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

Couchiching Family Health Team
Working together. Enhancing care.

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AIM		Measure							Change				
Quality dimension	Issue	Measure/ Indicator	Unit / Population	Source / Period	Org. Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	**Effective transitions**	Percentage of patients for whom discharge notification was received who were followed up within 7 days of discharge, by phone or in-person visit, with any clinician.	% / Discharged patients	In house data collection / Last consecutive 12 month period.	92260 *	CB	CB	Current performance reflects a pilot project in a 5 physician office with a patient cohort with COPD. We are unable to measure this indicator organization wide at this time.	1)Follow up within 7 days of hospital discharge for CFHT patients with COPD.	Pilot with AAMMOP (physician group) - nursing staff to be notified of OSMH discharge, nursing staff/physician contacts patient (could be through office visit, physician contact, telephone call) and utilize the newly developed custom form for tracking. Book further follow-up if required.	a) % of nursing/physician follow-up calls within 7 days of hospital discharge b) % of nursing/physician follow-up calls within 3 business days of hospital discharge	a) 85% of nursing/phsycian follow up calls to be made within 7 days by March 1, 2018 b) 75% of follow up calls made within 3 business days by March 1, 2018	
									2)Education and engagement about community programs to AAMMOP staff and physicians.	Lunch n Learns by community partners, Clinical Program Team to distribute information to AAMMOP offices (handout)	a) # of education and information sessions provided to physician office b)% of patients with community services in place (when required)	a) 1 lunch and learn, 2 updates by Clinical Team by March 1, 2018 b) 80% of patients have community services in place when required by March 1, 2018	
									3)Education to physicians through pod meetings on indicator and importance of dictations within 24 hours post-discharge for patients with COPD.	Communication at AAMMOP pod meetings, e-mail blast re: importance of dictations within 24 hours post-discharge for patients with COPD	% of discharge summaries received by nursing staff/physician within 2 business days of d/c in order to contact patient within 7 days post d/c	50% of discharge summaries received by nursing staff/physician within 2 business days of d/c by March 1, 2018	

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		Percentage of acute hospital inpatients rostered to CFHT physicians discharged with COPD that are readmitted to Orillia Soldiers Memorial Hospital for COPD within 30 days of the discharge for index admission.	% / patients with COPD	In house data collection / 04/01/2017 to 03/01/2018	92260 *	CB	CB	This is our collaborative indicator that we are working on with CCAC, OSMH and Health Link. We aren't anticipating a significant change in the overall indicator as this is a small pilot project.	1)Follow up within 7 days of hospital discharge for CFHT patients with COPD.	Pilot with AAMMOP (physician group) - nursing staff to be notified of OSMH discharge, nursing staff/physician contacts patient (could be through office visit, physician contact, telephone call) and utilize the newly developed custom form for tracking. Book further follow-up if required.	% of nursing/physician follow-up calls within 7 days of hospital discharge	85% of nursing/phsycian follow up calls to be made within 7 days by March 1, 2018	
									2)Education and engagement about community programs to AAMMOP staff and physicians.	Lunch n Learns by community partners, Clinical Program Team to distribute information to AAMMOP offices (handout)	a) # of education and information sessions provided to physician office b)% of patients with community services in place (when required)	a) 1 lunch and learn, b) 2 updates by Clinical Team by March 1, 2018	
									3)Education to physicians through pod meetings on indicator and importance of dictations within 24 hours post-discharge for patients with COPD.	Communication at AAMMOP pod meetings, e-mail blast re: importance of dictations within 24 hours post-discharge for patients with COPD	% of discharge summaries received by nursing staff/physician within 2 business days of d/c in order to contact patient within 7 days post d/c	50% of discharge summaries received by nursing staff/physician within 2 business days of d/c by March 1, 2018	
	Reduce osteoporotic fractures	To increase the percentage of patients at high risk for fracture who are offered appropriate treatment according to Osteoporosis Canada Guidelines	% / Women over age 65 and Men 70 and over	In house data collection / 05/01/201/ to 11/01/2017	92260 *	CB	CB	Current performance unknown. Collecting baseline data.	1)Determine the usage of the Osteoporosis Canada screening tool	Perform search at six months time to determine how many physicians in FHT are using the Osteoporosis Canada Screening Tool	All searches completed at six month mark (December 1, 2017)	50% of physicians using tool by November 1, 2017	
									2)Determine the effectiveness of the Osteoporosis Canada Fracture Prevention Nurse	Perform search at six months time to determine if recommendations from Osteoporosis Fracture Prevention Nurse were carried out by the physicians	All searches completed at six month mark (December 1, 2017)	75% of recommendations by Osteoporosis Canada Fracture Prevention Nurse have been carried out by physicians by November 1, 2017	
									3)Educate physicians about the use of the Osteoporosis Canada Screening Tool	Provide education sessions to physician about the Osteoporosis Canada Screening Tool	% of physicians attending education session.	100% of physicians are educated about the Osteoporosis Canada Screening tool.	

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Safe	**Improve stroke prevention in patients with Atrial Fibrillation (AF)**	To increase the percentage of patients with atrial fibrillation on appropriate anticoagulant treatment based on current Canadian Cardiovascular Society (CCS) Guidelines.	% / Patients with Atrial Fibrillation	In house data collection / last consecutive 12 month period	92260 *	72	80.00	Stretch target	1)Standardize documentation of Atrial Fibrillation	Conduct searches to capture all AF patients and standardize documentation to include one of these 4 indentifiers: Afib, Atrial Fibrillation, ICD Code 427, SNOWMED-CD code 49436004	% of physicians that complete standization of documentation for AF	100% of physicians will standardize documentation by Feb. 1, 2017	
									2)Increase percentage of INRs completed within 45 days	Monthly search to identify patients on warfarin for atrial fibrillation that have not had an INR in the preceeding 45 days	% of physicians that complete search of patients on warfarin	95% of INRs done on patients on warfarin in the prior 45 days by April 1, 2017	
									3)INRs are within therapeutic range	Insert Rosendaal calculator to determine time in therapeutic range for patients with Afib on warfarin	% of patients identified with AF that have the Rosendaal calculator inserted in chart	100% of patients with AF have calculator inserted in chart by April 1, 2017	
									4)Anticoagulation management is within Canadian Cardiovascular Society Guidelines for patients on warfarin	Change to NOAC if Cr is within range and INR is below TTR of 70% (unless management changed by expert opinion)	# of patients changed to NOAC	80% of patients with AF will be managed according to CCS Guidelines by March 1, 2018	