. We've ensured that our QIP aligns with the priorities established by the Ministry of Health and Long Term Care (MOHLTC), the Central East Local Health Integration Network (CE LHIN) Integrated Health Service Plan (IHSP) 4 Strategic Aims, Health Quality Ontario (HQO) and our Key Directions for Success as set out in our 2016-2019 strategic plan:

1. Lead locally and provincially through collaboration and integration (QIP Priorities: Effective, Patient-Centred, Timely)

2. Meet the diverse needs of all the residents of our community (QIP Priorities: Equitable, Patient-Centred, Timely)

3. Enhance team-based patient-centred care (QIP Priorities: Equitable, Patient-Centred)

4. Support primary care delivery through organizational effectiveness (QIP Priorities: Effective, Patient-Centred, Timely)

Our organization saw positive change in 2016/17. Our operational plan was developed and is currently being carried out, our board successfully transitioned to a mixed-governance model, and our quality committee now better established, played a vital role in the development of this QIP.

QI Achievements From the Past Year

Our patient perception of same/next day access (54%) exceeds that of the Central East Local Health Integration Network (CE LHIN) (46%) as well as Ontario (44%) and Canada (38%). We recognize that there is more work to do in this area and continue to seek ways to improve timely access to care for our patients.

We continue to demonstrate a high degree of patient involvement in the care we provide. According to our 2016/17 patient experience survey results, ninety-six percent (96%) of patients indicated that they were involved as much as they wanted to be in decisions about their care. This rate exceeds that of the CE LHIN (86%), Ontario (86%) and Canada (81%).

In addition, we also continue to demonstrate high performance with respect to spending enough time with our patients and giving them an opportunity to ask questions about their care and recommended treatment.

Mental health was identified as a priority in our 2016-2019 strategic plan and in response to this, we increased mental health programming to serve more patients.

Our Mindfulness program was centralized and expanded to serve a greater number of patients across all five (5) Family Health Organizations (FHOs.) In addition, our Mindfulness-Based Cognitive Therapy (MBCT) program was expanded from a FHO based program to a FHT wide program. Centralizing the programs enabled more flexible scheduling with sessions and offered patients the choice of attending more days of the week at various times, which provides more.

Population Health

According to 2011 census data, Peterborough has a more elderly population with 20% of its residents aged 65+ compared with 14.6% in Ontario. The residents of Peterborough have a higher burden of chronic disease and are more complex than the average Ontarian. According to our Primary Care Practice Group Report (period ending: March 31, 2016), our percentage of patients with various chronic disease conditions (hypertension, congestive heart failure, acute myocardial infarction, mental illness and diabetes) is higher than the province of Ontario.

Our admission rate for COPD is significantly higher 3.8 per 1,000 versus the province which is 1.5 per 1,000. In response to this and in collaboration with our local hospital, Peterborough Regional Health Centre (PRHC) we are working on reducing 30-day readmission rates for COPD. The readmission rate for COPD has increased from 15% in 2014/15 to 27% 2016/17 May YTD. A working group has been formed between PRHC, primary care and Respiratory to address barriers and optimize the management of patients living with COPD. Our Clinical Support Services (CSS) team will be supporting patients once they are discharged from hospital to help ensure that they have the services they need to remain in their homes.

We continue to receive CTAS 4,5 data from PRHC and surrounding hospitals and we use this data to identify trends and potential opportunities to increase access for our patients.

We've been working in collaboration with one of our palliative care physicians and a clinical nurse educator in cancer care at PRHC to develop an Advance Care Planning (ACP) EMR tool. Primary care providers can use this tool to help guide the conversation around advance care planning with the recognition that ACP discussions most appropriately begin at the primary care level.

Equity

A gap was identified in our community with respect to the primary care of transgender individuals. In response, we collaborated with the Canadian Mental Health Association (CMHA) to develop a plan to better support this underserviced population. We took the initiative to create a Trans Care Clinic that will help bridge the current gap within our system. The clinic will be NP-Led with physician consultation and patients will also be supported by mental health clinicians and pharmacists. The clinic has two goals: 1) to provide gender transition support care to the transgender and gender diverse community of the PFHT and 2) to increase the PFHT clinician skill and comfort in the provision of this care so that these patients can ultimately receive this care by their PFHT primary care provider. Concurrently we will foster knowledge and education within primary care practices across PFHT through the provision of LGBTQ training to providers and employees as well as other educational opportunities.

