Primary Care Quality Improvement Plans

ANALYSIS FOR IMPROVEMENT

2013-2014

Ontario
Health Quality Ontario

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Executive Summary

In April 2013, Ontario's primary health care organizations submitted their Quality Improvement Plans (QIPs) for 2013/14. An essential element of Ontario's health care transformation agenda is the introduction of QIPs to the primary health care sector. This was the first year that Ontario's primary care sector was required to submit QIPs, which were originally mandated for the hospital sector by the *Excellent Care for All Act* (ECFAA), 2010.

Health Quality Ontario (HQO), an arms-length agency of the provincial government, was also created by ECFAA. Health Quality Ontario works in partnership with Ontario's health system to support a better experience of care, better outcomes for Ontarians and better value for money. Our legislated mandate under ECFAA is to monitor and report to the people of Ontario on the quality of their health care system, support continuous quality improvement, and promote health care that is supported by the best available scientific evidence.

Health Quality Ontario is responsible for finding evidence of what works best and translating it into concrete tools and guidelines that providers and organizations from across the health system can put into practice to benefit patients/clients and improve outcomes. Conducting a thorough analysis of primary care QIPs and providing feedback is a key way HQO supports primary care organizations, assists them in the achievement of their goals, and helps them exceed their improvement targets. This analysis of the 2013/14 primary care QIPs is written to acknowledge the commitment of primary care organizations to quality improvement, analyze the number and type of indicators included in this year's QIP, and provide guidance and recommendations to help primary care organizations produce robust QIPs in the future.

In this first year of primary care QIP submissions, the focus was on developing a sense of familiarity with the QIP development and submission process, the setting of effective goals and methods for measurement, and the collection of useful baseline data.

Many of Ontario's primary care organizations are just beginning their quality improvement journey and, as such, were challenged by a lack of available data. In the years to come, as data and quality improvement resources become increasingly available, it is anticipated that primary care QIPs will include clearer targets for improvement and a greater variety of change ideas and process measures. Effective quality improvement relies on effective measurement and despite the data challenges faced by a number of primary care organizations, many developed interesting and adaptable methods for improving the quality of care they deliver.

Overall, the 2013/14 primary care QIPs highlight the excellent work that is underway in Ontario to improve quality of care. Our analysis of these plans is divided into three distinct sections:

1) HQO's Analysis of the 2013/14 QIP Narratives

The QIP Narrative summarizes and contextualizes an organization's quality improvement goals and activities. Within the Narrative, organizations describe how they plan to improve the quality of care they deliver and elaborate on the challenges they faced during the QIP development process.

Many of this year's QIP Narratives included descriptions of how Ontario's primary care organizations are aligning their quality improvement efforts with local, regional, and health system priorities.

Many of Ontario's primary care organizations also discussed accountability in their QIP Narratives, emphasizing the fact that the responsibility for improving quality in an organization is shared by everyone – from front-line nurses to administrators and doctors to senior management. This is a positive trend, as HQO's analysis of QIPs has demonstrated that the most effective plans come from organizations whose leaders use the QIP as a lever to drive information gathering and productive quality improvement conversations.[1]

2) Overview of the 2013/14 Quality Improvement Plans

This section discusses the Model for Improvement (which is the basis for the format and structure of QIPs) and addresses the steps primary care organizations took to establish clear aims, develop effective measures, and identify innovative ideas for improvement.

Identifying, implementing, and sustaining effective ideas for improvement is essential to improving quality of care in Ontario. It is equally important to identify methods for measuring the success of these ideas, which will help primary care organizations determine whether or not the changes they make actually lead to improvement. Quality improvement occurs when ambitious goals are linked to effective measurement methodology.

3) Quality Improvement by Priority Theme

This section of the report is an analysis of each of the attributes of a high-performing health system that were prioritized in the *2013/14 QIP Guidance Document for Primary Care*, and an examination of primary care organizations' ideas for improvement in these areas.

Many excellent examples of quality improvement activities are detailed in the plans and a variety of effective change ideas were identified across the access, integrated and patient-centred quality of care attributes.

The primary care QIPs that were submitted also provided clear descriptions of efforts to support health system integration, and gave examples of how the primary care sector, hospitals, Health Links, Community Care Access Centres (CCACs), community support services, Local Health Integration Network (LHINs), mental health, and long-term care are working together to provide the best possible care to their communities.

In the year ahead, HQO will continue to play a key support role while organizations work to meet their quality improvement goals and the goals outlined in *Ontario's Action Plan for Health Care*.[2] We will do this by continuing to build capacity for using measurement for improvement and by working with stakeholders to assist them in the application of quality improvement knowledge and skills.

Ontario's primary care organizations shaped this report by providing rich and diverse perspectives on quality improvement and on Ontario's health system as a whole. The differences between primary care providers in terms of their patient populations and communities are reflected in this report, as they naturally result in differing quality improvement priorities. Similarly, differing organizational priorities mean that organizations face unique challenges and, as such, develop unique quality improvement programs.

Nevertheless, despite diverse opportunities and challenges, clinical practices and health care quality should be consistent, all across Ontario. This analysis of the 2013/14 QIPs is a learning tool that will help primary care organizations share innovations, effective strategies and success stories, and communicate quality improvement progress to help achieve that consistency of care.

Quality Improvement and a High-Performing Health System

The common goal of a health care system that provides the right care, at the right time, and in the right place has ensured that quality improvement is a priority in Ontario. This prioritization of quality is supported by the following legislation and strategies.

The Excellent Care for All Act (ECFAA): In 2010, the provincial government passed the *Excellent Care for All Act (*ECFAA), which is designed to support the health system and help enhance the quality and safety of care that it provides.[3] ECFAA established a set of requirements for health care providers (beginning with hospitals), which includes:

- The creation of quality committees to report on quality related issues, including the annual Quality Improvement Plan
- Linking executive compensation to the achievement of quality improvement targets
- The implementation of patient and employee satisfaction surveys and a patient complaints process

Quality Improvement Plans: Quality Improvement Plans play a pivotal role in improving the quality of care that is delivered in Ontario. They allow organizations to formalize their quality improvement activities, articulate their goals, and identify concrete ways of achieving those goals. Organizations also use QIPs to communicate their ongoing commitment to delivering high quality care and to demonstrate their dedication to the transformation of Ontario's health system.

Ontario's Action Plan for Health Care: In January 2012, the Ministry of Health & Long-Term Care released *Ontario's Action Plan for Health Care.* The *Action Plan* lays out an ambitious blueprint for health system transformation, with health care integration as the centerpiece of this transformational change.[4]

The Hallmarks of a High-Performing Health System

Ontarians share the vision of a high-performing health system that is safe, effective, accessible, integrated, patient-centred, equitable, efficient, appropriately resourced, and focused on population health. These nine hallmarks of a high-performing health system are defined below.

1. **Safe** - People should not be harmed by an accident or mistakes when they receive care
2. **Effective** - People should receive care that works and that is based on the best available evidence
3. **Accessible** - People should be able to receive the right care, at the right time, in the right setting and from the right health care provider
4. **Integrated** - All parts of the health system should be organized, connected and work with one another to provide high quality care
5. **Patient-centred** - Health care providers should offer services in a way that is sensitive to an individual's needs and preferences.

6. **Equitable** - People should receive the same quality of care regardless of who they are and where they live

7. **Efficient** - The health system should continually look for ways to reduce waste, including waste of supplies, equipment, time, ideas and information

8. **Appropriately resourced** - The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people's health needs

9. **Focused on population health -** The health system should work to prevent sickness and improve the health of the people of Ontario

The indicators that are recommended for this year's QIP reflect three of the attributes listed above, namely: accessibility, integration, and patient-centredness. Improving performance on the indicators related to these attributes may have a positive influence on all nine.

These features appear throughout this report:

INSIGHT — Information on quality improvement best practices, the activities of other primary care organizations, and methods for improvement

Opportunity for Improvement — Identifies areas where there is room for improvement and includes information on how primary care organizations may improve.

QIP TIP — Helpful ideas to consider during the development of next year's Quality Improvement Plan

Part 1: HQO's Analysis of the 2013/14 QIP Narratives

Every QIP consists of two core elements: a Narrative and an Improvement Targets and Initiatives Spreadsheet, also referred to as a QIP Workplan. This section is an analysis of the 2013/14 QIP Narratives.

The QIP Narrative summarizes an organization's quality improvement goals and activities and describes how the plan aligns with other processes within an organization (and more broadly with initiatives underway across the province). The Narrative is a Word document that allows organizations to provide context for the information in the QIP Workplan. It includes a description of how organizations expect to improve the quality of services and care they deliver, as well as descriptions of challenges or risks faced by organizations and the mitigation strategies that were employed.

As an engagement tool for staff, the QIP Narrative can communicate commitment to the organization's quality improvement goals and provide a practical framework to communicate the organization's priorities for the upcoming year.

Key Findings from the QIP Narratives

The majority of the 290 QIPs that were reviewed by HQO included thoughtful and thorough Narratives that clearly described the reasoning behind organizational improvement efforts. The quality improvement strategies most often mentioned in the 2013/14 QIP narratives were:

1. **Alignment of the QIP with other planning:** When organizations align their QIP development process with provincial priorities (e.g., *Ontario's Action Plan for Health Care,* National Standards for Accreditation Canada), with their planning processes (i.e., LHIN Service Accountability Agreements), and performance management frameworks they are better able to focus their efforts on the quality improvement initiatives that will have the greatest impact.

INSIGHT: QIPs & Primary Care Delivery Models

HQO reviewed 290 QIPs that were submitted April 1, 2013, by Ontario's four interprofessional, team-based primary care models: Aboriginal Health Access Centres, Community Health Centres, Family Health Teams, and Nurse Practitioner-Led Clinics. The number of primary care QIP submissions by model of care are outlined below:

- 98% of Ontario's Family Health Teams (FHTs) – 181 of 185 total submissions were considered in this analysis. Four (4) were not submitted in time to be included in this analysis
- 100% of Ontario's Community Health Centres (CHCs) - 75 submissions of 75 total
- 100% of Ontario's Nurse Practitioner Led Clinics (NPLCs) - 24 submissions of 24 total. Two NPLC's opened in July and thus are not included in the total count
- 100% of Ontario's Aboriginal Health Access Centres (AHACs) - 10 submissions of 10 total

2. **Mitigating challenges and risks:** There are many circumstances that may make it difficult to improve quality in an organization. For example, some organizations struggle with human resources issues, while others may have challenges with Electronic Medical Records (EMRs) or the availability of data. It is important for organizations to be aware of where they face challenges, identify root causes, and develop mitigation strategies.

3. **Improving accountability management:** Many of the QIP Narratives submitted by primary care organizations articulated well-developed strategies to improve the quality of care they deliver. The majority of organizations recognized that quality improvement is a shared responsibility, from the Board of Directors through to the staff and patients/clients. The top five groups mentioned in the accountability management section of the QIP Narratives were:

   i. Boards (77%)
   ii. Quality committees (61%)
   iii. Staff (52%)
   iv. Ministry of Health & Long-Term Care (9%)
   v. Patients/clients (7%)

INSIGHT: Quality Governance in Primary Care

Board members of primary care organizations require an understanding of the role they play in quality improvement initiatives and, in turn, organizational QIPs.

The Ministry of Health & Long-Term Care supported the delivery of a governance and safety training program that was offered in the spring of 2013 to board members and the senior management of Ontario's primary care organizations. Developed by the Canadian Patient Safety Institute (CPSI) in partnership with the Association of Family Health Teams (AFHTO), the Association of Ontario Health Centres (AOHC) and Nurse Practitioners' Association of Ontario (NPAO), the training program gave participants the unique opportunity to develop and implement evidence-informed approaches to governance, leadership, processes for safety, and quality and share innovative health governance practices, resources and tools.

Over 506 representatives from across 238 primary care centres attended.

