2018/19 Quality Improvement Plan for Centretown CHC

AIM		Measure				Change				
Quality dimension	Issue	Measure/Indicator	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	**Effective transitions**	Percentage of patients who have had a 7-day post hospital discharge follow up. (CHCs, AHACs,NPLCs)	30	35.00	Maintain 3-year improvement trend.	1)Consider resource implications of calling every discharged client for select conditions & implement, resources permitting.	Identify best practices used by high-performing peers (Central Ottawa CHCs) and resource implications.	To be determined.	To be determined.	
						2)Improve data entry for post-discharge follow-up visits to ensure that reported performance (Practice Profile) mirrors our actual performance.	Review current data entry practices and work with Data Management Coordinator to ensure that post-discharge encounters are properly coded by providers.	% of post-discharge encounters properly coded. (Quarterly chart audit)	100%	
Equitable	**Population health - cervical cancer screening**	Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period.	75	77.50	Maintain 3-year improvement trend.	1)Book eligible clients overdue/soon to be overdue for PAP test.	Generate lists of clients soon-to-be overdue prior to each quarter using our Business Intelligence tool (BIRT) and recalling them for PAP screening.	Monitor recall rate (effectiveness); Monitor disparities in sociodemographics (equity)	Quarterly PDSA cycles targeting process improvements to be defined after analyzing Q1 results (Starting end of Q1 F18-19).	
						2)Monitor screening rates by provider and develop individualized improvement targets for 2018-19.	Generate quarterly reports on overdue screenings by provider to set individualized improvement targets.	Each provider will set year-end target by end of Q1 for % eligible clients overdue for PAP test.	All providers will have targets below 25% eligible clients overdue for PAPs by year-end.	
						3)Monitor screening rates by clients' sociodemographic background in order to identify access inequities for cervical cancer screenings.	Monitor % clients overdue who were offered a PAP test by sociodemographic background (income, race/ethnicity, etc).	Engage providers in dialogue surrounding perceived barriers to the active offer of cervical cancer screenings for sociodemographic groups at highest risk of being overdue.	3 barriers to active offer identified and change ideas developed by end of 2018-19.	
	Population health - colorectal cancer screening	Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for colorectal screening in each calendar year	32.7	28.00	Maintain 3-year improvement trend.	1)Book eligible clients overdue/soon to be overdue for FOB/FI test.	Generate lists of clients soon-to-be overdue prior to each quarter using our Business Intelligence tool (BIRT) and recalling them for colorectal cancer screening.	Monitor recall rate (effectiveness); Monitor disparities in sociodemographics (equity)	Quarterly PDSA cycles targeting process improvements to be defined after analyzing Q1 results (Starting end of Q1 F18-19).	

						2)Monitor screening rates by provider and develop individualized improvement targets for 2018-19.	Generate quarterly reports on overdue screenings by provider.	Each provider will set year-end target by end of Q1 for % eligible clients overdue for colorectal cancer screening.	All providers will have targets below 30% eligible clients overdue for colorectal cancer screening by year-end.	
						3)Monitor screening rates by clients' sociodemographic background in order to identify access inequities for colorectal cancer screenings.	Monitor % clients overdue who were offered a colorectal cancer screening by sociodemographic background (income, race/ethnicity, etc).	Engage providers in dialogue surrounding perceived barriers to the active offer of colorectal cancer screenings for sociodemographic groups at highest risk of being overdue.	3 barriers to active offer identified and change ideas developed by end of 2018-19.	
	Priority Population (Trans* Health Care)	Percentage of clients for whom self-reported mental health improves as a result of accessing Centretown CHC's Trans Health Clinic.	CB	30.00	Acuity of depression scores improved for ~30% of transgendered clients after hormone therapy in a 2014 pre/post observational study by Colizzi, Costa & Todarello.	1)Identify trans clients' unmet needs for care/support using a pre/post survey.	Trans Health Clinic (THC) will collect a client survey to measure client experience for the THC after the 1st visit, 3rd (last) visit, and at 3-month follow-up. Unmet needs and areas for performance to be reviewed quarterly to inform improvements to the THC model.	% of Trans Health Clinic clients completing the client experience survey at t1, t2 and t3.	Aim for 75% completion rate of 3rd visit survey at t2 by THC clients, by the end of 2018/19 fiscal year.	
	Sociodemographic Data	Percentage of clients where complete information is recorded on their socio-demographics.	9	15.00	Maintain 2017-2018 QIP target, as we are still working towards it.	1)Blitz to collect missing SD information for existing clients.	Medical receptionists to use all client encounters (phone and in-person) as opportunities to update client sociodemographic information.	% improvement in number of clients with complete sociodemographic information (measured after each quarter by our Data Management Coordinator).	1.5% improvement in absolute rate per quarter.	
						2)Data cleanup to ensure that our denominator includes only 'active clients' (clients seen within past 3 years). Many non-Primary Care clients (e.g. MHA, CHPEY, Diabetes) may be listed as 'active' in our EMR due to less intentional process for changing clients to 'inactive' status.	Data Management Coordinator to eliminate non-active clients from denominator when reporting quarterly % clients for whom we have complete sociodemographic information, using criteria for 'active clients' that are consistent across our programs & services.	% of clients listed as 'active' in our EMR who have accessed our programs & services in the past 3 years (and/or meet other criteria for 'active status' as appropriate).	The Data Management Coordinator will ensure that 100% of clients listed as 'active' in our EMR meet consistent criteria for this status by the end of the 2018-19 fiscal year.	

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?	95.92	95.00	Maintain strong performance. Currently ranked 1st among 6 Central Ottawa CHCs (peer comparators).	1)Improve our ability to monitor quality of care in between annual client surveys, by reviewing our client on-boarding forms and increasing the number of active invitations to clients to provide feedback on their quality of care (including client involvement in decisions about their care).	Increase the visibility of our feedback and complaints processes on our on-boarding forms as well as during care visits.	# of client feedback comments received from all sources.	Client feedback received will increase by 20% by the end of 2018-19 fiscal year as a result of improved communication about our feedback/complaints process as well as new client engagement initiatives.	
						2)Continue to monitor self-reported client involvement in care decisions by clients' sociodemographic background in order to identify inequities in care quality.	Annual client experience survey	% clients who report 'always' or 'usually' being involved in decisions about their care, stratified by priority population identifiers (e.g. LGBTQ2S; low-income; newcomer; older adult; homeless or temporarily housed)	Aim for no significant difference between self-reported involvement in care decisions between priority populations.	
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.	60.9	66.00	Maintain 3-year improvement trend.	1)Identify and address risks to minimize the impact of our renovations on timely access to appointments.	Review scheduling options and work flows in our temporary and newly renovated spaces.	Monitor Third Next-Available (TNA) appointment quarterly.	Collect baseline for TNA appointment as well as peer performance on same indicator to develop performance targets by end of Q1 2018-19.	
						2)Educate providers on modified advanced access concept in order to increase adoption.	Primary Care manager to track the # of providers adopting modified Advanced Access model.	# of providers adopting modified Advanced Access model.	1 additional provider will move to modified Advanced Access model by end of 2018-19.	