2018/19 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

North Muskoka
Nurse Practitioner-Led Clinic

North Muskoka NPLC 5
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Huntsville, ON P1H 2C1

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	Effective transitions	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	91617*	85	90.00	The broadening of the client population will increase the number of clients who are eligible for post discharge follow up and aligns more closely with our team based model of care, ensuring the most appropriate provider for the client can connect and by the means that is most acceptable to the client (i.e. in clinic, at home, by phone, etc.).	1)Morning huddle	Every morning huddle will include a review of all admitted and discharged client.	Number of clients admitted/discharged for which documentation has been received within 48hr will be identified by the primary NP or administrative assistant, dependent upon the mode of communication.	100% of admitted/discharged clients will be identified at morning huddle.	Increase communication with staff regarding admitted patients. Ensuring this is included in daily huddles
										2)Tracking dates of discharge and follow up	Administrative assistant will refine in-house tracking documents and frequency of updates to ensure all admitted/discharged clients are identified accurately.	Weekly updates to tracking documents and quarterly audits to ensure process is working as planned.	100% of admitted/discharged clients are identified in house with accurate reporting.	The NPLC has developed several processes to track this data as we do not have access to HQO practice profiles. Therefore, refining data collection, analysis and audits in this case will not require an inordinate amount of administrative time.
										3)Date of client communication is documented both on the client's chart and on the NPLC tracking document.	Upon identification of admitted clients, the team will determine most appropriate provider to follow up, including a timeline for completion. Administrative assistants will book the appointment. Upon completion of the visit, the administrative assistant will document the follow up on the tracking record.	All post discharge follow up visits, by any provider, by any means, will be documented in a manner that is easily identifiable and can be audited for accuracy.	100% of completed visits will be documented; 90% of clients will receive post discharge follow up by the NPLC.	Despite our focus on team improvements, we recognize that this goal represents a team goal which may or may not align with a client goal. Thus, although we aim to contact 100% of clients, we recognize that not every person will accept a visit and are setting a SMART goal for this measure.
	Smoking Cessation	Percentage of active smokers who are ready to quit and have completed a Quit Plan visit.	C	Number / Active Smokers, Ready to Quit	In-home audit / April-March	91617*	CB	70.00	We are working with the Ottawa model of smoking cessation to identify all active smokers within the practice and offer evidence-based interventions.	1)70% of all clients of the clinic will be screened for smoking status in the course of the fiscal year.	Ask about smoking status at clinic visits	Updated documentation (ICD 305 for smokers or non-smoking status) on clients CPP with date of inquiry	70% of clients have updated smoking information on their CPP.	
										2)Advise 70% of active smokers to quit.	Clinic staff will use with auto amount of smoking cessation advice asked to assess template within clinical encounters to document this advice.	70% of active smokers will be advised to quit.	Data audit will review that 70% of active smokers have been advised to quit.	
										3)For active smokers expressing readiness to quit, 70% complete a Quit Plan visit.	For active smokers related to quit, a quit plan visit will be arranged	We will use the Ottawa Model of Smoking Cessation to educate staff and by documentation processes.	Identified active smokers who expressed readiness to quit according to documents will have a completed quit plan visit, using the templates in the EMR	