Peterborough County is home to two Indigenous communities; Curve Lake First Nations and Hiawatha First Nations. Our aboriginal population is higher than Ontario's average (3.6% versus 2.4%.) These 2 communities receive comprehensive team based primary care and have access to all programs and services run by the FHT.

We belong to the Refugee Mental Health Advisory Committee which was formed to discuss providing access to services for refugees.

PFHT is a member of the Refugee Resettlement Task Force which meets monthly with a variety of community agencies to discuss the settlement of the Syrian Refugees into our community. To date Peterborough has received more than 250 refugees and has been very successful with this integration. Healthcare, housing, education, social services, and other community groups are represented at this table.

We are represented at the Peterborough Situation Table which is a collaborative, integrated multi-agency group which aims to meet the immediate needs of individuals and families experiencing acutely elevated levels of risk. Once an acute situation is managed, the CSS team may become involved to assist community members in moving towards long term solutions. If a patient identified at the Situation Table meets the Health Links criteria, the CSS team will provide navigation services and a coordinated care plan if required.

Peterborough has also been proactive in the area of Cultural Competency training. Educating our staff in this area will be a priority for the coming year. A number of key organizations have begun the process of creating a database of available training within our community and will be working collectively to offer a suite of training to the various organizations in our community.

Integration and Continuity of Care

Our CSS team continues to work closely with PRHC to facilitate transitions of care for our patients post-discharge. Our CSS team acts as a single point of contact with PRHC to ensure that patients receive follow-up care post discharge. We receive daily discharge lists which are used to ensure that proper follow-up care is arranged. In 2017/18 the CSS team in collaboration with PRHC, is going to have a special focus on reducing readmission rates for patients with COPD.

The CSS team continues to work in partnership with the Congestive Heart Failure (CHF) Centre and PRHC to coordinate and optimize care for our patients with congestive heart failure. The team ensures that patients receive timely follow-up care and that patients are offered FHT programs/services as appropriate for their care needs. PRHC has seen a decrease in readmission rates for CHF over the past few years (23% in 2014/15 to 14% 2016/17 May YTD) partly due to successful collaborations such as this.

In collaboration with Telehomecare (CCAC), we will be supporting patients with COPD and CHF who don't meet the eligibility criteria for the Telehomecare program. The CCS team will be supporting these patients in identifying patient care needs and providing linkages to primary care and community programs and services. The CSS team will also provide follow-up to patients discharged from the 6-month Telehomecare program.

Finally, for patients with COPD we will consider developing an education program related to the disease state and optimal treatment and management.

Access to the Right Level of Care - Addressing ALC Issues

The Patients First Action Plan and the CE LHIN's Integrated Health Service Plan 2016-2019 both place emphasis on more coordinated care for patients with complex medical conditions. As one of the partners in the Peterborough Health Link, we continue to work on improving co-ordination of care for high-needs patients with

complex conditions in an effort to keep them out of hospital. The CSS team's work around follow-up after hospitalization helps to ensure that patients receive appropriate care post discharge and thereby prevent readmissions. Through the COPD program, the CSS team will be identifying patients who meet the Health Links criteria and developing individualized coordinated care plans and linking patients with community resources.

PFHT has also worked closely with PRHC and the Peterborough Housing Corporation over the last year on a submission to the CE LHIN regarding funding of supportive housing in Peterborough that would provide temporary housing for ALC patients currently occupying a hospital bed.

Engagement of Clinicians, Leadership & Staff

We recognize that a quality improvement plan will be more successful if all members of the team are involved in its development and implementation. To this end, we have developed a Quality Improvement Plan (QIP) Working Group. This group will have front line input into the development and implementation of our annual QIP. The working group will have multi-disciplinary representation including administration, physician, nurse practitioner and other disciplines. The working group will work closely with our Quality Committee alongside the senior leadership team to help fulfill our commitments set out in our annual QIP. This group will convene in the spring to be introduced to and begin development of our 2018/19 QIP.

