# Theme I: Timely and Efficient Transitions

## Measure

**Dimension:** Efficient

| Indicator #1 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge. | C | % / All inpatients | EMR/Chart Review / April 1/23 -March 31/24 | 68.30 | 72.00 | Although we are in the top 4th percentile in Ontario our goal is to improve to our target of 72 percent for all conditions. | |

## Change Ideas

Change Idea #1 1) Doctors and staff will be reminded to perform timely follow-up of patients post-discharge. 2) Doctors will be reminded to make use of support staff and the Allied Health Team that could be used to follow up on discharges especially mental health and diabetics. 3) Use of the message system needs to be improved to be timely if this will be the mode of communication for follow-up. 4) Follow-up post-discharge messages should be made urgent to be done within 7 days.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| After 6 months, the researcher will perform a search and inform all providers of individual progress. This should help to improve individual goals. | The percentage differences will be brought to the attention of the lead who will inform each provider. | 72 percent of all inpatients discharged from Apr 1/23 to March 31/24 will be followed up by any clinician in any form. | Although we are in the 4th percentile in Ontario for follow-up with certain conditions, we would like to improve to 72 percent for all conditions. Education of staff and providers will be integral in improving to target. |

## Measure

**Dimension:** Timely

| Indicator #2 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of screen eligible patients aged 52 to 69 years who had a mammogram within the past two years. | C | % / PC organization population eligible for screening | Other / 2022/23[PCP], 2023/24 [EMR] | 67.40 | 75.00 | We have set a target of 75. We are using data from Primary Care Practice reports to report our performance, but we also compare these numbers for the same time period to numbers collected through our EMR. Our EMR numbers are more accurate but feel we should use PCP report numbers as a guide.<br><br>Our target reached [67.4%] is already higher than LHIN [51.4%] and Provincial average [51.2%] on PCP reports as of March 2022. But we strive always to do better and increase screening percentages for better prevention of disease.<br><br>Our EMR data suggests screening rate of 81.9% in eligible patients for fiscal year Apr 1/22- March 31/23. | |

## Change Ideas

Change Idea #1 Use CCO SAR, reminders and Target reports reviewing eligible patients who have not been screened.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Process measures 1)Research assistant generates lists of patients due for mammogram screening and calls to inform: If agreeable, schedule an appointment with our local OBSP. 2) Reminding staff to check reminders in EMR and keep updated. 3) Percentage of patients up to date with mammogram screening will be compared to our EMR searches to ensure all patients are being accounted for. These measures are working to increase screening in these eligible women. Target for process measure percentage of patients up to date with screening goal of 75% by March 31, 2023, on Primary Care Practice Reports. Our main local OBSP was closed or had diminished capacity for the months of 2021/22 while they underwent a major renovation to their mammogram equipment. This had a significant effect on our mammogram statistics for this year. Their backlog has improved and is running more efficiently at present. | The percentage of patients screened compared to the previous year will be examined. | We will see an increase in the PCP report percentage of this population screened to 70 percent by Mar 2023 and to 75 percent by 2024. | Our performance is somewhat influenced by the performance of our local hospital mammogram OBSP site. They have recently dealt with their backlog due to COVID so it should improve our stats. |

## Measure

**Dimension:** Timely

| Indicator #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of female patients aged 23 to 69 years who had a Pap test within the previous three years. | C | % / PC organization population eligible for screening | Other / April 1/22 - Mar 31/23 [PCP], Apr 1/23-Mar 31/24 [EMR] | 74.50 | 82.00 | Our target is set to 82. We feel we already achieve this through more accurate EMR stats. Although since we use Primary Care Report numbers we feel we can improve with time from 74.5 to 82.<br><br>Our target reached [74.5%] is already higher than LHIN [53.5%] and the Provincial average [50.3%] on PCP reports as of March 2022.<br><br>The metric from our practice reports could be lower in comparison to our EMR data due to labs being behind on submitting tests and CCO not having a record of non-eligible patients who are therefore included in the total.<br><br>Apr 1/2022 - March 31/23 from EMR Pap-eligible women were up to date and screened 82.9%. | |

## Change Ideas

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|---|---|
| Change Idea #1 | Increase the percentage of patients who are up to date with cervical cancer screening by calling to inform them. 2)Increase the percentage of patients, who are up to date with cervical cancer screening when in office for other reasons. 3)Increase the percentage of patients who are up to date with cervical cancer screening through the SAR report. 4)The research assistant will continue to call and follow up with patients to encourage them to follow up on their cervical cancer screening. 5) Physicians will remind patients during office visits if they have a reminder in their EMR that they are not up to date for cervical cancer screening. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| The researcher will scan the CCO SAR reports monthly to see who is coming due/overdue for screening. The researcher will look at the percentages of eligible patients screened and evaluate them quarterly. This will be given to each provider at board meetings as a reminder. | The percentages of patients screened will be compared to the previous quarter to see if improves. | Increase the percentage of patients up to date with screening to our goal of 82% by March 31, 2024. | With the slowing of the COVID pandemic along with CCO resumption of letters being sent to eligible patients, we are hoping to see an increase in screening percentages. |