Part 2: Overview of the 2013/14 Quality Improvement Plans

Quality Improvement Plans provide a framework for primary care organizations to identify their improvement initiatives and targets for the next fiscal year. The QIP Improvement Targets and Initiatives Spreadsheet, or Workplan, allows organizations to express their dedication to Ontario's shared vision of improvement by documenting in detail their plans to improve the quality of the care they deliver. The Workplan is also flexible enough that it allows organizations to address organization-specific and regional priorities.

It was recommended in the *2013/14 QIP Guidance Document for Primary Care* that primary care organizations focus on access, integration, and patient-centredness indicators in their QIPs.[5] Many organizations also chose to include population health indicators to measure the success of their efforts to provide influenza immunizations, and prevent breast, cervical, and colorectal cancers by screening.

Three-hundred and thirty-six "non priority" indicators were included in the QIPs that were submitted. These were non priority in the sense that they were not part of the pre-defined list of priority indicators, nor are they the "optional" indicators identified in Appendix 1 of the QIP guidance materials.[6] Although these indicators were not identified in the QIP guidance materials as priorities, their inclusion in the submitted QIPs reflects the primary care sector's commitment to improving the quality of the care that it delivers.

The Model for Improvement and QIPs

The concept and format of the QIP Workplan aligns with the Model for Improvement framework for quality initiatives, originally developed by the Associates in Process Improvement (API).[7] The Model asks three simple questions, which can be used to effectively guide any improvement initiative. These questions are:

1. What are we trying to accomplish? (*Aim*)
2. How do we know that a change is an improvement? (*Measure*)
3. What changes can we make that will result in the improvements we seek? (*Change*)

This section provides an overview of how Ontario's primary care organizations addressed these questions in their 2013/14 Quality Improvement Plans.

2.1 Aims

Every quality improvement initiative requires a clearly defined goal or "aim" that answers the question: "What are we trying to accomplish?" This "aim statement" should be:

Clear, specific, and meaningful: A clearly articulated and specific aim is essential. The statement should articulate exactly when the goal will be achieved and should clarify how and how much something will be changed.

The aim should also meet the expectations and needs of patients/clients.[8]

Stretchable: The aim should be supported by a stretch goal. Stretch goals are forward-thinking but achievable results that surpass an organization's past performance and set the stage for achieving the best possible performance in priority areas for improvement. Setting out to achieve the goal of small, incremental change (e.g., moving from below average to average), does not

necessarily represent a real breakthrough in quality, nor does it generate enthusiasm for improvement amongst staff, patients, and providers.

A stretch goal is shared by an entire health organization and drives quality improvement in two ways: it communicates to the organization that maintaining the status quo is not an option, and it allows senior leadership and boards to mobilize the resources necessary to drive quality improvement.

Reviewing the practices of leading organizations and well established benchmarks is helpful when setting stretch goals.

Opportunity for Improvement: Aim Statements

Example of a poor aim statement:

We will work more efficiently to reduce wait times for new patients this year.

Example of a good aim statement:

Within seven months, we will reduce wait times for all new patients referred to our specialty clinic from 53 days to no more than 26 days.

2.2 Measures

In addition to a clearly defined aim, every quality improvement initiative requires a method of measuring success in order to answer the question: how do we know that a change is an improvement? The *2013/14 QIP Guidance Document for Primary Care* prioritized three attributes of a high-performing health system (accessible, integrated, and patient-centred) and provided a set of indicators to measure performance on these attributes. Over the past year, organizations began to measure their baseline performance on the recommended indicators and provided details about the measures they used.

Establishing current performance is critical to effective quality improvement planning, as baseline measures are used to track the success of quality improvement projects.

Quality improvement teams were asked to develop stretch targets for each indicator. As mentioned above, stretch targets are forward-thinking but achievable results. A stretch target requires reaching beyond the normal and easy capabilities of a team, without being set so far that the goal is unattainable. Targets that are too difficult hinder an improvement effort, while targets that are too easy lead to disengagement.

Effective stretch targets have two components:

1. Concrete and measureable goals, which are expressed as numeric values

2. A justification, which provides more details about the chosen target value. Examples include driving toward theoretical best, meeting and eventually exceeding provincial averages, where available

Measurement for improvement should be conducted regularly to ensure that organizations have access to timely, relevant data that will assist in organizational decision-making. Data should effectively illustrate the quality of processes and health outcomes and be presented in a user-friendly manner so all branches of an organization can gain insight from it.

2.3 Change

The third phase of the Model for Improvement requires organizations to describe in detail the change ideas they plan to implement. It is these change ideas that, when implemented, will allow teams to achieve their improvement goals.

Change ideas are actionable steps for change, targeted at improving specific processes. They often originate from evidenced-based best practices, brainstorming, and creative thinking by front-line staff, providers and patients. Not all change leads to improvement, so organizations are encouraged to include more than one change idea for each indicator in their QIPs. Change ideas help quality improvement teams develop a strategy for improvement, anticipate common barriers to implementation, and create a plan to address those barriers.

Primary care organizations identified process measures to capture whether their change ideas were contributing to improvement. Continuous evaluation of process measures is a key component of quality improvement. Using process measures involves assessing a system or process before changes are implemented, and re-evaluating once changes have been made, to ascertain whether the system or process has actually been improved. The data that emerges from these measurements will reveal further opportunities for improvement.

There are two aspects of an effective process measure in QIPs:

- Process measures link the change idea to be tested to the desired outcome
- Process measures must be measurable in order to demonstrate the impact of the change ideas and gauge improvement

It is recommended that organizations include process measures for each of the change ideas they identify, to measure whether or not the changes being made are leading to the desired outcomes.

Part 3: Quality Improvement by Priority Theme

In order to focus the quality improvement activities that will be underway in Ontario in the coming year, primary care organizations were asked to consider predefined indicators from each of the following attributes of a high performing health system: access, integration, and patient-centredness. Many organizations also chose to include population health and other indicators.

The following sections are an analysis of the access, integration, and patient-centredness priority themes and the indicators related to these attributes of a high performing health system. Each section includes:

1) **Definition:** An explanation of the particular attribute of a high performing health system, why it is important, and why it was prioritized in this year's QIPs.

2) **Excerpts from QIP Narratives:** Relevant excerpts from submitted QIP Narratives that discuss the particular attribute of a high-performing health system, and the reasons the organization chose to address it in their QIP.

3) **HQO's Analysis of *Aims, Measures,* and *Changes:*** Each section includes:

- How many organizations selected the recommended indicators for each attribute of a high performing health system
- Examples of the measures organizations adopted to gauge the success of their improvement efforts
- Examples of the change ideas implemented by primary care organizations

4) **Conclusions:** An assessment of further opportunities for improvement and summative comments on the performance of quality improvement initiatives that were undertaken in Ontario's primary care organizations during 2013/14.

Access: Timely access to care, when needed

Primary care is often the first point of contact for people seeking medical care. Having a family health care provider for every Ontarian who wants one – and providing more patients/clients with faster and more convenient access to this care – is a key priority of *Ontario's Action Plan for Health Care*.[9]

Why improving access to care is important

Access to a regular primary care provider can:

- Reduce the use of the emergency department
- Reduce the use of walk-in-clinics
- Improve continuity of care.[10]

QIP Narrative Excerpts

"2013/2014 will see a focus on… Service access [which] encompasses studying the need for and enhancing access to same-day or next-day primary care appointments; addressing those on our wait list; and reducing the number of same day no show appointments."
— Glengarry Nurse Practitioner-Led Clinic

"The objectives of our organization's QIP are to: increase access to care by monitoring access for primary care, mental health and diabetes education." — De Dwa Da Dehs Nye>s Aboriginal Health Centre

2013/14 Access Aims

88% of the organizations that submitted a QIP included the access indicator. The number of organizations that selected the access indicator by model type is:

- 67 of 75 CHCs (89%)
- 160 of 181* FHTs (88%)
- 8 of 10 AHACs (80%)
- 19 of 24 NPLCs (79%)

2013/14 Access Measures

Within the QIP guidance documents, primary care organizations were encouraged to survey patients/clients to measure their perceptions of their access to care. A survey question was provided ((see text box "Measuring Patient Perceptions of Access") to ensure consistent measurement in this area.

Measuring Patient Perceptions of Access

Q. The last time you were sick, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone else in their office?

- same day
- next day
- 2-19 days (enter number of days: _____)
- 20 or more days
- Not applicable

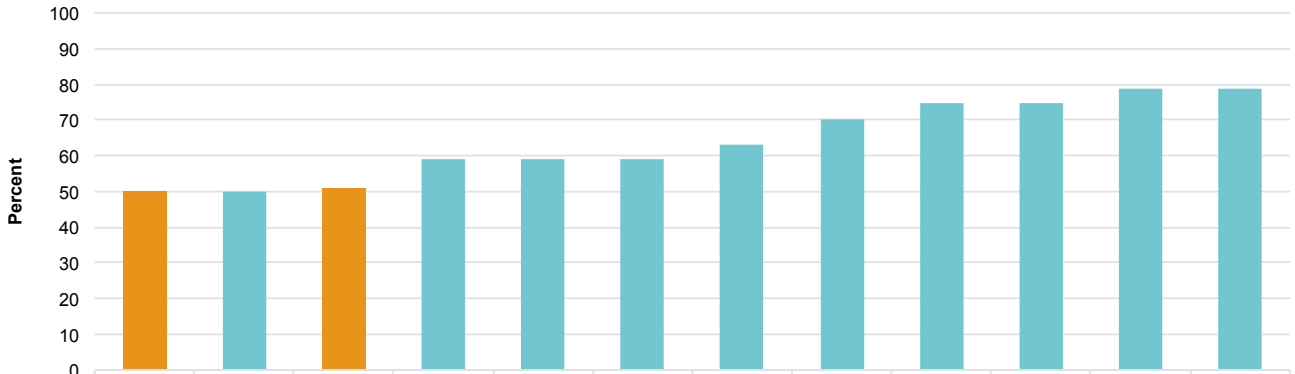
To calculate the percentage of your patients/clients who are experiencing timely access (same day/next day) to primary care, add up the number of "same day" and "next day" responses and divide by (total number of respondents) minus (number of "not applicable").

Opportunity for Improvement: Access

The *2011 Commonwealth International Survey of Sicker Adults* highlighted the achievement of improved access in other regions, including the United Kingdom (UK), Switzerland, New Zealand, France, and the Netherlands. Ontario (50%) and Canada (51%) have some of the worst access rates of the countries polled. This survey reports at the provincial level and demonstrates the opportunity for improvement at the organizational level.

Source: Schoen, C., Osborn, R., Squires, D., Doty, M., Pierson, R., & Applebaum, S. (2011).

Percentage of sicker adults who were able to see a doctor or nurse on the same day or the next day, the last time they were sick in Ontario, Canada, and in other countries.



	Ontario	Sweden	Canada	Germany	Norway	US	Australia	Netherlands	France	New Zealand	Switzerland	UK
Percent	50	50	51	59	59	59	63	70	75	75	79	79

Patient/client perceptions will often differ from what is revealed by the data. For example, patients/clients may perceive access to be worsening, when measurement reveals that it is in fact improving. That is why it is important to regularly survey patient/client groups. Well conducted patient surveys will ultimately provide a comprehensive understanding of what patients believe in terms of their access to primary care, which is also an essential component of high quality care.

Process measures for access include Third Next Available (TNA) appointment and availability through scheduling software. In the future, it is anticipated that more organizations will be able to measure access through the use of electronic scheduling. When measuring access, it is important to not only consider TNA and scheduling data, but also patient/client perceptions of access as well.

The primary care sector is familiar with surveys: Almost one third of primary care organizations (32%) reported in their QIPs that they have been surveying their patients/clients. Another 32% of QIP submissions indicated that organizations plan to begin a patient/client survey within the next year.

For consistency, comparability and understanding, shared definitions are essential: Many primary care organizations used the standardized survey questions provided in the QIP and guidance materials. That said, the same day/ next day access to primary care indicator was often modified and, in many cases, third next available (TNA) appointment was used instead of the same day/next day access indicator.

It is important to use the standardized definitions of indicators, which will enable organizations to monitor their progress and allow for both provider- and system-level comparison.