Resident, Patient, Client Engagement

We are in the final stages of forming our Patient and Family Advisory Council (PFAC). This council will provide feedback on current & future programs and services to help strengthen the local primary healthcare system.
The patient experience survey is another way that we engage with our patients for input and feedback. Feedback from our patient experience surveys is shared with the quality committee and the FHT as a whole at various levels. All members receive our FHT level results, FHO physician leads and FHO administrators receive FHO-level results and providers themselves receive their own individual results.

Another avenue for patient engagement and communication is our website. Our patient experience survey is available on our website. In addition, we have a patient relations section and contact for patients to voice their opinions, concerns, and to have issues resolved. As well, a patient relations process is in place to ensure that all patient concerns are addressed in a timely and appropriate manner.

We use social media platforms such as Facebook and Twitter to engage with our patients and share information. We recently launched our first semi-annual community newsletter which was shared via social media and posted to our website.

Staff Safety & Workplace Violence

In accordance with Bill 168, we have a policy on Violence in the Workplace and are committed to building and preserving a safe working environment.

We recently established a more formal communication algorithm for both clinical and HR related issues or concerns. Staff can access these 2 algorithms to bring forward any work related issue. These algorithms were developed by our Employee Council and distributed to all staff.

We have developed and distributed privacy policies capturing the following areas: Privacy Policy, Privacy Breach Protocol, Lockbox Policy, Computer/Electronics Policy, Access and Corrections Policy.

Contact Information

Our QIP is posted on both the HQO website and our organizational website.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair
Quality Committee Chair or delegate
Executive Director / Administrative Lead
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2016/17 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

Measure/Indicator from 2016/17	**Current Performance as stated on QIP2016/17**	**Target as stated on QIP 2016/17**	**Current Performance 2017**	**Change Ideas from Last Year's QIP (QIP 2016/17)**	**Was this change idea implemented as intended?**	**Comments**	**Lessons Learned: (Some questions to consider) What was your experience with this indicator? What were your key learnings? Did the change idea make an impact? What advice would you give others?**
Percent of patients who responded positively to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office **spend enough time** with you?" % PC organization population (surveyed sample); April 2015 – March 2016; In-house survey	94.18	94.18	95.84	Maintain current performance as we are above the provincial and the CE LHIN average.	Yes	We had planned to maintain performance for this indicator.	
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? % PC organization population (surveyed sample); April 2015 – March 2016; In-house survey	95.72	95.72	95.54	Maintain current performance as we are above the provincial and the CE LHIN average.	Yes	We had planned to maintain performance for this indicator.	
Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions % Discharged patients with selected HIG conditions; April 2014 – March 2015; CIHI DAD)	25.56	25.56	33.91	Use the Welcome Home program to facilitate post-discharge follow-up care.	Yes	We continue to receive daily discharge lists for select floors at our local hospital PRHC and use these to facilitate follow-up care.	We recently learned that the data provided by the Health Data Branch for use in our 2016/17 QIP was incorrect. Errors were recently identified in the exclusions that were used for the 2014/15 results and revised results were provided. Our follow-up rate as per the data branch last year was 25.56%. With the revised results, our follow-up rate was actually 35.91%. What originally appeared to be a 27.21% decrease was actually a 2.25% increase. In addition to this, we are finding that practices are proactively arranging and providing follow-up care in the recommended time frame on their own. Often when Clinical Support Services (formerly the Welcome Home program) contacts them, they have already arranged follow-up care for their patients. The definition for this indicator and the data we receive from the Health Data Branch continues to be inaccurate as it isn't inclusive of the care provided by the FHT model.