## Measure

**Dimension:** Timely

| Indicator #4 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of screen-eligible patients aged 52 to 74 years who had an FOBT/FIT within the past two years, other investigations (i.e., flexible sigmoidoscopy), or colonoscopy within the past 10 years. | C | % / PC organization population eligible for screening | Other / 2022/23 [PCP report], 2023/24 EMR | 79.60 | 80.00 | We are very close to this target. With the introduction of FIT kits [easier for patients to do], we feel our target of 80 percent is achievable and reproducible annually.<br><br>Our target reached [79.6%] is already higher than LHIN [62.9%] and the Provincial average [61.2%] on PCP reports as of March 2022. But we strive always to do better and increase screening percentages for better prevention of disease. | |

## Change Ideas

| Change Idea #1 | Increase the percentage of patients, who are up to date with colorectal screening when in the office for other reasons. 2)Increase the percentage of patients, who are up to date with colorectal cancer screening by calling to inform. 3)Increase the percentage of patients who are up to date with colorectal cancer screening through the SAR report. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1)Utilizing reminders in EMR to keep on top of screening required by physicians. 2)Utilizing EMR chart review to assess which patients are due for colorectal cancer screening. 3)Access Cancer Care Ontario Screening Activity Reports (SARs). The SAR report will give us a list of patients due for a screening or needing follow-up with their screening. | 1)The Research Assistant will continue to call and follow up with patients to encourage them to follow up on their colon cancer screening. 2) Physicians will remind patients during office visits if they have a reminder in their EMR that they are not up to date for colon cancer screening 3) Reminding staff to check reminders in their EMR and keep updated. 4)Percentage of patients up to date with colorectal cancer screening will be compared to our EMR searches to ensure all patients are being accounted for. Our measures we feel are working well since the percentage of eligible patients who are screened for colon cancer steadily keeps improving. Improve the percentage of patients up to date with screening to over 80% by March 31, 2024. We will be making calls in follow-up to the letter mailed out by CCO/MOHLTC. | Improve the percentage of patients up to date with screening to over 80% by March 31, 2024. | We will be making calls in follow-up to the letter mailed out by CCO/MOHLTC. |

# Theme II: Service Excellence

## Measure

**Dimension:** Patient-centred

| Indicator #5 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) involve them as much as they want to be in decisions about their care and treatment | P | % / PC organization population (surveyed sample) | In-house survey / April 2022 - March 2023 | 98.18 | 98.18 | We are happy to maintain this target. We collected 672 surveys this year. | |

## Change Ideas

Change Idea #1 We will continue to use our encrypted email system to send surveys to patients who have had an in-person appointment.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Currently, we send surveys to any patient who has come to the clinic for an in-person appointment. Criteria for the emailing survey: Must be in-person, no survey completed within the year, and must have an email address on file. | Number of completed surveys we feel should be greater than 450. | We will maintain this percentage at 98.18 or above for fiscal year 23/24 | Total Surveys Initiated: 672<br><br>We are confident that this is an accurate measure and have had very positive feedback from our patients. |

## Measure

**Dimension:** Patient-centred

| Indicator #6 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed. | C | % / All patients | In house data collection / 2023/24 | 43.20 | 100.00 | We collected 672 surveys this year. | |

## Change Ideas

Change Idea #1 Collect more surveys to analyze patients' feedback. 2) Utilize our method of phone surveys. 3) Random surveys conducted twice monthly and data evaluated by Researcher. 4) Use our email communication system for mailing

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| We constantly strive to provide exceptional access to our patients. We conduct our poll twice monthly on random dates and collect data to determine whether patients who require same-day/next-day appts receive them or are turned away due to unavailability. Our in-house random survey indicated that from April 1/22 to Mar 31/23 our same day/next day appts given totalled 99.2 percent which is excellent and we feel is more representative and accurate of our clinic’s accessibility. | % of patients given same/ next day appointments when asking for urgent appointments. | We always aim for 100%. Maintain 100% for in-house phone surveys and collect at least 450 surveys to evaluate patients' needs. | |

# Theme III: Safe and Effective Care

## Measure

**Dimension:** Effective

| Indicator #7 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Proportion of patients with a progressive, life-limiting illness who were identified to benefit from palliative care who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment.<br>( %; All patients; April 2023 - March 2024; Local data collection) | C | % / Palliative patients | EMR/Chart Review / 2023-2024 | 16.24 | 21.00 | Our highest percentage ever was 20.70%. We dropped our percentage last year to 16..24% and are hoping to get back and improve on our best percentage ever. | |

## Change Ideas

Change Idea #1 Physicians will be given a list at the beginning of the year to identify possible palliative patients. Physicians will be reminded throughout the year to consider palliative visits. A reminder in the EMR will encourage physicians to consider a palliative evaluation