Moving forward on a shared vision of improvement requires everyone to be on the same page when it comes to how the primary care sector defines the indicators they use in their QIPs. Operational definitions and standardized methodologies are designed to minimize confusion and promote consistency and understanding.[11]

* Organizations could include more than one access indicator

Table 1: Access - Examples of Effective Measures from the 2013/14 QIPs

MEASURE: ACCESS				
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
St. Michael's Hospital Academic FHT	Timely access to primary care, when needed: Percent of patients able to see a doctor or nurse practitioner on the same day or next day, when needed	37% (2011); 39% (2012) (based on waiting room survey of approx. 700 patients done once in the year)	Collect baseline data via monthly on-line survey	Previous data collected as part of a time-limited research project. Moving forward, we will be developing a sustainable way to collect ongoing feedback from patients, including those not presenting to the clinic
North Simcoe FHT	Timely access to primary care, when needed: Percent of patients/clients able to see a primary care provider on the same day or next day, when needed	Baseline: 12%	30% **QIP TIP** This organization has baseline data and a stretch target (as they expect to improve more than 100%)	Increase accessibility to FHT patients within 24 hours and prevent ER visits
Country Roads CHC	Timely access to primary care, when needed: Percent of clients able to see a doctor or nurse practitioner on the same day or next day, when needed	2012 client surveys show 86-96% response to 2 similar questions. Currently monitoring usage of urgent same day appointments	Establish baseline from provincial benchmarks with initial goal to improve TNA to 2 days. Analyze Monthly ER reports to assess PC access. 25% of existing clients living in southern part of catchment utilize new Elgin site	Improve access to meet provincial benchmarks

2013/14 Access Changes

Almost 77% of the QIPs that were reviewed considered more than one change idea to improve access to care. The majority of these QIPs mentioned the principles of Advanced Access and Efficiency.

Measurement is essential to change: The 2013/14 QIP submissions included many innovative change ideas to improve access and efficiency in Ontario's primary care sector. However, only 35% of QIP submissions included a quantifiable process measure to gauge the success of the ideas for improvement. Processes must be measureable as rates, percentages and/or numbers over prescribed time frames (e.g., number of visits requested per month, number of available visits per month, post education test results 100% of staff participate and obtain 80% per year, TNA).

QIP TIP To support your planning and celebrate successes:

- Use EMRs to obtain patient/client demographic data (e.g., age, gender, chronic diseases, lab results, and blood pressure/ body mass index measurements)
- Refer to regional and provincial data (e.g., complexity of care)
- Administer patient experience surveys
- Obtain feedback from your health care team

It is important to consider the fact that it may take years to achieve the desired outcome for some targets. In such cases, consider setting "interim" targets. For example, if current performance on a certain indicator is 24% and the ultimate goal is to reach 16%, an interim target would be to reach 20% the following year, with plans to work toward 16% during the year after.

INSIGHT: The National Health Service's Approach to Improving Access

The United Kingdom's National Health Service (NHS) used national performance targets to drive improvement in timely access to primary care. These targets ensured access to a primary care professional within 24 hours and to a primary care doctor within 48 hours. Strategies included expanding the number and mix of general practice staff who share the primary care workload. Approaches to improving after-hours access to primary care services included a mix of formal deputizing mechanisms and collaborative partnerships across organizations. Another important trend has been government support of initiatives that enhance access to a broader range of primary care services or that encourage better integration between primary care and specialist services.

Source: Schoen, C., Osborn, R., Squires, D., Doty, M., Pierson, R., & Applebaum, S. (2011). New 2011 survey of patients with complex care needs in eleven countries finds that care is often poorly coordinated. Health Affairs, 30(12), 2437-2448.

QIP TIP Visit HQO's Quality Improvement Framework for details on how you can build QI know-how in your organization.

Access & Efficiency are linked: The following are some change ideas for "providing patient access to a scheduling appointment with the patient's primary care provider (access)" and "being more efficient in the office processes leading up to, during, and after a patient appointment (efficiency)".

Table 2: Access - Examples of Effective Change Ideas from the 2013/14 QIPs

CHANGE: ACCESS				
Organization	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
Noojmowin Teg AHAC	Increase supply of appointments via optimization of scheduled appointments	Measure no shows. Measure Red zone time. Analyze data and apply PDSAs to increase supply. Improve use of EMR for scheduling/tracking	Establish baseline. Reduce no show rate by 10% by March 1, 2014 **QIP TIP** The "No Show Rate" is an excellent example of a goal that is Specific, Measurable, Achievable, Relevant, Time-bound (SMART). When patients do not attend an appointment, and their appointment is not cancelled, it is a "no show." These appointments represent lost productivity and resources	Participated in HQO Wave 3 Advanced Access — our AHAC did not "fit" HQO's assessment tools, i.e., no rostering, and shared care with FHT, so panel size not determinable — modification/adaptation required in principal application
North Huron FHT	1) Conduct "Patient Experience" surveys. Collect information about patient/clients perception about receiving a visit within the same day or next day when needed	Development of survey, number of patients surveyed, results of survey questions	Goal is for 20 percent of rostered patients to have completed a patient survey by March 31, 2014 and baseline data to be compiled **QIP TIP** Making sure you have a thorough understanding of the change process is an essential first step to identifying opportunities that will improve efficiency and patient value	1) Conduct "Patient Experience" surveys. Collect information about patient/clients perception about receiving a visit within the same day or next day when needed
	2) Using Advanced Access principles, set infrastructure to monitor "percent of patients/clients able to see a doctor or nurse practitioner on the same day or next day, when needed." 3) Using Advanced Access principles, set infrastructure to be able to monitor "Time to Third Next Available Appointment" for all physician's practices	Development of process map and algorithm for booking of appointments and data capture. This will include engagement of all staff involved in scheduling and booking appointments, as well as physicians and the Information Technology department. All staff and physicians will also receive training on the process	Goal is to be able to state "yes" we can monitor these two indicators by March 31, 2014, have a process map that reflects the process and all staff and physicians have received training on the process	2) Using Advanced Access principles, set infrastructure to monitor "percent of patients/clients able to see a doctor or nurse practitioner on the same day or next day, when needed"

CHANGE: ACCESS				
Organization	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
North Lambton CHC	Increase supply of visits: • Increase number and type of group medical visits • Optimize the care team — ensure all team members functioning to full scope, trial "provider partners" • Encourage patient engagement and self-management	• Number of group visits in addition to diabetes and meet & greet • Attendance at group visits • Retrospective comparison of demand for primary care since attending group visits • Number of RN clinical visits traditionally done by MD/NP (i.e., pain assessments, HTN f/u) • Number of self-management goals set	• Offer 1 additional group medical visit by April 1, 2014 • Attendance of at least 3 people per group visit • Average 20% reduction in demand for primary care appointments since attending group visits • Attendance at CHC forum re RN full scope of practice by July 2013 • 20% of people with chronic pain will have an RN assessment by March 2014, 50% of people with HTN will have a self-management goal set by a non MD/NP provider by April 2014 • 25% of clients with diabetes or COPD will have a documented self-management goal by December 2013	Increase supply of visits: • Increase number and type of group medical visits • Optimize the care team — Ensure all team members functioning to full scope, trial "provider partners" • Encourage patient engagement and self-management

Conclusions: Access in the 2013/14 Primary Care QIPs

Improving access to care is one element of ensuring smooth transitions between providers and is critical to managing acute illnesses or exacerbations of chronic conditions so that they do not worsen, potentially leading to hospitalizations that might have been avoided.

When patients have to wait two weeks or more to see their own physician, it can create a cascade of issues for physicians, patients, staff and the health care system as a whole.[12] However, Ontario's primary care sector is working diligently to improve access, efficiency, and chronic disease management. Organizations are starting to use patient experience surveys to understand the "voice of the customer," specifically in regard to their perceptions of access to care. Organizations have also begun to collect baseline survey data and are implementing change ideas to improve access.

Although there was relatively little data to draw upon this year, next year's QIP analysis will provide baseline data and tell the story of how primary care organizations improved access to care. To further strengthen next year's submissions, organizations are encouraged to link their strategies to improve access to local initiatives, performance goals, and the provincial quality agenda.

Integration: Timely primary care appointments post-discharge through coordination with hospital(s)

Ontario's primary care providers help patients/clients navigate the health care system. They are instrumental in smoothing transitions between care settings, particularly for seniors and people with complex needs.

Why integrated care is important

Evidence supports health system integration: In an integrated health system, all parts of the system are organized, connected and work together to provide high quality care. An integrated system of care inspires trust and confidence and has the potential to smooth transitions of care, improve patient/client outcomes, improve patient experiences, and lower total health system costs. In addition,

research demonstrates that patients/clients who are seen by their primary care provider for post-hospital follow-up care are less likely to be readmitted.[13]

When patients experience transitions in care (such as between primary care, specialists, and hospitals), they may be at increased risk of adverse events as a result of errors in the transmission of information.[14,15]

Integrated care entails continuity of care: Continuity of care refers to the ability of patients/clients to access health care with (and through) the same professional care provider over time.[16] Continuity of care has been associated with fewer hospitalizations and emergency department (ED) visits.[17-20] Continuity of care has therefore become a key component of integrated care in Ontario.[21]

Continuous, integrated care improves patient satisfaction: When patients/clients see an interprofessional health care team, they want reassurance that their providers: know their name; can explain what is happening; are 'in charge' and are able to address questions or concerns and will refer them to the right health care provider, at the right time.[22]

QIP TIP Consider forging new partnerships (or building on existing ones) with health care specialists in your community, as well as with agencies that provide social services, settlement services and mental health supports to foster integration.

QIP Narrative Excerpts

"Increase integration of care through our Hamilton and Brantford "Health Links" collaborations by establishing the greatest users of the Emergency Department, and linking those who are aboriginal to the services available at De dwa da dehs nye>s Aboriginal Health Centre."
— De dwa da dehs nye>s Aboriginal Health Centre

"Four CHCs in Ottawa are working in collaboration to develop elements of their strategic plans. In addition, these CHCs plan to work together with Ottawa hospitals to improve referral processes between Primary Care Outreach to Seniors (PCO) program and emergency departments."
— Pinecrest - Queensway Health and Community Services

"Our QIP will focus on integration and continuity of care, both at the individual and systems levels. We currently have a range of partnerships that enhance integration and continuity of care for clients with complex health needs, including Shared Care with Specialists (e.g., psychiatrists, internal medicine specialists, Family Way); Integration with Social Services and Public Health (e.g., Woodgreen Community Services, Toronto Public Health, Toronto East General Hospital, etc.); Systems Integration (e.g., Health Links, CCAC, Toronto Central LHIN Catch ED project, community primary care providers including Solutions, CHC-GT, TCLHIN initiatives, etc.)."
— South Riverdale Community Health Centre

"Within our community there is a need to enhance community partnerships and build on existing initiatives to address shared challenges associated with transitions in care for our clients. ...We are setting a new standard for health professionals and organizations to work closer together by participating in a Health Links Project with a focus on stabilizing complex health care needs of individuals living without a primary care provider."
— Georgian Nurse Practitioner-Led Clinic

INSIGHT: Health System Integration

Primary care is not the only group interested in measuring and tracking integration efforts:

- **Hospitals** are measuring integration indicators in their QIPs
- **LHINs** are collecting integration data for their Multi-sectorial Accountability Agreements (MSAAs)
- **Health Links** are including the post-hospital discharge indicator as a results-based metric

2013/14 Integration Aims

Ninety-two percent of the organizations that submitted a QIP included integration and continuity of care across health care sectors as key priorities in their QIP Narratives.

The number of PC organizations reporting the indicator by model type:

- 72 of 75 CHCs (96%)
- 167 of 181 QIPs received from FHTs (92%)
- 20 of 24 NPLCs (83%)
- 8 of 10 AHACs (80%)

The priority indicator for integration is the percentage of patients/clients who visit their primary care provider within seven days after discharge from hospital for selected conditions.[23]

2013/14 Integration Measures

To measure integration, primary care organizations were asked to use the indicator provided in the *2013/14 QIP Guidance Document for Primary Care.* Data for this indicator was only available to primary care organizations with rostered patients. As a result, only FHTs were able to include this data in this year's QIP.