Measure/Indicator from 2016/17	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Comments	Lessons Learned: (Some questions to consider) What was your experience with this indicator? What were your key learnings? Did the change idea make an impact? What advice would you give others?
Percent of respondents who responded positively to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office give you an opportunity to **ask questions** about recommended treatment? % PC organization population (surveyed sample); April 2015 – March 2016, In-house survey	95.10	95.10	96.47	Maintain current performance as we are above the provincial and the CE LHIN average.	Yes	We had planned to maintain performance for this indicator.	
Percentage of acute hospital inpatients discharged with selected HIGs that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission, by primary care practice model. % Discharged patients with selected HIG conditions; April 2014 – March 2015; CIHI DAD	16.50	16.50	18.78	Maintain or improve performance using the Welcome Home program.	Yes	We aim to ensure that proper follow-up care is arranged post-discharge in an effort to decrease readmissions. We try to track readmissions internally however we aren't always aware of readmissions. In some cases we may learn of readmissions inadvertently and with others we likely remain unaware.	We have been working closely with the Peterborough Health Link and other community partners to improve transitions and coordinated care. Unfortunately we saw a slight increase in readmissions. Although we aim to provide timely follow-up care to prevent readmissions, readmissions often occur for various reasons some of which are beyond our control. This measure remains challenging given that the data from the Health Data Branch is outdated upon receipt.
Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed. % PC organization population (surveyed sample); April 2015 – March 2016 (or most recent 12-month period available); In-house survey	54.21	54.21	53.83	Maintain current performance as we are above the provincial and the CE LHIN average.	Yes	We had planned to maintain performance for this indicator.	We continue to work on improving access for our patients and increasing patient awareness of same/next day access.

2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

Peterborough FHT 150 King Street, 4th Floor, Peterborough, ON K9J 2R9

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Coordinating care	Percentage of medical patients with COPD for whom discharge notification was received identified as meeting Health Link criteria who are offered access to Health Links approach	% / Discharged patients with selected HIG conditions	In house data collection / April 2017 - March 2018	CB	75.00	We aim to offer the Health Links approach to all patients with COPD, discharged from medical floors at PRHC who meet the Health Links criteria.	1)Offer the Health Links approach to patients with COPD who meet the Health Links criteria	Upon discharge notification, assess whether patients meet the Health Links Criteria Offer the Health Links approach to those who meet the criteria Complete a CCP for patients who consent	# patients with COPD discharged from PRHC # patients with COPD who meet the Health Links criteria # patients offered the Health Links approach # patients who accept the Health Links approach # Coordinated Care Plans (CCPs) developed	75% of patients with COPD discharged from PRHC who meet the Health Links criteria will be offered the Health Links approach.	
	Effective transitions	Percentage of medical patients with COPD for whom discharge notification was received readmitted to hospital within 30 days of acute discharge	% / Discharged patients with selected HIG conditions	In house data collection / April 2017 - March 2018	CB	CB	Collecting baseline.	1)Use our Clinical Support Services (CSS) team to reduce 30-day readmissions.	Receive PRHC discharge lists and summaries on Meditech Telephone calls within 1 week then monthly for 3 months to: 1. Assess and triage - prioritize individual patient acuity of need - considering gaps in care and service 2. Assess for follow-up appointments with primary care provider (PCP) practice or offer CSS NP 3. Offer education on disease condition, medications-puffers, exercise, diet, acute exacerbation (action plan) 4. Provide learning tools and handouts - education specific to new diagnosis, acute, chronic/readmits 5. Assess or refer to Respiratory clinic and or Respiratory Rehab at PRHC 6. Assess palliative suggest ACP to PCP when appropriate 7. Assess/refer patients to CCAC Telehomecare with option for them to refer back upon completion of Telehomecare 8. Quality of Life (QOL) COPD Assessment Test (CAT) survey for all patients initially then 3 months. Follow-up CAT survey for patients CSS services with education. 9. Direct patients to Central East LHIN Self-Management Program website 10. Link to Navigator for coordination of Health Links (HL) Coordinated Care Plans (CCPs) as needed	# patient discharges with COPD # patients readmitted within 30 days	Target will be determined following collection of baseline.	
		Percentage of medical patients with COPD for whom discharge notification was received who were followed up within 7 days of discharge, by phone or in-person visit	% / Discharged patients with selected HIG conditions	In house data collection / April 2017 - March 2018	CB	75.00	We aim to follow-up with all patients with COPD discharged from medical floors at PRHC within 7 days of discharge.	1)Use our Clinical Support Services (CSS) team to facilitate post-discharge follow-up care.	Receive PRHC discharge lists and summaries on Meditech Telephone calls within 1 week then monthly for 3 months to: 1. Assess and triage - prioritize individual patient acuity of need - considering gaps in care and service 2. Assess for follow-up appointments with primary care provider (PCP) practice or offer CSS NP 3. Offer education on disease condition, medications-puffers, exercise, diet, acute exacerbation (action plan) 4. Provide learning tools and handouts - education specific to new diagnosis, acute, chronic/readmits 5. Assess or refer to Respiratory clinic and or Respiratory Rehab at PRHC 6. Assess palliative suggest ACP to PCP when appropriate 7. Assess/refer patients to CCAC Telehomecare with option for them to refer back upon completion of Telehomecare 8. Quality of Life (QOL) COPD Assessment Test (CAT) survey for all patients initially then 3 months. Follow-up CAT survey for patients CSS services with education. 9. Direct patients to Central East LHIN Self-Management Program website 10. Link to Navigator for coordination of Health Links (HL) Coordinated Care Plans (CCPs) as needed	# patient discharges with COPD # patients served including number of calls/visits # patients who saw our NP (who would not have otherwise had access to primary care) # patients who received follow-up appointment and phone call from any care provider # patients who saw Respirologists/Respirology Clinic # patients who went to Respiratory Rehab # referrals to FHT to Quit # patients linked to other community services # CAT QOL at 1 week and end of 3 months # HL Coordinated Care Plans completed including how many were offered.	75% patients identified with COPD discharged from PRHC will receive a follow-up care with the FHT within 7 days by phone or in-person with any clinician	In collaboration with our local hospital, Peterborough Regional Health Centre (PRHC) we are working on reducing 30-day readmission rates for COPD. A working group has been formed to address barriers and optimize the management of patients living with COPD. Our Clinical Support Services (CSS) team will be supporting patients once they are discharged from hospital to help ensure that they have the services they need to remain in their homes. In collaboration with Telehomecare (CCAC), we will be supporting patients with COPD and CHF who don't meet the eligibility criteria for the Telehomecare program. The CCS team will be supporting these patients in identifying patient care needs and providing linkages to primary care and community programs and services. The CSS team will also provide follow-up to patients discharged from the 6-month Telehomecare program.