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Physicians will be given a biannual reminder about considering palliative care for identified patients (currently this is only done annually). | Percentage of patients with a progressive, life-limiting illness who were identified to possibly benefit from palliative care who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment. | 21% of patients with a progressive, life-limiting illness who were identified to possibly benefit from palliative care who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment. | The Beamsville Medical Centre FHT feels this is attainable as physicians will be re-educated/reminded of this important metric. |

## Measure

**Dimension:** Safe

| Indicator #8 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system. | P | % / Patients | CAPE, CIHI, OHIP, RPDB, NMS / 6 month period ending Mar 31, 2022 | 3.50 | 3.00 | As of March 31, 2022, 3.5% of our FHT patients have been newly dispensed opioid prescriptions. 24.2% of those opioids were prescribed by the patient's physician within the FHT and 75.8% were prescribed by other providers (e.g., other family or ER physicians, dentists, and surgeons) within or outside of the FHT.<br><br>Our LHIN percentage is 3.7%. The provincial percentage is 3.1%.<br><br>We would like to be better than the provincial average. | |

## Change Ideas

Change Idea #1 Investigate opioid prescribing in our practice including searching methods of current physician practices when prescribing opioids. 2)Determine the number of opioid users given urine drug screens. 3)Standardization of charting opioid initial assessment.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Research Assistant creates a search to indicate how many patients have been prescribed opioids in the past 6 months. A search is run for each physician practice to determine a baseline of opioid users in each practice using the EMR meds profile. 2. The Lead reviews chart to see how each doctor manages their opioid population. Doctors are then given a list to eliminate short-term patients who have not been taken out. 3. Research Assistant runs a search of all patients prescribed opioids in the past 6 months as well as which of these patients have had random urine drug screening. 4. Physicians will be asked to use the TELUS Opioid Initial Assessment custom form and Opioid Risk Tool, including opioid contracts when initiating opioids. Physicians to discuss and agree on the process at Board meetings. | 3.30 3.00 Org ID 92252 \| Beamsville Medical Centre FHT As of Sep 2020 3.3% of patients in our FHT have been newly dispensed an opioid prescription. 30.1% of those opioids were prescribed by the most responsible physician and 69.9% were prescribed by other providers (e.g., other family physicians, ER physicians, dentists, and surgeons). P % / Patients Process measures 1) Percentage of patients prescribed opioids on Primary care Practice reports. 2) Number of patients given urine drug screen when prescribing opioids compared to previous searches. 3) Number of physicians who use standardized methods available and researcher to conduct random searches to measure the percentage of standardized methods being used. | Target to equal or better provincial percentage. 2) Increase in the number of urine drug screens by 100% of physicians. Greater than the present % is the target. 3) 100 % of physicians will use standardized and agreed-upon methods. | We will continue to do quarterly searches of non-palliative patients who are newly prescribed opioids and distribute them to the providers to keep them aware of their list and the need for evaluation of opioid use. We also cross reference this list to see what percentage of these included patients have had a urine drug screen within 6 months of being prescribed the new opioid. This information is distributed to the providers. |

## Measure

**Dimension:** Safe

| Indicator #9 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| What percentage of the FHT's non-palliative patients have had at least one high-dose opioid >90 MEQ daily within the last 6 months? | C | % / Population | Other / 2023-2024 | CB | CB | We are using data reported on the primary care practice report. Data for next year will not include current improvements from our change ideas since the data reported is always one year behind. But for 2023-2024 reporting we are hoping to improve better than the LHIN average of 0.7 percent. | |

## Change Ideas

Change Idea #1 We will improve our percentage by collecting baseline numbers. MEQ will be noted in patient charts to remind physicians if the MEQ is greater than 90.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| MEQ will be noted in patient charts to remind physicians if the MEQ is greater than 90. Physicians will be reminded quarterly of performance. | Primary Care Practice Reports data will be used to see if there is improvement to match the LHIN average. | Match LHIN average of 0.7 percent. | We will have to work on this measure for at least 2 years to see if our change ideas are working since we are using PCC Reporting [which is a year behind] |

## Equity

### Measure

**Dimension:** Equitable

| Indicator #10 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of screening eligible trans patients up-to-date with Papanicolaou (Pap) tests. | C | % / Population | Local data collection / 2023-2024 | CB | CB | New Target | |

### Change Ideas

| Change Idea #1 | Investigate how many eligible trans patients who are Male and have a cervix, are being monitored and screened routinely for Pap smears and are up to date. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1) Conduct a biannual search of Male trans patients who have a cervix age 21-69. 2) Cross reference who has had a Pap in the last 3 years 3) Researcher will present doctors with patient names and up-to-date data to ensure screening. 4) Doctors will be encouraged to chart specific data in EMR regarding trans patients who require screening, | the number of eligible patients who have been screened/ number of eligible patients. | 100% of all trans patients should be screened for cervical cancer | This is a new measure. We want to ensure that we are providing equitable health care, especially to this population. |