Other organizations could report on the provided indicator, but did not have access to administrative data.

Primary care organizations prioritized integration: The vast majority of the organizations that submitted a QIP included the indicator for integration. Thirty-six percent (36%) of the FHTs (65) that submitted a QIP reported their current performance using the numeric value from the data portal, as recommended in the guidance materials.

Establishing baselines is a complex process: As only FHTs had the necessary data, not all primary care organizations were able to provide a numerical score for the percentage of patients who visited them within seven days of being discharged from the hospital for select conditions. Even when data was available, many FHTs did not include it in their QIPs. This may be due to the fact that 1) some FHTs felt the available data did not accurately reflect their post-discharge patient visit performance, as the indicator only captures physician visits within the roster and does not include other interprofessional providers, and 2) many FHTs were not familiar with the methodology of calculation, particularly the case mix groups that were used to select the patients.

In addition, the limitations of communications infrastructure and lack of sector level data sharing agreements did not support the timely transfer of patient/client information (e.g., some providers had no way of knowing when their patient/client had been to a hospital).

Measuring integration: There were many integration indicators in the QIPs that were submitted. This variety is demonstrative of the primary care sector's inventiveness and commitment to improved health system integration.

While it is sometimes appropriate to modify indicator definitions to better reflect your organization's priorities, the practice makes it difficult to aggregate the results to evaluate provincial performance, or track performance within an organization over time. One solution is to keep to the QIP-defined indicator and use the modified indicator as a process measure.

QIP TIP CHCs, AHACs and NPLCs that are members of the Association of Ontario Health Centres (AOHC) are encouraged to contact Regional Decision Support to access the integration indicator data for the 2013/14 QIP.

Table 3: Integration - Examples of Effective Target Setting in the 2013/14 QIPs

MEASURE: INTEGRATION				
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
Barrie Family Health Team	Primary care visits post discharge: Percent of patients/ clients who see their primary care provider within 7 days after discharge from hospital for selected conditions: COPD, CHF	43%	75%	Ideal goal is 100%, but this requires change outside of our organization and process changes within physical offices **QIP TIP** When setting targets, recognize the theoretical best — but still set an aggressive target.
Marathon Family Health Team	Primary care visits post discharge: Percent of patients/ clients who see their primary care provider within 7 days after discharge from hospital for selected case mix groups (CMG: stroke, pneumonia, COPD, CHF, DM, cardiac conditions and GI disorders)	45/65 = 69%	86% **QIP TIP** When recording your current performance, include the percentage and consider adding the fraction in the comments section to allow for an appreciation of the sample sized used in your organization.	25% improvement from baseline
Rexdale Community Health Centre (RCHC)	Primary care visits post discharge: Percent of patients/ clients who see their primary care provider within 7 days after discharge from hospital for selected conditions	Determine centre-wide baseline. A pilot project involving two providers will be tested in 2013/14. 80% of clients are seen by 2 providers within 7 days discharge from hospitals (given the hospital is known to the providers)	This information is currently not readily available due to lack of electronic data connectivity between the CHC and area hospitals	RCHC is transitioning to a new EMR software with the go live date of 20 June 2013. After the successful transition, accurate client data will be established to determine the target of performance measurements for all primary care providers in 2014/15

2013/14 Integration Changes

Almost 80% of the QIPs that were submitted considered more than one change idea to foster integration in Ontario's health system. Most of these change ideas addressed transitions of care. Transitions are the transfer of a patient/client between different care settings and health care providers during the course of an acute or chronic illness.[24]

Transitions can occur at many different times and places in a person's health care journey and might include: referrals from a person's primary care provider to specialist care; admission into a hospital; discharge out of the emergency department or hospital; and admission to a long-term care facility from the person's home.[25]

QIP TIP Download Enhancing the Continuum of Care – Report of the Avoidable Hospitalization Advisory Panel for recommendations on care transitions

The majority of FHTs have effective change plans in place: Almost 70% of the FHTs that submitted a QIP included methods and process measures to track the progress of each of their change ideas.

Patient discharge data is challenging to gather: Although many QIPs identified discharged patient visit performance data as a process measure for integration, some experienced challenges capturing this data in real time. For example, many organizations reported that they had no idea when their patient was discharged, particularly in scenarios where the patient was treated in a hospital that was not linked to their primary care health team. Instead of using patient discharge data, some organizations turned to the following data sources: patient admissions, discharge, and post discharge visits within their EMRs

INSIGHT: Primary Care Integration Initiatives in Ontario

The top four integration improvement initiative themes:

1. Hospital discharge processes (90%)
2. Interaction with hospitals, CCAC, etc. (31%)
3. Health Links (18%)
4. Risk for readmission (15%)

Health Quality Ontario's *Transitions of Care Evidence-Informed Improvement Package* introduces change ideas and concepts designed to improve the transition of individuals between care professionals and environments. Key concepts addressed in this package are:

- Health Literacy
- Medication Management
- Risk Assessment and Follow-up Care
- Individualized Care Planning

Health Quality Ontario's Quality Compass, a comprehensive, evidence-informed online tool designed to support providers as they work to improve health care performance in Ontario, also includes a variety of best practices to help you improve transitions of care.

Table 4: Integration - Examples of Effective Change Ideas in the 2013/14 QIPs

INTEGRATION				
Organization	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
Guelph FHT	Identify 2 GFHT physicians to work with GGH Identify their discharged patients with a dx of stroke/or require warfarin therapy and or with a LACE score >10 or a similar tool score Develop a process to book follow up appointment with the provider/team before leaving hospital **QIP TIP** Interested in finding out how LACE scoring can help your organization improve transitions of care? Go here for more details	Number of total discharges with a LACE score >10 and Percent with appointment within 7 days of hospital discharge Number seen by primary provider/team within 7 days of discharge	Target: LACE score assessment tool used to assess and identify patients at risk for readmission Follow up appointments booked with primary care before discharge — quarterly collaborative review meetings to assess data	GGH data admits for 11/12 year (5868) assume 10% complex (587) require f/u post discharge Shared electronic portal to access admission and discharge information by collaborating organizations (hospital / FHT)
Carefirst FHT	Identify high risk senior patients to provide wrap around care to maintain their independent living in the community through the application of "On Lok" - Program for All Inclusive Care for the Elderly (PACE) model of care Develop partnerships and referral protocols with various providers in the community (i.e., CCAC's public health, hospitals, family health services and other related health care providers (PT, OT) Participate in the CCAC's new RM&R initiative Undertake weekly round for case management by physicians, nurses and social worker	Through tracking of service statistics # of patients referred and or linked to community services agencies Through tracking client satisfaction survey clients self-report Number of patients benefited from service navigation	Patients will have an improved overall quality of life, decreased visits to the ER hospital admission and readmission and improve self-management **QIP TIP** For assistance with individualized care and discharge planning please download the bestPATH program's evidence-supported improvement packages	—

Integration: Reduce emergency department use by increasing access to primary care

Walk-in clinics and emergency departments are often the source of routine and on-going care during evenings and weekends. ED visits are often used as a measure of access to primary care, and where primary care services are readily available to the community, ED visits should be lower. A recent patient survey conducted in 11 developed countries identified Canadians as the highest users of ED.[26]

Research has shown that having a regular doctor is associated with a decreased likelihood of ED use among patients with chronic diseases. Similarly, better access to immediate care is associated with a decreased likelihood of ED use among the general population.[27]

2013/14 Aims for this Optional Integration Indicator

There were 26 indicators within the submitted QIPs that related to the percent of patient/clients who visited the ED for conditions best managed elsewhere (BME).

Table 5: Number of ED Indicators by Model Type

Frequency of Reporting on:	Primary Care Organization Type				
	FHT	CHC	NPLC	AHAC	Overall
Percentage of patients/clients who visited the ED for conditions best managed elsewhere (BME)	16	3	2	5	26

2013/14 Measures for this Optional Integration Indicator

To measure performance on this indicator, the Ministry of Health & Long-Term Care provided organization-level data for primary care organizations with patient/client rosters.

Organizations without patient/client rosters were encouraged to measure this indicator using other methods (e.g., patient/client reported ED or walk-in use).

2013/14 Changes for this Optional Integration Indicator

The tables below include effective examples of change ideas from the 2013/14 QIPs that incorporated the optional indicator: Percent of patients/clients who visited the ED for conditions best managed elsewhere (BME).

Example 1 – The Barrie and Community FHT

The Barrie and Community FHT obtained data from the Ministry of Health's data portal and provided a stretch target and justification for that target. They also included an innovative change idea that involves integration with partners and a clearly written, time-sensitive aim statement.

Table 6: Measures & Change Ideas at the Barrie & Community FHT

MEASURE: INTEGRATION				
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
Barrie and Community FHT	Percent of patients with ED visits best managed elsewhere	1.51% (1743 patients)	1.2% approximately	Goal for 150 complex care patients to decrease ED visits per year by 75%
	CHANGE: INTEGRATION			
	Planned improvement initiatives (Change Ideas)	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
	Opening of complex care clinic for high users of ED.	Patients will be referred from the ER department to the complex patient clinic, once receiving care here the goal is to reduce ER visits for conditions best managed elsewhere	Goal for complex care clinic: to see 150 patients and reduce their # of ED visits by 75%	—

Example 2 – The Canadian Mental Health Association, Durham NPLC

The Canadian Mental Health Association, Durham, collected baseline data and established a partnership with a local hospital.

Table 7: Measures & Change Ideas at the Canadian Mental Health Association, Durham NPLC

MEASURE: INTEGRATION				
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
Canadian Mental Health Association Durham NPLC	Reduce ED use by increasing access to primary care: % of patients/clients who visited the ED for conditions best managed elsewhere	Unknown (some data on ED visits)	Collect baseline over annual period	This data is currently not available
	CHANGE: INTEGRATION			
	Planned improvement initiatives (Change Ideas)	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
	Improve communication system with hospitals to consistently report ED use to NPLC	• Determine potential for integrating hospital ED visit information into the EMR for ease of data collection and analysis. • Set up electronic (or manual) collection of ED visit information	Discussion with hospitals summer 2013	Currently the hospitals provide NPLC with some information on ED visits by clients. We do not have control over whether hospitals inform us of hospital ED use in a timely manner. Currently not all visits or admissions are known and there is a 6-month delay

Example 3 – Marathon FHT

Marathon FHT has current performance data on the percent of patients who visited ED for conditions best managed elsewhere, and they plan to improve performance on this indicator by an inspiring 50%.

They are collaborating with their hospital partner and developing data sharing and analysis strategies focused on ambulatory care sensitive conditions, as well as program development.

Table 8: Measures & Change Ideas at Marathon FHT

MEASURE: INTEGRATION				
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
Marathon FHT	Percent of patients who visited ED for conditions best managed elsewhere (BME)	161 people, 4.4% of rostered patients 1-74 years old	2.20%	Reduce 50% from baseline
	CHANGE: INTEGRATION			
	Planned improvement initiatives (Change Ideas)	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
	1) Improve availability of same day urgent care appointments by matching supply with weekly and seasonal variation in demand 2) Collaborate with WMGH re: data sharing and analysis of ED and admissions for ACSC	1) Create tracking table and graph for number of urgent care appointments available at the beginning of the day (track one week/month) 2) Review seasonal and weekly patterns 3) Analyze types, frequency, day of week and time of ED visits 4) Analyze types, frequency of ACSC admissions	1) Seasonal and weekly variation in availability of urgent care appointments determined 2) Identify new/enhanced services/programs, integration improvements and patient education to reduce ED use for conditions BME and hospital admissions for ACSC	—

Integration: Reduce unnecessary hospital readmissions

Unplanned readmissions are disruptive to patients/clients, costly to the health system, and often avoidable. Poor communication and a lack of care coordination between health care providers can hinder continuity of care, and may lead to more errors, unsatisfactory health outcomes and dissatisfied patients/clients and providers. Better integration with hospitals, as well as other initiatives such as patient/client education, may help reduce hospital readmissions.