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
	Population health - cervical cancer screening	Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years	% / PC organization population eligible for screening	See Tech Specs / Annually	66.57	68.00	We improved by 3.6% (Mar 2015 to Mar 2016) and we aim to continue this improvement in small increments. We are currently above AFHTO's Data to Decisions (D2D 4.0) average of 65.7% for Family Health Teams across the province. In addition, we are above the provincial average of 58.90% (Primary Care Practice Group Report Mar 2016.)	1)Hold a cancer screening day to engage the under screened and marginalized women within the Peterborough Family Health Team. We want to build on the success of past years cancer screening days and expand to capture these women as a quality improvement project for early cancer detection.	Host a 'Women's Wellness Day' on a Saturday where patients of the Peterborough FHT can access Cervical screening (paps), Colorectal screening (FOBT kits), and Breast Screening (mammograms.)	# Paps completed	200 Paps completed during the event	This integrated 'Cancer Screening Day: A Wellness Day for Women, by Women' is a collaboration between the Peterborough County-City Health Unit, Peterborough Regional Health Centre's Breast Assessment Centre, the Peterborough Clinic, and The Medical Centre. This will be our 4th time hosting an integrated screening day. Participants enjoy this one-stop-shop approach to staying up to date with their cancer screening. All of our FHOs are encouraged to participate in this quality improvement initiative.
	Population health - colorectal cancer screening	Percentage of screen eligible patients aged 50 to 74 years who had a FOBT within the past two years, other investigations (i.e., flexible sigmoidoscopy) within the past 10 years or a colonoscopy within the past 10 years.	% / PC organization population eligible for screening	See Tech Specs / Annually	67.34	69.00	We improved by 3.2% (Mar 2015 to Mar 2016) and we aim to continue this improvement in small increments. We are currently above AFHTO's Data to Decisions (D2D 4.0) average of 62.7% for Family Health Teams across the province. In addition, we are above the provincial average of 64.15% (Primary Care Practice Group Report Mar 2016.)	1)Hold a cancer screening day to engage the under screened and marginalized women within the Peterborough Family Health Team. We want to build on the success of past years cancer screening days and expand to capture these women as a quality improvement project for early cancer detection.	Host a 'Women's Wellness Day' on a Saturday where patients of the Peterborough FHT can access Cervical screening (paps), Colorectal screening (FOBT kits), and Breast Screening (mammograms.)	# FOBT kits distributed/collected	60 FOBT kits distributed during the event	This integrated 'Cancer Screening Day: A Wellness Day for Women, by Women' is a collaboration between the Peterborough County-City Health Unit, Peterborough Regional Health Centre's Breast Assessment Centre, the Peterborough Clinic, and The Medical Centre. This will be our 4th time hosting an integrated screening day. Participants enjoy this one-stop-shop approach to staying up to date with their cancer screening. All of our FHOs are encouraged to participate in this quality improvement initiative.
								2)Encourage primary care providers to assign a 'due back by' date for FOBT kits to be returned to office.	Each time an FOBT kit is given to a patient, a 'due back by' date will be printed on an appointment card and given to the patient.	# providers assigning due back by dates # FOBT kits distributed # FOBT kits returned	25% of our providers will assign due back by dates for FOBT kits 33% of FOBT kits distributed will be returned	This was a suggestion by one of the medical secretaries. She started printing a due back by date on an appointment card and giving it to the patient along with the FOBT kit. She noted an increase in the number of kits being returned.
Patient-centred	**Person experience**	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?	% / PC organization population (surveyed sample)	In-house survey / April 2016 - March 2017	95.54	95.54	We plan to maintain performance on this indicator. We are currently above AFHTO's Data to Decisions (D2D 4.0) average of 90.8% for Family Health Teams across the province. In addition, we are above the provincial average of 85.9% and CE LHIN average of 86.2% (2015 Health Care Experience Survey, provided by the Ministry of Health and Long-Term Care (HQO Measuring Up Report 2016))	1)Enhance provider awareness of patient feedback received via patient experience surveys	Provide each physician/NP/AHP with provider-level results collected via patient experience surveys.	% of providers who receive individual feedback	100%	
								2)Continue to conduct patient experience surveys and maintain or exceed target on survey question	Patient Experience Surveys	% of patients responding "always" or "often" to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office involve you as much as you want to be in decisions about your care and treatment?"	Maintain or improve % of patients responding "always" or "often" to question on patient experience survey.	