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.	A	% / PC organization population eligible for screening	CCO-SAR, EMR / Annually	91617*	68	70.00	Although statistics show that provincial cervical screening participation declined from 2009 to 2011 (68%) to 2012 to 2014 (63%), the North Muskoka NPLC was successful in increasing is performance between 2016 and 2017 and sits slightly above the provincial comparators. As an organization, this will be challenging as internal audits show us that 49% of our eligible patient are due for screening over the next 12 months. In order to meet our target, we will have to screen 39% of those eligible and due in the coming year.	1)Set individual targets for each provider	Using EMR report capabilities, Administrative Lead will run individualized reports for each provider, providing regular updates on screening rates.	Bi-Monthly audits will enable us to track our progress. Reports will provide the number of eligible patients, due for screening, who have completed a pap test in each 2 month interval.	Organization Goal - Complete 170 pap test over the next 12 months. Completed pap test must be for eligible patients who are due for cervical cancer screening.	Individualized reports will help support provider engagement in this process change idea.
										2)Continue the use of standardized documenting practices.	Report audits to review proper procedures are used to help track clinic progress.	Providers are responsible for entering each completed procedure on patients CPP, once pap test results have been received	100% of the procedures will be entered on each patient's CPP - using the clinics standardized documenting practices; MSAA indicator (Pap done/ ordered, Pap Ineligible)or system procedure (Hysterectomy)	As a primary care organization that does not receive group practice reports, data is extracted directly from the clinic's EMR. Providing a standardized documenting practice to staff helps ensure data reliability and accuracy to facilitate proper reporting.
										3)Continue to train, educate administrative staff on cancer screening guidelines and recommendations, empowering them to discuss with patients.	Staff education / training	Provide yearly update on cancer screening guidelines	Complete 1 staff education session.	
	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	A	% / PC organization population eligible for screening	See Tech Specs / Annually	91617*	36.7	35.00	Provincial statistics show us that 38.7% of screen eligible Ontarians were overdue for colorectal screening in 2015. Although our clinic is currently performing well in comparison to provincial rates, an increase in our performance target will be challenging as internal audits show us that 45% of our eligible patient will be due for screening by the end of 2018 if screening does not continue. In order to meet our target, 23% of those overdue will need to screened by the end of 2018.	1)Set individual targets for each provider	Using EMR report capabilities, Administrative Lead will run individualized reports for each provider, providing regular updates on screening rates.	Bi-Monthly audits will enable us to track our progress. Reports will provide the number of eligible patients, due for screening, who have had a Colonoscopy, Sigmoidoscopy or FOBT screening in each 2 month interval.	Organization Goal – Complete appropriate screening for 72 patients who will be overdue for colorectal cancer screening by the end of 2018.	Individualized reports will help support provider engagement in this process change idea.
										2)Continue the use of standardized documenting practices.	Report audits to review proper procedures are used to help track clinic progress.	Providers are responsible for entering each completed procedure on patients CPP, once Colonoscopy, Sigmoidoscopy or FOBT results have been received and reviewed.	100% of the procedures will be entered on each patient's CPP - using the clinics standardized documenting practices; MSAA indicator (FOBT done/ ordered) or system procedure (Colonoscopy, Sigmoidoscopy)	As a primary care organization that does not receive group practice reports, data is extracted directly from the clinic's EMR. Providing a standardized documenting practice to staff helps ensure data reliability and accuracy to facilitate proper reporting.
										3)Continue to train, educate administrative staff on cancer screening guidelines and recommendations, empowering them to discuss with patients.	Staff education / training	Provide yearly update on cancer screening guidelines	Organize 1 staff education session.	