Many people are readmitted to hospital due to:

- Unclear or delayed discharge plan and instructions
- Conflicting plans and instructions from different providers
- Medication errors, including dangerous drug interactions and duplications[28-31]

2013/14 Aims for this Optional Integration Indicator

There were a total of 15 indicators related to the percent of patients who are readmitted to hospital after they have been discharged with certain specified conditions.

Table 9: The Number of Readmission Indicators by Model Type

Frequency of Reporting on:	Primary Care Organization Type				
	FHT	CHC	NPLC	AHAC	Overall
Percentage of a primary care organization's patients/clients who are readmitted to hospital after they have been discharged with a specific condition	12	2	0	1	15

INSIGHT: Six strategies to reduce readmissions

A study sponsored by the Commonwealth Fund identified six strategies hospitals could use to significantly lower risk-standardized 30-day readmission rates:

1. Partner with community physicians or physician groups
2. Partner with other local hospitals
3. Have nurses take responsibility for medication reconciliation
4. Arrange follow-up appointments prior to discharge
5. Have a process in place to send all discharge papers or electronic summaries directly to the patient's primary physician
6. Assign staff to follow up on test results that return after the patient is discharged

Source: Bradley, E. H., Curry, L., Horwitz, L. I., Sipsma, H., Wang, Y., Walsh, M. N., ... & Krumholz, H. M. (2013). Hospital strategies associated with 30-day readmission rates for patients with heart failure. Circulation: *Cardiovascular Quality and Outcomes,* 6(4), 444-450.

2013/14 Measures for this Optional Integration Indicator

The ministry provided organization-level data for groups with rostered patients. As a result, only FHTs were able to include data for this indicator in the 2013/14 QIPs.

Organizations that do not have rostered patients were encouraged to measure this indicator using other methods. For example, by identifying all patients/clients who were admitted and readmitted to hospital within the past 12 months, and by identifying themes or reasons these patients/clients were readmitted to hospital (e.g., fall, social supports, poly-pharmacy, pain, etc.).

2013/14 Changes for this Optional Integration Indicator

The table below depicts the efforts of Marathon FHT to improve performance on the optional indicator: Reduce Unnecessary Hospital Readmissions.

Marathon has a small number of clients that experience readmissions. Nevertheless, they are working with the local hospital to determine the root causes of readmissions and exploring potential change ideas to improve even further.

Table 10: Measures & Change Ideas at Marathon FHT, II

MEASURE: INTEGRATION				
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
Marathon FHT	Hospital readmissions within 30 days of acute discharge for selected case mix groups (as above)	8/65 = 12%	TBD	Current number is low, need to evaluate whether realistic to reduce
	CHANGE: INTEGRATION			
	Planned improvement initiatives (Change Ideas)	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
	1) Work with local hospital re: data sharing to evaluate cases readmitted within 30 days and whether there are ways to reduce this number	1) Contact local hospital director of patient care and data management 2) Assess cases readmitted and reasons for readmission, potential changes to reduce readmission rate	Determine target and change ideas	—

Conclusions: Integration in the 2013/14 Primary Care QIPs

Individuals have complex care needs, often requiring the involvement of primary care, home care, hospitals, and specialists. Establishing smooth transitions between these areas of care is crucial to improving the quality of care Ontarians receive. Safe and reliable care that is better coordinated – the right drugs, monitoring, and timely access to services and procedures – can improve quality of life and lessen the burden on families and the health care system.[32]

In their 2013/14 QIPs, primary care organizations overwhelmingly demonstrated their commitment to improving integration across sectors of the health system and between community partners. However, they were challenged by a lack of familiarity with the data and access to current state measures. As more data becomes available and integration change ideas are tested and implemented, collaboration between sectors is likely to increase and integrated, improved care will be realized.

Consistent, integrated, and coordinated care is one the primary goals of *Ontario's Action Plan for Health Care* and Ontario's Health Link communities.[33] If the health system is to meet the needs of a growing population with multiple, complex and chronic conditions, it must be better coordinated, with seamless levels of care. Primary care providers should consider partnering with their colleagues in the hospital and long-term care sectors to further promote and achieve truly integrated care for their patients.

Patient-Centredness: Receiving and utilizing patient/client experience feedback

At the centre of Ontario's health care system are individuals, their families, and the communities in which they live. The care that the health system provides should be responsive to, and driven by, the needs of Ontarians.

Ontario's Action Plan for Health Care emphasizes the importance of patient-centred care and outlines a vision of a health system that delivers care that is truly patient-centred.[34] This transformation of Ontario's health system will require a shift in attitudes, culture and the working relationships between health care providers.

Why Patient-Centred Care is Important

Although patient-centred care is a priority in Ontario, a gap still exists between the kind of care patients/clients receive, and the kind of care they should be receiving. About one in four sicker adults say they do not get to ask enough questions or feel involved in their care. One in three sicker adults do not believe someone always coordinates the care they receive from other doctors or places of care.[35]

Patient-centred care recognizes the patient/client as a person and partner in care and takes their values, beliefs, culture and feelings into consideration. Patient-centred care involves listening to what patients/clients have to say about the care they are receiving and engaging them in the design, delivery and evaluation of services provided.[36] When patients/clients are engaged in improving quality, they can be instrumental in supporting and directing change.

QIP Narrative Excerpts

"Achieve patient-centred quality improvement objectives through continued surveys of clients; and increase quality of care through increased efforts related to clinical monitoring for diabetes and hypertension."
— De dwa da dehs nye>s Aboriginal Health Centre

"We will conduct the survey and track the information gathered and have a patient/client as an actor walk through the clinic and document his or her experience through testimonials to assist in improving the clinical practice. There is evidence that satisfaction with health services is linked with increased adherence to treatment and provider recommendations, improved psychological well-being, and increased likelihood of seeking care with their primary care provider in the future."
— Essex County Nurse Practitioner-Led Clinic

2013/14 Patient-Centred Aims

Patient/client experience surveys are often used to identify and explore patient/client views and opinions regarding their health and health care. The manner in which these surveys are conducted is pivotal to their success.

For the purposes of QIP planning, organizations were asked to conduct a patient survey that included three QIP-defined indicators:

- Patient/client views on whether patient/client feels encouraged to ask questions
- Patient/client views on their involvement with the decisions that are made about their care
- Patient/client views on the amount of time their primary care provider spends with them

Table 11: The Percentage of Primary Care Organizations that Selected Patient/Client Experience (by Indicator) as a Priority in their QIP Submissions

PRIORITY/INDICATOR	FHT	CHC	NPLC	AHAC	OVERALL NUMBER
Patient/client views on whether patient/client feels encouraged to ask questions	76% (137)	80% (60)	75% (18)	70% (7)	222
Patient/client views on their involvement with the decisions that are made about their care	77% (140)	84% (63)	79% (19)	70% (7)	229
Patient/client views on the amount of time their primary care provider spends with them	74% (134)	80% (60)	75% (18)	70% (7)	219

2013/14 Patient-centred Measures

More than 80% of the primary care organizations that submitted a QIP have plans to obtain a patient-centredness "baseline" for next year's QIP submission. However, few details were provided on projected sample size or how organizations intend to survey their patients/clients. Just over half (51%) did not describe the survey methodology they intend to use in their QIP submissions.

Measuring patient-centredness: Many organizations expressed interest in patient-centred indicators in their QIPs (overall there were 693 patient experience indicators reported in the QIPs). However, only a small proportion (less than 8%) reported numerical values under the current performance column of the QIP Workplan. Furthermore, the quality of the measurements reported was variable (e.g., no data, multiple data or irrelevant data were provided).

Effective measurement is essential to quality improvement: Many organizations modified the priority indicators and included different questions in the surveys that they conducted. These variations in data and processes make it difficult to determine whether or not indicator performance is improving provincially or to share best practices.

Organizations also sometimes developed their own patient satisfaction indicators. Over 100 non-priority patient satisfaction indicators were included in the QIPs that were submitted in 2013/14. This variety is indicative of the primary care sector's dedication to delivering patient-centred care.

Table 12: Effective Measurement at Chigamik Community Health Centre

ORGANIZATION	CURRENT PERFORMANCE TARGET FOR 2013/14	TARGET FOR 2013/14	TARGET JUSTIFICATION
Chigamik Community Health Centre	85%	95%	Initial results indicate clients are quite satisfied with the patient-centered care they receive (although questions asked were not exactly as stated for this quality dimension)

Many organizations mentioned using common surveys across LHIN geographies: The standardization of surveys across LHINs will provide more informative results. This will in turn inform primary care organizations of what change ideas work in specific settings. The implementation of standardized surveys will also decrease administrative costs, such as development, analysis and translation.

Health Quality Ontario is developing a primary care patient experience survey to support practices and primary care organizations in their quality improvement efforts. Following pilot-testing, the survey and an accompanying implementation guide will be available to all primary care practices in Ontario. Implementation of the survey will be the responsibility of practices and/or organizations either on their own or in collaboration with other practices or organizations.

2013/14 Patient-centred Changes

Over 85% of the QIPs that were submitted included ideas for improvement related to patient-centred indicators. Many QIPs also included methods and process measures to track the success of the suggested change ideas, as well as quantifiable stretch targets.

QIP TIP

Consider the following change ideas for patient-centred indicators:

- Involve patients in quality improvement committees
- Conduct a clinic walkthrough to see your organization through the eyes of the patient/client

Table 13: Patient-Centred Change Ideas

CHANGE: PATIENT-CENTREDNESS				
Organization	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
Woodstock and Area Communities Health Centre	Update Client satisfaction survey to ensure effective feedback	Survey is a collaborative exercise between the 5 CHCs in the SWLHIN. Request to have additional questions regarding access added Staff will approach and assist clients to complete surveys	Survey to be revised by April 5, 2013 and administered during the first few weeks of April	—
Peterborough Network FHT (Primary Health Care Services of Peterborough)	• Increase frequency of targeted patient/client survey to annual • Expand/revise targeted patient/client survey to include questions related to: patient/client engagement; opportunity to ask questions of your care provider; having sufficient time to discuss issues with your care provider • Add demographic questions along with experiential feedback • Expand focus of patient/client survey to include all members of the care team who impact the patient/client experience (i.e., physicians, nurse practitioners, nursing, allied health professionals and receptionists) • Provide multiple avenues for patients/clients to provide feedback on an ongoing basis • Develop 'dashboard' to report to stakeholders and patients/clients (e.g., what are we doing well? in what areas could we improve?)	Include three QIP-defined patient/client experience questions to survey. Add this question to survey: Please indicate your gender, age and how would you describe you own health? Track process measures (number of surveys completed) and outcome measures (satisfaction rate)	85% or greater	—
Sudbury East CHC	1) Patient/client satisfaction surveys to be implemented using a pre-approved template. Use of Social Media for survey accessibility	Facebook, CHC website.	An increase in patient/client satisfaction and improvement in patient/client access and quality of care	—

CHANGE: PATIENT-CENTREDNESS				
Organization	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
Jane -Finch FHT	1) Educate patients about the importance of having a substitute decision maker and making their wishes for medical care known should they not be able to do so in the future 2) Educate and train staff to discuss importance of advance directive and have a standardized form used in FHT for all patients **QIP TIP** See the Speak Up website for tools and resources on advance care planning that will provide documentation of involvement of patients/clients in decision making and Cancer Care Ontario's Advance Care Planning Quality Improvement Toolkit	Measure the number of patients who have had a discussion about advance directive planning	Discuss advanced directives with 50 patients by the end of Q4	Advance directive planning is essential for patients. Often a substitute decision maker has not been selected when a crisis occurs or the patient's family is unable to make a decision about a treatment path because the patient's wishes were not known. This can result in a great amount of stress for the family as well as a potential for costly medical interventions the patient may not have desired. We will also share this test of change with CCAC and other relevant partners.