AIM		Measure						Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Timely	Timely access to care/services	Percentage of patients and 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 2016 - March 2017	53.83	55.00	Continue to improve in small increments. We are currently above AFHTO's Data to Decisions (D2D 4.0) average of 51.9% for Family Health Teams across the province. In addition, we are above the provincial average of 43.6% and CE LHIN average of 46.3% (2015 Health Care Experience Survey, provided by the Ministry of Health and Long-Term Care (HQO Measuring Up Report 2016)) *Initially we compared our performance with that of our peer group (internally created using similar size FHTs.) We found that the performance of the peer group was higher however upon reaching out to the peer group FHTs, we learned that they weren't fair comparators. The main reason for this was differences in models of care delivery. Many of the providers who participate in PES at our peer group FHTs practice advanced access whereas only a few of our physicians practice this model.	1)Hosting an education session on the topic of Advanced Access.	At our annual Brain FHT education day, we will be hosting a session on Advanced Access presented by one of our physicians who currently practices this model. This session is intended to introduce the topic and pique interest in this model of primary care delivery. This session will be recorded and distributed to promote this concept.	# providers who attend session # accessed recorded session	30+ providers attend the session	A greater number of providers may have access to the presentation than the number of providers who attended the session.
								2)Increase patient awareness of same/next day and extended hours service access.	Messaging via social media, semi-annual community newsletter, electronic billboards, and other print media across the city/county.	n/a	n/a	Our QIP working group has targeted this performance measure to develop change ideas to improve access.
								3)As a pilot project, one FHO has implemented nurse practitioner (NP) supported day call to increase access to same day appointments.	Mondays, Wednesdays and Fridays, an NP is scheduled in the day call clinic to see patients who require a same day appointment.	# available appointments # unfilled appointments % unfilled appointments	To increase same/next day access as reported by the patient and as measured by the patient experience survey.	