	Population health - diabetes	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months	A	% / patients with diabetes, aged 40 or over	ODD, OHIP-CHDB,RPDB / Annually	91617*	55	60.00	Target was not set based on provincial benchmarks, but rather increased from previous years progress rate. Through patient engagement, education, program offering and in-clinic point of care testing, the clinic will continue to increase it performance.	1)Increase the number of HbA1C point of care test completed in-house using the Siemens DCA Vantage Analyzer	Quarterly report audits and result sharing with staff	Number of HbA1c point of care testing completed each quarter, using the Siemens DCA Vantage Analyzer	10 HbA1c point of care test completed per quarter.	We acknowledge that point of care testing is not meant as a mean of replacing quality controlled laboratory testing but rather presents itself as an additional opportunity to engage patients with their diabetes management journey.
										2)Increase the percentage of patients with Diabetes, aged 40 or over, with at least 1 HbA1C point of care test in the nest 12 months	Quarterly report audits and result sharing with staff	Increase in percentage	30% of patients with diabetes, aged 40 or over, will have at least 1 HbA1C point of care test completed in the next 12 months.	We acknowledge that point of care testing is not meant as a mean of replacing quality controlled laboratory testing but rather presents itself as an additional opportunity to engage patients with their diabetes management journey.
										3)Increase in Diabetes Annual Reviews	Data pull from EMR	Percentage of patients with diabetes with a completed Annual Diabetes Reviews in a 12 month period. (Appointment Type and Procedure on CPP)	25% of patients with diabetes, aged 40 or over will have a completed Annual Diabetes Review in the next 12 months	For this indicator, patients accessing other diabetes management programs will be counted (i.e.. Follow up with other local diabetes education programs). Annual Reviews help initiate a client appointment and promotes regular blood work monitoring.
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?	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	91617*	97.97	98.00	Clinic as always functioned exceptionally well in this area. Patient involvement will continue to be at the forefront of every clinic visit.	1)Provide clients an opportunity to provide feedback on their most recent visit.	Distribute patient experience surveys	Percentage of completed surveys received between April 1, 2018 and March 15, 2018	Survey 12% of patients, over the age of 16, who visited the clinic during fiscal 2018/19	Clinic has continually performed extremely well in this regard. Although we will continue to monitor our performance, we will not focus on change management for this particular indicator.
Safe	**Medication safety**	Percentage of patients with medication reconciliation in the past year	A	% / All patients	EMR/Chart Review / Most recent 12 month period	91617*	62	85.00	We have refined our population to be those clients over age 65 with five or more medications and a hospital discharge within the past 30-days. With this population, we aim to complete a medication reconciliation for 85% of this client base over the next year.	1)Identification of potential clients who fit the criteria	Morning huddles	Morning huddles include a review of all admitted or recently discharged clients.	100% of potentially eligible clients will be identified at morning huddle either at the time of admission to hospital and/or time of discharge.	
										2)Client level data analysis to include number of medications and date of discharge	Administrative review of all admitted/discharged clients to determine number of medications and discharge date.	Of all discharged clients, those identified as needing a medication reconciliation will be identified either at the time of admission or discharge.	100% of clients who fit the criteria for medication reconciliation will be identified.	
										3)In house communication	Upon identifying clients who require medication reconciliation, administrative assistant will bring the information to the Most Responsible NP and Registered Nurse to discuss and arrange client appointment.	Number of clients who are subsequently identified by the primary NP and RN as requiring medication reconciliation.	100% of clients identified will be brought to the attention of the MRP and RN to discuss planning for medication reconciliation visit/process.	

										4)Primary NP/RN will communicate the desired type of visit (targeted vs time add on) to complete the medication reconciliation, will communicate this and administrative assistant will book the appointment to be completed by the clinician as per the agreed upon plan.	Following primary NP/RN review of the client's care plan, a process for medication reconciliation will be determined and communicated to the administrative assistant. This could include a targeted visit or allowance of time to complete the task within another visit.	Number of completed medication reconciliations for the targeted population.	85% of clients will accept and complete a medication reconciliation.	We recognize that the goal of medication reconciliation is set by the clinic and not by the client who may not appreciate the role or importance. Therefore we recognize that despite our best intentions and processes, not every client will wish to participate or complete this work with clinicians.
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.	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	91617*	55.81	60.00	The clinic is currently performing well in comparison to provincial (43.1%)and regional (30.9) statistics. The North Muskoka NPLC continues to apply the knowledge, tools and resources which have been provided by Health Quality Ontario through their Advanced Access training. Despite a decrease in same day/ next day access over last year, 96% or survey clients expressed they got an appointment on the day they wanted. Our clients continue to have timely access to care, same day, next day or on the day they wanted.	1)Continue to balance supply and demand	Track supply and demand for NP's	Each NP's supply and demand will be tracked for a 2 week period.	Ensuring supply exceeds demand will provide the needed appointment availability for clients	Interdisciplinary care team utilization play a key role in Advanced Access. The North Muskoka works diligently at ensuring clients are booked with the most appropriate clinician based on appointments needs. Supply and Demand for NP's is therefore better balanced, providing access for those who require timely care.
										2)Track third next available appointment.	Each quarter, and administrative staff will have the responsibility of tracking a providers 3rd next available appointment and reporting back the findings to the team.	Third next available will be tracked the first Tuesday of May (Provider 1), August (Provider 2), October (Provider 3) and February (Provider 4).	Target is to have the 3rd next available appointment for each provider between 0 - 1 day.	Refreshing our skills using the Supply/Demand and 3rd Next Available tools provided by the Advanced Access workshop, will enable our clinic to stay engaged in timely in process improvements.