Conclusions: Patient-Centredness in the 2013/14 Primary Care QIPs

The 2013/14 QIP submissions demonstrated that Ontario's primary care sector is dedicated to providing patient-centred care. Organizations are starting to use patient experience surveys to understand the "Voice of the Customer," particularly in regard to their perceptions of access to care. [37] At its core, improving the quality of health care and service delivery is about meeting or exceeding the needs and expectations of the customer, and Quality Improvement science has evolved to embrace the basic business concept that the customer is 'always right.'

In the coming years, as data is increasingly available and standardized surveys are implemented, the amount of input patients have into their own care is likely to increase. This is good news for Ontario's heath care system, as a patient-centred, integrated health care system can lead to improved health quality, decreased costs, increased provider satisfaction, and improved patient experiences.[38] While surveys are an excellent first step, true involvement of the patient in their care will require an on-going, reciprocal dialogue between patients and their providers. Essentially, the patient must be the focal point of any discussions surrounding their care.

A "doing with" approach to health care delivery is when administrators and clinicians work in partnership with patients and their families to design and deliver health care that is focused on their needs.[39] The importance and benefits of this approach is at the heart of Ontario's prioritization of patient-centredness. Primary care organizations should assess their commitment to patient-centered care and how they will create and deliver care that considers and incorporates patient needs.

For example, patients may want reassurance that their health care team has received and reviewed any relevant diagnostic and consultative reports before their appointments. This suggests to patients that the care they are receiving is seamless and instills a sense of confidence that their care is progressing in an organized, timely manner. From a patient's perspective, having to redo diagnostics or schedule a subsequent visit to receive a consultation is frustrating, time consuming, and erodes trust. This is not a positive experience. Having a prepared and proactive primary care team is something that patients should be able to expect every time they visit a primary care practice.

Part 4: Optional Theme - Population health

According to *Ontario's Action Plan for Health Care*, a quarter of health care costs are due to preventable diseases. Nearly half of all cancer deaths are related to tobacco use, diet and lack of physical activity. Obesity has a direct effect on the rate of type 2 diabetes, which costs Ontario $4.9 billion a year. Currently, over 50% of adults in Ontario, and about 20% of youth, are overweight.[40]

Helping people remain healthy will require health care organizations to re-think their approaches to chronic disease management, which will include building health promotion and disease prevention into not only health organizations, but into the lives of patients/clients.[41]

QIP TIP Download organization assessment tools to identify opportunities to improve management of patients/clients with chronic disease and to improve workflow for the health care team.

INSIGHT: Chronic disease management and prevention programs

The six most frequently mentioned diseases and strategies related to chronic disease management and prevention programs in the 2013/14 QIP Narratives were:

1. Diabetes (75%)
2. Smoking cessation (33%)
3. COPD (27%)
4. Cancer (26%)
5. Hypertension (24%)
6. Mental health (20%)

QIP Narrative Excerpts

"A key component of this QIP will be to understand the patient/client population we provide service to in a different way. Current provincial and national databases have yet to collect and report patient/client and provider information from nurse practitioner-led clinics. The data collection and analysis from this initial QIP will be used to support the development of benchmarks for the clinic, which will be used in future improvement initiatives and evaluations."

— Belleville Nurse Practitioner-Led Clinic (BNPLC)

"In addition to exploring our own patient/client data, we have obtained information at conferences and referred to regional and provincial data. For example, The Canadian Lung Association provided information on smoking rates in different regions across the province of Ontario, with Peel Region having one of the higher rates of smoking and COPD (Canadian Lung Association, 2011). This information helped to justify the importance of having a smoking cessation and respiratory health program, as well as an office spirometer."

— Central Brampton Family Health Team

"We have been focusing on diabetes, cancer, cardiac, nutrition and mental health and addiction issues and are involved in the following activities to address these: working in partnership with Cancer Care Ontario (CCO) to provide increased education around early screening; implementing a children and youth mental health prevention and early intervention program by utilizing the Ontario TeleHealth Network; and expanding traditional healing with a focus on holistic wellness by offering a variety of programs (i.e., sweat lodge, medicine making, traditional teaching/counseling, drum circle)."

— Shkagamik-Kwe AHAC

The following section is an analysis of the Population Health indicators that were included in the 2013/14 QIPs, which include:

1. Percentage of patient/client population over age 65 that received influenza immunizations
2. Percentage of eligible patients up-to-date in colorectal cancer screening
3. Percentage of eligible patients up-to-date in cervical cancer screening
4. Percentage of eligible patients up-to-date in breast cancer screening

QIP TIP Work closely with your community partners and front-line staff to develop and maintain an extensive needs assessment and community profile. This profile will serve as one of your key QIP inputs.

Population Health - Optional indicator: Percentage of patients/ clients over age 65 that received influenza immunizations

Why is this Indicator Important?

Seniors are at especially high risk of complications due to influenza. However, only 68% of Ontario's community dwelling seniors reported having the flu shot in the past year.[42]

Ontario's Universal Influenza Immunization Program (UIIP) has had a positive effect on influenza cases and mortality rates and mitigates the impact that influenza has had on health system costs. UIIP was implemented across the province in 2000 and provides free seasonal influenza vaccines for the entire population.

2013/14 Aims for this Indicator

There were 27 indicators submitted related to reducing influenza rates in older adults by increasing access to the influenza vaccine. The number of optional indicators included in QIPs, by model type, is as follows:

Table 14: The Number of Influenza-Related Indicators by Model Type

Frequency of Reporting on:	Primary Care Organization Type				
	FHT	CHC	NPLC	AHAC	Overall
Percentage of patient/client population over 65 that received influenza immunizations	12	13	2	0	27

2013/14 Measures for this Indicator

Primary care organizations were encouraged to measure this indicator using electronic medical records (EMRs) or through patient/client surveys. CHCs could use data that are currently reported in the LHIN Multi-service Sector Accountability Agreement-specific to high-risk clients (includes seniors and immunosuppressed patients/clients). The following example, from the Upper Grand FHT's QIP Narrative, illustrates the effective use of EMRs to identify at risk individuals:

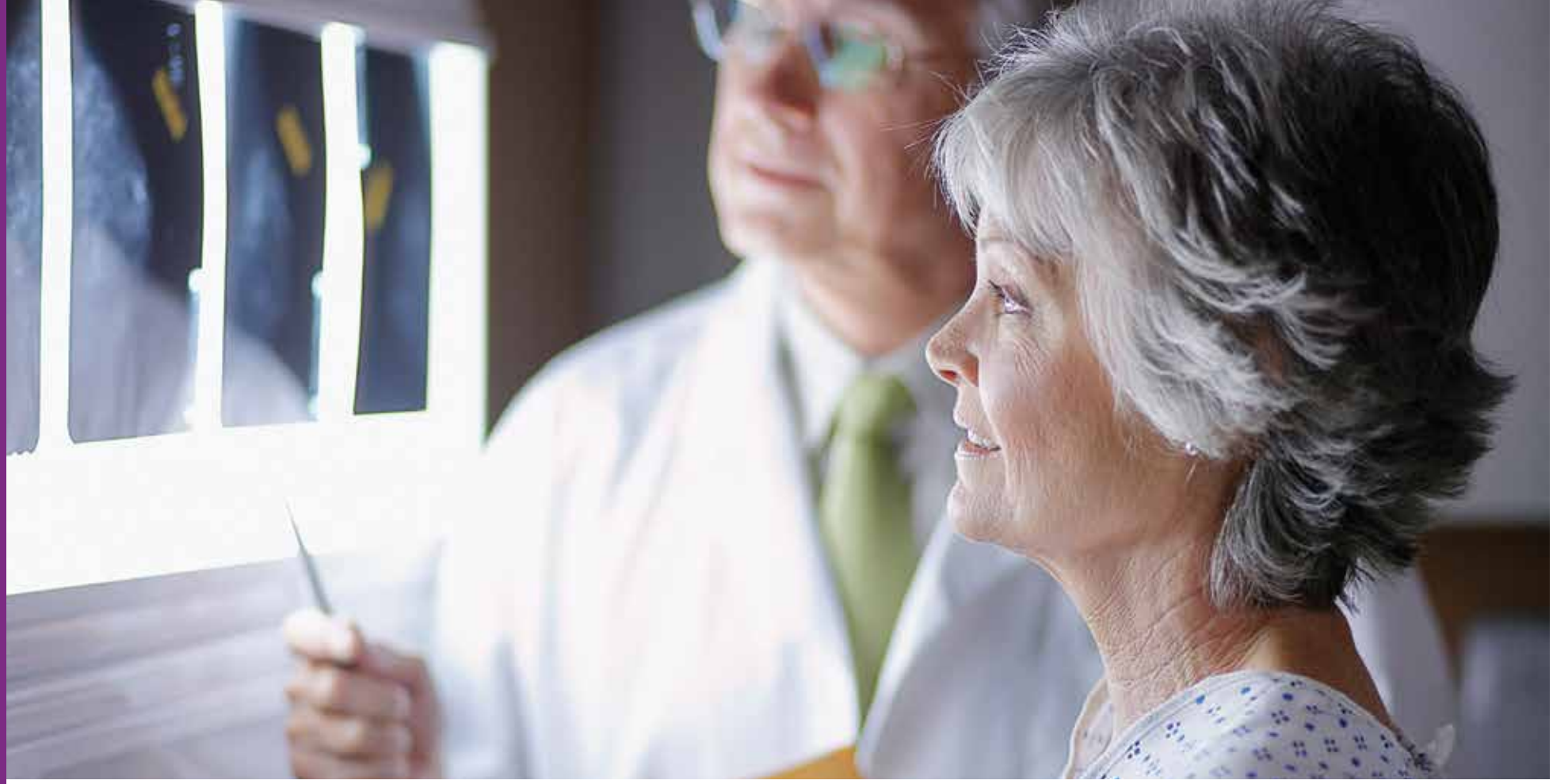
"We recognize that data, EMR functionality/utilization and technology usage/ management are key supports to the quality improvement process. Currently, the EMR is primarily used to help profile and document care of the rostered patients/clients served by the FHT. We are at the beginning stages of using the EMR to identify high-risk populations and high users, and we currently use the EMR to help identify "at risk" individuals for specific FHT programming."

2013/14 Changes for this Indicator

Many of the QIPs that were submitted included innovative and creative ideas for improving performance on this indicator. The table below depicts effective measurement of current performance and target setting, as well as good change ideas and linked process measures.

Table 15: Measures & Change Ideas for Influenza-Related Indicators

MEASURE: POPULATION HEALTH				
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
Brockton and area FHT	Reduce Influenza rates in patients over 65 by increasing access/education around the influenza vaccine. Percent of rostered patients over 65 who have had the flu shot	Three sites —average 47%	60%	Better data collection is first step, along with education on value of flu shot
	CHANGE: POPULATION HEALTH			
	Planned improvement initiatives (Change Ideas)	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
	1) Consider reminder on EMR for flu shot 2) List from Public Health re: patients seen in their clinics and from local pharmacies 3) Work with clinic staff to ask re: flu shots at clinic visits if reminder on chart 4) Continue flu shot days within clinic 5) Obtain info from LTC facilities re: flu shots given 6) Poster in all sites for education on immunization	1) Percent of patients over 65 2) Percent of patients over 65 with flu shot	60% of patients > 65, receive flu shot	—



Population Health - Optional indicators: Prevent breast, cervical and colorectal cancers by screening

Why are these Indicators Important?

There is strong evidence that demonstrates that screening for colorectal, breast and cervical cancers can reduce mortality.[43-47] Although the same tests can sometimes be used for both diagnosis and screening, a screening test identifies those healthy asymptomatic individuals in the population who may have or may be at risk of disease.

The purpose of screening is to prevent cancer by identifying pre-cancerous changes, or to find cancer at an early stage when it is easier to treat.[48]

2013/14 Aims for these Indicators

The number of primary service organizations (by model) reporting on cancer screening indicators is illustrated in the table on page 45.

Table 16: Number of Organizations Reporting on Cancer Screening Indicators by Model Type

PRIORITY/INDICATOR	FHT	CHC	NPLC	AHAC	OVERALL NUMBER
Percentage of patients/clients who are up-to-date in screening for breast cancer	25	19	6	1	51
Percentage of patients/clients who are up-to-date in screening for colorectal cancer	32	18	6	1	57
Percentage of patients/clients who are up-to-date in screening for cervical cancer	24	19	6	1	50
Number of organizations reporting all three cancer screening indicators	23	17	6	1	47

2013/14 Measures for these Indicators

Cancer Care Ontario (CCO) collects provincial screening data for breast, cervical and colorectal cancers. Primary care providers are encouraged to measure this indicator and access the target setting information using the provincial screening data reported by the Cancer Quality Council of Ontario.

Table 17: Cancer-Screening Measures

MEASURE: POPULATION HEALTH				
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
Grandview FHT	% screening eligible patients who are up-to-date with breast cancer screening (mammograms)	On Jan. 1, 2013 a snapshot was taken and our clinic average was at 64% of eligible patients have had screening done in the last 30 months	For year ending March 31, 2014, we would like to have 75% of eligible pts screened by way of receiving a mammogram	Improving our screening efforts by dedicated HR resources to contact patients (health promoter)
Jane-Finch FHT	Increase the amount of breast, cervix and colorectal cancer screening	Unknown	Determine Baseline	Not available
Windsor Essex CHC	Cervical Cancer Screening Percentage of female ongoing primary care clients age 20-69 years who received or were offered a pap smear in the last 3 years	71%	75%	Benchmark for Southwest Ontario

2013/14 Changes for these Indicators

For the purposes of next year's QIP, Ontario's primary care organizations are encouraged to use Cancer Care Ontario's Quality Improvement toolkit to help plan, implement, monitor and report on improvements in colorectal, cervical and breast cancer screening.

The tables on pages 47-49 include effective examples of change ideas from the 2013/14 QIPs that addressed preventing breast, cervical and colorectal cancers by screening.

Table 18: Cancer-Screening Change Ideas & Measures

CHANGE: POPULATION HEALTH				
Organization	**Planned Improvement Initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
Grandview FHT	1) Health Promoter to contact eligible pts directly to either enroll and print req to enter OBSP or if already enrolled, fax over the req. 2) Educate nurses on using the Status Report on EMR to identify eligible pts who are coming in for non-related appts	1) We are going to track on a quarterly basis the clinic percentage of compliant pts who have had the screening and report to the physicians. 2) Create a blitz/contest for nurses to educate and print requisitions for patients eligible for the Mammogram Screening	1) Give Docs numbers on a quarterly basis to generate reminders to every eligible pt. 2) Generate teamwork amongst nurses to screen as many pts as possible to better pt. care	Once calculation of 2012-2013 numbers are complete, the health promoter will begin to track on a monthly basis the mammogram numbers
Jane-Finch FHT	1) Determine baseline for cancer screening rates 2) Create a master list of which patients require which cancer screening tests 3) Choose staff who will call patients and book them for required cancer screening test(s) 4) Create available appointments slots to do cancer screening	Measure the absolute number of cancer screening tests done	Develop baseline/perform an additional 150 cancer screening tests on patients overdue for screening	This initiative will create opportunities to highlight scope of practice opportunities for IHPs
Windsor Essex CHC	1) Continue to hold Well Women Clinics for screening women in the community (under-served and never-served). 2) Partner with VP Cancer Services at the Windsor Regional Cancer Centre to expand opportunities for screening for under-served or never-served community members.	Number of clinics held and # of women attending. **QIP TIP** This is an example of a SMART process measure.	Utilize technology to support reminders. Nightingale being implemented in September 2013 which support “pop up” reminders when exams or screening are required.	—

MEASURE: POPULATION HEALTH				
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
Marathon FHT	% of population who are up-to – date in cancer screening a) colorectal b) cervical c) breast	a) 51.3 % b) 90.7 % c) 70.2 %	a) 70% b) 92% c) 80%	a) rate was 69% in 2009-10 b) Currently surpassing provincial targets. Will aim for modest increase c) rate was 79% in 2010-11
	% of eligible patients with positive FOBT who receive notification of results and follow-up, including referral, within 2 weeks	Unknown	Determine Baseline	—

CHANGE: POPULATION HEALTH				
Organization	**Planned Improvement Initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
Marathon FHT	1) Revamp current tracking and reminder system. 2) Improve charting of screening results ensuring preventions section of chart current. 3) Identify non-locum providers to be responsible for cancer screening test results 4) Update preventions section of patient charts so accurate reminder lists and alerts in charts. 5) Promote opportunistic screening	1) create QI team for preventive care including IT 2) identify ways to address current problems 3) have new system created based on current EMR as only data source for tracking and reminders 4) printout current status of patients from Abel and use with current EMR data to update EMR preventions section 5) update screening status in preventions so alert in schedule only present when needed. 6) inform providers and staff of use of alerts (stop signs) on OSCAR scheduler for preventive care (immunizations and screening)	Efficient and accurate tracking and reminder system developed and implemented	Lower rates in past year may be in part due to errors/ omissions in tracking results in current multi-program system. **Priority Level 1** **QIP TIP** This is an excellent example of how comments can be used to contextualize change ideas
	1) Develop system to track positive/ abnormal results and alert providers of patients with positive results to ensure appropriate and timely follow up	1) Review prevention section capabilities in OSCAR 12.1 2) Identify ways to generate lists of patients with positive/abnormal results for tracking and timely follow up	1) Determine baseline and target values. 2) Have system for tracking abnormal/positive results and follow up and alerting providers of need for follow-up	**Priority Level 2**

MEASURE: POPULATION HEALTH				
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
Glengarry NPLC *(colorectal)*	Percent of screening eligible patients who are up-to-date with ***colorectal*** cancer screening	333 screened patients of 402 total patients who fall within guidelines (83%)	Collect base line data	36% Champlain LHIN target for 2013
(cervical)	Percent of screening eligible patients who are up-to-date with ***cervical*** cancer screening	364 screened patients of 414 total patients who fall within guidelines (88%)	≥90% of those eligible will be screened	>85 % Champlain LHIN target for 2013 was already achieved by GNPLC in 2012/2013
(breast)	Percent of screening eligible patients who are up-to-date with ***breast*** cancer screening	192 screened patients of 246 total patients who fall within guidelines (78%)	≥ 85% of those eligible will be screened.	>70 % Champlain LHIN target for 2013 was already achieved by GNPLC in 2012/2013

CHANGE: POPULATION HEALTH			
Organization	**Planned Improvement Initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**
Glengarry NPLC *(colorectal)*	1) Utilize the Cancer Care Ontario Cancer Screening Toolkit to assist with planning, implementing, monitoring and reporting cancer screening at the GNPLC. 2) Developing patient packages that include completed requisitions, an FOBT kit and any other information. Patients can pick up their packages when they are in the area or before/after an appointment. Package contents could include: CCC; FOBT kit; Instructions (tear -away sheet- CCO has a sample)	a) Identify number of clients not up to date for colon cancer screening and issue patient/ client reminder/ follow-up. b) Update recall list in EMR	Monthly review of recall list by each provider to identify those needing to be contacted
(cervical)	1) OCSP (Pap): book appointments or conduct screening on an opportunistic basis (i.e., when a patient attends an appointment for another reason)	1a) Identify No. of patients/ clients not up to date with cancer screening and issue reminder/ follow-up. 2a) Update recall list in EMR	Monthly review of recall list by each provider to identify those needing to be contacted
(breast)	OBSP: Mammography requisition Lab locations sheet Instruction sheet for patients/ clients to have better understanding of purpose and procedure	1a) Identify no. of patients/ clients not up to date with cancer screening and issue reminder/ follow-up. 2a) Update recall list in EMR	Monthly review of recall list by each provider to identify those needing to be contacted

Population Health: Other Indicators

A total of 336 other indicators were submitted by primary care organizations in their 2013/14 QIPs, which is indicative of their passion for quality improvement and their dedication to local improvement priorities.

One hundred and fifty two (45%) of these indicators were related to chronic disease management and mental health. The distribution of these other indicators across primary care models is illustrated in the table below.

Table 19: Additional Population Health Indicators in 2013/14

MODEL	CHRONIC DISEASE MANAGEMENT				MENTAL HEALTH
	Diabetes	COPD	CHF/hypertension	Asthma	
FHT	66	26	16	8	7
CHC	12	2	4	0	6
NPLC	1	0	2	0	0
AHAC	2	0	0	0	0
Overall	**81**	**28**	**22**	**8**	**13**

Diabetes had the highest frequency of additional indicators, which broke down into the following areas.

Table 20: Diabetes Management Indicators

DIABETES MANAGEMENT INDICATORS	MODEL				
	FHT	CHC	NPLC	AHAC	Overall
Blood pressure control in diabetes patients	13	0	0	0	**13**
HbA1C	5	0	0	0	**5**
Eye exam	4	0	0	0	**4**
Diabetes hospitalization (Admission/re-admission)	2	2	0	0	**4**
Foot exam	2	1	0	0	**3**
Diabetes self-management/education	1	0	0	0	**1**
Other diabetes indicators	39	9	1	2	**51**
Total	66	12	1	2	**81**

QIP Narrative Excerpts

Many of the primary care organizations that submitted a QIP remarked on the importance of EMRs in the tracking of these population health indicators.

"Our FHT fully adopted an EMR in the fall of 2011. We have made significant efforts at changing our workflow to use the EMR to improve efficiency and patient/client safety. Over the next year, we will also be collaborating with the EMRALD initiative run out of the Institute of Clinical Evaluative Sciences. This collaboration should provide us with readily available data related to quality of care for diabetes, hypertension, and coronary heart disease. The collaboration may also make it easier for us to run searches on our own practice database."

— St. Michael's Academic Family Health Team

"The biggest challenge with the current state of the EMR is that the data that can be extracted is only as reliable as that data that has been put in. There has been much inconsistency in the way that inputting diagnostic information, medications, etc., has been input into the patient/client chart. Moving forward, this needs to improve."

— Dufferin Area Family Health Team

QIP TIP For consistency in EMRs, consider using standardized terminology for medications and diagnostics, and ensure that everyone on the health care team enters patient/client data in exactly the same way.

2013/14 Changes for these Indicators

Ontario's primary care organizations are including additional indicators in their QIPs for the purposes of quality improvement and performance management. Many organizations stated in their QIP Narratives that they are reporting on some of these additional indicators elsewhere, such as within the LHIN Multi-Service Accountability Agreements (MSAAs).

The assertion was that these organizations are using additional indicators to maintain performance and monitor existing strategies. Although sharing these strategies with the sector is valuable, the intent of QIPs is not to create redundancy by addressing processes and indicators reported elsewhere. Essentially, the QIP is designed to foster and drive unique, innovative, system-level improvement.

The tables below include examples of change ideas from the 2013/14 QIPs that address population health indicators.

Table 21: Measures & Change Ideas for Population Health Indicators

	MEASURE: POPULATION HEALTH			
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
Sunnybrook Academic FHT	Regular assessment of glycemic control - Percent of patients: • Less than 65 years old with A1C less than 0.07 • Between 65-85 years old with A1C less than 0.08 • Over 85 years old with A1C less than 0.09	Under 65: 44% 65-85: 80% Over 85: 87%	Maintain	The current change ideas might not effect much change in A1Cs in year one but are the first step in the process
	CHANGE: POPULATION HEALTH			
	Planned Improvement Initiatives (Change Ideas)	**Methods and Process Measures**	**Goal for Change Ideas (2013/14)**	**Comments**
	1) Sunnybrook Academic Family Health Team is part of the EMRLD project and as such each physician will be getting individual performance as well as practice aggregate performance data	EMRLD will be collecting our data electronically and sharing it with the SAFHT on a regular basis		Strong emerging evidence about needing to tailor A1C targets to comorbidities and life expectancy
	2) Ensure that CPPs are kept up to date with respect to DM diagnoses by triangulating with billing data and EMRLD data	**Method:** Lists of patients who have been billed as DM or on the EMRLD list as DM but not listed in the CPP to send to MDs for clarification Q6months **Process Measure:** percent of physicians returning their lists	List are created and distributed Q6 months	—

	MEASURE: POPULATION HEALTH			
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
Sunnybrook Academic FHT	Regular assessment of glycemic control: Percent of patients with DM who have an A1C done and recorded in the EMR in the last 6 months	61%	70%	Almost 10% increase for a value that will need to be redone on every single patient with diabetes every 6 months
	CHANGE: POPULATION HEALTH			
	Planned Improvement Initiatives (Change Ideas)	**Methods and Process Measures**	**Goal for Change Ideas (2013/14)**	**Comments**
	1) Collaborate with local endocrinologists and their administrative staff to facilitate copying the family doctor when ordering blood tests	Process Measure: Percent of randomly sampled patients whose endocrinologists have copied the family doctor	Depends on initial findings	Strong emerging evidence about needing to tailor A1C targets to comorbidities and life expectancy
	2) Work with the lab at our local hospital to ensure that when we are copied on lab requisitions the results are populated in our EMR in such a way that they are searchable	**QIP TIP** This is an excellent example of integration and collaboration with local hospital.	N/A	Experience tells us that changing process at the hospital lab level is challenging
	3) Write medical directives allowing members of the Diabetes Education team to order DM related blood tests	**QIP TIP** Building standard work for evidence based practice and using an interprofessional team approach will increase the likelihood that the interventions get done.	Medical Directive written and approved by Nov. 2013	—
	4) Contact patients with DM who have not been seen in over 6 months and invite them for an appointment	**Method:** Multiple PDSAs to determine which patients have not been seen by Family Doctor, endocrinologist or SUNDEC in last 6 months	Pilot the process on one team and spread if it works	—
	5) Electronic reminders.	N/A	N/A	—

MEASURE: POPULATION HEALTH				
Organization	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**
Peninsula FHT Inc.	1a) Quarterly reporting of % of smoking patients who are over 40 yrs. old that have been screened with spirometry 1b) Quarterly reporting of COPD related OPD visits per patient on COPD registry 1c) Quarterly reporting of COPD related admissions per patient on COPD registry	Just beginning. Establishing baseline.	1) 25% reduction of: a) COPD related OPD visits per patient on COPD registry b) COPD related admissions per patient on COPD registry	To leverage the FHT to reduce hospital usage

CHANGE: POPULATION HEALTH				
Organization	**Planned Improvement Initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
Peninsula FHT Inc.	Have engaged CCAC and Partner's for Quality to collaborate with FHT Physician's and key Allied Health Professionals to develop an evidenced based and sustainable program for COPD	1a) Quarterly reporting of % of smoking patients who are over 40 yrs. of age that have been screened with spirometry 1b) Quarterly reporting of COPD related Out Patient Department visits per patient on COPD registry 1c) Quarterly reporting of COPD related admissions per patient on COPD registry	—	—

Conclusion

This *Analysis for Improvement* has highlighted the excellent quality improvement work underway in Ontario's primary care sector, and identified examples of QIPs that stood out for having a clear vision and strategy for improvement.

It is clear from Health Quality Ontario's analysis of the 290 QIPs that primary care organizations have embraced quality improvement and committed themselves to improving the care they deliver on a daily basis. Many excellent examples of quality improvement activities were detailed in this year's QIPs, and a variety of effective change ideas were identified across the access, integrated and patient-centred attributes of a high-performing health system.

Many of the plans also provided clear descriptions of organizational efforts to support health system integration. There were superb examples of the work being done around integration involving hospitals, Health Links, Community Care Access Centres (CCACs), community support services, Local Health Integration Network (LHINs), mental health, long-term care and the primary care sector working together to provide the best possible care for their communities. Greater patient-centredness and integration across all facets of the patient journey will mean that Ontarians receive more coordinated care, while gaining greater value from the health system.

It must be emphasized that effective quality improvement relies on measurement and, despite a comparative lack of available data, many primary care organizations developed interesting and adaptable methods for improving the quality of care they deliver. It is anticipated that next year's QIPs will include more robust data, clearer numerical targets for improvement, and a greater variety of change ideas and process measures.

As they develop their 2014/15 QIPs, Ontario's primary care organizations are encouraged to make use of the valuable data they collected during the past year, which will guide the identification and prioritization of indicators, targets, and organizational improvement activities. In order to gauge the success of these activities, it is essential for organizations to regularly measure the impact of their efforts through process measures that link their change ideas to desired outcomes.

Organizational quality improvement plans must also be informed by patients/clients. Surveys, conversations, comment boxes, and the involvement of patients/clients on Quality Committees or organizational boards will provide a wealth of valuable information, which can be incorporated into QIPs to ensure that Ontario's health system is increasingly patient-centred.

It is important to recognize that quality improvement plans are meant to be organizational level and not specific to one provider or practice. Therefore, a robust QIP requires all levels of an organization (staff, physicians, nurse practitioners, managers/administrators and the board) to contribute to and be engaged in the development process. By fostering a culture of continuous improvement through their QIPs, organizations will be better able to achieve their shared goals, demonstrate meaningful quality improvement, and meet the diverse health care needs and expectations of Ontarians.

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Appendix A: Snapshot of Ontario's four primary care interprofessional team-based models required to submit QIPs (as of December 2013)

1. **Aboriginal Health Access Centre (AHAC)**

AHACs are Aboriginal community-led, primary health care organizations that provide traditional healing, primary care, cultural programs, health promotion programs, community development initiatives, and social support services.

Number of AHACs in Ontario: 10

Patient/client profile: First Nations, Métis and Inuit communities in Ontario — both on and off reserve; and in urban, rural and northern locations.

2. **Community Health Centre (CHC)**

CHCs contribute to the development of healthy communities by providing a wide range of primary care and health promotion programs to children, youth and their families, based on local needs.

Number of CHCs in Ontario: 75

Patient/client profile: Children, youth and families, who typically live in Ontario's rural communities and lower income urban neighbourhoods. Compared to other care models, CHCs serve a higher proportion of people with severe mental illness, asthma and COPD.

3. **Family Health Team (FHT)**

FHTs include groups of physicians working alongside interprofessional health care providers such as Nurse Practitioners, Registered Nurses, Dieticians, Social Workers, Occupational Therapists and others to deliver comprehensive primary health care to patients. Each team differs in size, composition and programs/services delivered based on local health and community needs. FHTs deliver a range of specialized programs in the areas of chronic disease management, health promotion and disease prevention.

Number of FHTs in Ontario: 185

Patient/client profile: FHTs serve 3 million enrolled patients, including over 700,000 previously unattached. FHTs are located in 206 communities and serve a range of clients – general population, homeless or under-housed, special religious and linguistic groups, in both rural and urban areas. There is a higher proportion of FHTs in northern and rural areas.

4. **Nurse Practitioner-Led Clinic (NPLC)**

Nurse practitioner-led clinics provide comprehensive, accessible, and coordinated family health care services through a collaborative approach which includes: Nurse Practitioners, Registered Nurses, Dieticians, Social Workers, Occupational Therapists and others.

Number of NPLCs in Ontario: 25

Patient/client profile: Typically patients who do not have access to a primary care provider (i.e., unattached patients)

Appendix B: Suite of Supports Provided by Health Quality Ontario

Individualized QIP Feedback	HQO's QIP specialists offer one-on-one "QIP Conversations" with primary care organizations to review their QIP feedback and provide them with resources and tools to aid them in the development and implementation of their Quality Improvement Plans. To connect with HQO's QIP specialists, contact QIP@hqontario.ca
QIP Navigator	Health Quality Ontario's QIP Navigator, created in consultation with primary care associations, the Ontario Hospital Association (OHA), and the Ministry of Health & Long-Term Care (MOHLTC), is designed to streamline QIP development and submission and enable HQO to produce a more robust analysis and more useful feedback. The QIP Navigator allows organizations to enter and save data as it becomes available throughout the year. The tool has the added benefit of acting as a collaborative space and includes online assistance in the form of: guides, videos, tools, and other resources - which will help organizations create and maintain their QIPs.
Quality Compass	A comprehensive, evidence-informed, searchable tool to help leaders and providers improve health care performance in Ontario. Quality Compass is centred around priority health care topics with a focus on best practices, change ideas linked with indicators, targets and measures, and tools and resources to bridge gaps in care and improve the uptake of best practices. Visit the Quality Compass website
Quality Improvement Webinars	Presented by HQO's QIP specialists, these live, web-based learning opportunities are designed to facilitate the uptake of quality improvement science. A variety of improvement topics will be addressed over the course of these sessions. Please contact QIP@hqontario.ca to share suggestions for future presentation topics, and join HQO's email list to be notified about upcoming events.
Institute for Healthcare Improvement (IHI) Open School	The IHI Open School's curriculum, designed by world class faculty, focuses on skill development in the areas of patient safety, teamwork, leadership, and patient-centred care. These courses are offered online, allowing access at any time. The Open School features a growing catalogue of courses, extensive content and resources, and a network of local chapters that organize events and activities on campuses around the world. In order to foster knowledge of quality improvement science, HQO offers enroll for up to two employees from each organization. Contact QIP@hqontario.ca to discuss how you can enroll
Advanced Access, Efficiency and Chronic Disease Management	As part of its work to foster quality improvement capacity and capability in Ontario's health system, HQO developed resources and strategies to assist primary care practices and providers. The core principle of the Advanced Access and Efficiency initiative is that patients calling to schedule a visit are offered an appointment with their primary care provider on the same day, or on a day of their choice. By participating in this program, primary care teams learn how to implement change concepts and evidence-informed care that will enable them to improve the patient experience for Ontarians. Contact learningcommunityinfo@hqontario.ca to learn more.

Appendix B: Suite of Supports Provided by Health Quality Ontario

Primary Care Provider-level Patient Experience Survey	Health Quality Ontario is developing a primary care patient experience survey to support practices and primary care organizations in their quality improvement efforts. Following pilot-testing, the survey and an accompanying implementation guide will be available to all primary care practices in Ontario. Implementation of the survey will be the responsibility of practices and/or organizations either on their own or in collaboration with other practices or organizations. For more information about HQO's primary care patient experience survey, please contact patientexperience@hqontario.ca
bestPATH	As a support to Health Links, bestPATH offers a suite of tools and expertise to help identify and address gaps in the quality of care and delivery of services to individuals with complex chronic illnesses. Specifically, bestPATH is designed to facilitate the achievement of Health Links objectives by providing leadership and support in: measurement, evidence-informed change ideas, and building sustainable capacity for change and improvement. The bestPATH initiative facilitates more coordinated, person-centered care for seniors and others with complex chronic illnesses. It is designed to be an integral support to Health Link communities as they work to smooth the gaps between sectors, improve access to care, reduce avoidable emergency room visits and hospital re-admissions, and improve the experiences of patients as they make their way through the health system.
Primary Care Performance Measurement Framework	Health Quality Ontario is collaborating with its health system partners and stakeholders on the Ontario Primary Care Performance Measurement Steering Committee to provide leadership on a coordinated and sustainable approach to measuring and reporting on primary care performance. For more information please visit http://www.hqontario.ca/public-reporting/primary-care or contact PCPMSummit@hqontario.ca
Primary Care Physician Practice Report	Developed by HQO in collaboration with the Institute for Clinical Evaluative Sciences (ICES), the Primary Care Physician Practice report provides physicians with practice-level data to support quality improvement efforts and track progress. This report provides consenting physicians with aggregated data about his/her practice population, including: • Demographic and health status • Utilization of services • Chronic disease prevention and management, including screening data. Reports will be available on a bi-annual basis. For more information on the Primary Care Physician Practice Report, please visit www.hqontario.ca
Yearly Report	HQO's eighth yearly report on Ontario's health system identifies significant achievements and challenges in areas such as access to health care, chronic disease management and keeping the population healthy. Read the latest yearly report on HQO's website

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