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	% / Discharged patients	EMR/Chart Review / April 2020 - March 2021	61.00	72.00	Due to covid this has been difficult to maintain. We will continue to educate our staff about the importance of following up patients within 7 days of discharge from hospital for any condition. We did notice that the follow-up days post discharge was closer to 10 days (delay possibly due to covid)	

Change Ideas

Change Idea #1 1) Doctors and staff will be made aware of the decrease in timely follow-up of patients post discharge. 2) Doctors will be reminded to make use of support staff and that AHP's could be used to follow-up on discharges especially mental health and diabetics. 3) Use of message system needs to be improved to be timely if this will be 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
1)Doctors to be reminded of stat and importance of follow up appointment scheduling. 2)Data entry will be changed to more easily catch hospital discharges. 3) Reception and all staff will be further educated regarding the importance of patient follow-up in less than 7 days post discharge. 4)Doctors will be reminded at board meetings of stats and importance of scheduling appointment post discharge. 5) Researcher will search biannually via EMR to see if on track and doctors will be made aware of stats mid year.	Number of patients with discharge summary in chart within 48 hours of discharge from hospital who is also seen within 7 days of discharge/ number of patients with discharge summary within 48 hours discharge in chart. This will be tallied via EMR by the researcher biannually and results will be given to staff.	% of patients discharged from hospital with discharge summary in chart within 48 hours of discharge that are seen by any clinician within 7 days.	Doctors and staff will be made aware of the decrease in timely follow-up of patients post discharge. Also, we will remind doctors to make use of support staff and AHP's could be used to follow-up on discharges especially mental health and diabetic patients. Use of message system needs to be improved to be timely if this will be mode of communication for follow-up. Follow up post discharge messages should be made urgent to be done within 7 days.

Measure

Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients who have had a 7-day post hospital discharge follow up, by a community care provider for selected conditions-CHCs.	C	% / Discharged patients	See Tech Specs / April 2020 - March 2021	72.00	75.00	We are presently functioning at a high percentage (top 4th percentile in Ontario). Further education of ALL staff including and most importantly receptionist and doctors.	

Change Ideas

Change Idea #1 We are presently functioning at a high percentage (top 4th percentile in Ontario). Further education of ALL staff including and most importantly receptionists and doctors.

Methods	Process measures	Target for process measure	Comments
1) Physicians will be reminded to see their discharged patients within 1 week of hospital discharge at annual meeting. 2) Receptionists will be reminded to prioritize booking these appointments within 1 week of hospital discharge. 3) Further education of all staff.	Physicians will be informed of the results and continued to be encouraged to follow-up with patients within one week of discharge.	Increase percentage of patients who see their primary care provider within 7 days after discharge from hospital to our goal of 75% by March 31, 2023.	The Beamsville Medical Centre FHT scored 72% which places us in the top 4th percentile of all clinics in Ontario. Our staff will continue to work hard to improve this target measure.

Measure

Dimension: Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen eligible female patients aged 52 to 69 years who had a mammogram within the past two years.	A	% / PC organization population eligible for screening	OHIP,RPDB, CCO-OCR,CIHI, SDS / April 2020 – March 2021	68.50	75.00	More complete data from EMR to Mar/21 is 81.7% screened patients 50-74. Due to covid and patient reluctance, it was more difficult this year to maintain mammogram screening. Patients are notified when they are overdue for mammograms via telephone or email communication. In most cases, appointments are facilitated by our office with the OBSP centres.	

Change Ideas

Change Idea #1 More of an effort will be made to contact patients prior to becoming due to secure more timely appointments (at times, mammogram appts were 5-6 months into the future)

Methods	Process measures	Target for process measure	Comments
1) Utilizing EMR chart review in order to assess which patients are eligible female patients aged 52-69 years who have not had a mammogram within the past two years. 2) Utilizing reminders in EMR to keep on top of screening required. 3) Access Cancer Care Ontario Screening Activity Reports (SARs). The SAR report will give us a list of patients due for screening or needing follow-up with their screening.	1)Research assistant generates lists of patients due for mammogram screening and calls to inform: If agreeable, schedules 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. Due to covid and closure of the mammogram department at the local hospital (due to repairs), more follow-up and phone calls by the RA was needed to ensure appointments.	percentage of patients up to date with screening goal of 75% by March 31, 2023.	During Covid, there was a reluctance by many patients to consider preventative measures such as performing mammograms. As well, our main local OBSP was closed or had diminished capacity for months while they underwent a major renovation to their mammogram equipment. This had a significant effect on our mammogram statistics for this year. Due to the back log of appointment scheduling of the OBSP and mammogram diagnostic imaging centres, more of an effort will be made to contact patients prior to becoming due to secure more timely appointments (at times, mammogram appts were 5-6 months into the future

Measure

Dimension: Timely

Indicator #4	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.	A	% / PC organization population eligible for screening	OHIP,RPDB, CCO-OCR,CIHI, SDS / April 2020 – March 2021	71.10	82.00	More complete data from EMR to Mar/21 shows that 82.6% age 21-69 were up to date with cervical cancer screening 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 record of non-eligible patients who are therefore included in the total.	

Change Ideas

Change Idea #1	1)Increase percentage of patients who are up to date with cervical cancer screening by calling to inform. 2)Increase 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
1) Utilizing EMR chart review in order to assess which patients are due for cervical cancer screening. 2) Utilizing reminders in EMR to keep on top of screening required by physicians. 3) Access Cancer Care Ontario Screening Activity Reports (SARs). The SAR report will give us a list of patients due for screening or needing follow-up with their screening. These patients will be called or sent email reminders that they are due.	Change ideas are working as planned according to our EMR data. We will continue to utilize our change ideas to keep our target within reach.	Increase percentage of patients up to date with screening to our goal of 82% by March 31, 2023.	Since letters sent by Cancer Care Ontario during covid were stalled, follow up phone calls were made. Since letters have been resumed by Cancer Care Ontario we will be making calls in followup to this letter, which should increase patient awareness and increase screening rates.

Measure

Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen eligible patients aged 52 to 74 years who had a FOBT/FIT within the past two years, other investigations (i.e., flexible sigmoidoscopy) or colonoscopy within the past 10 years.	A	% / PC organization population eligible for screening	OHIP,RPDB, CCO-OCR,CIHI, SDS / April 2020 – March 2021	74.50	80.00	More complete data from our EMR to September 2020 showed 77% had a FIT/FOBTs or colonoscopy performed for patients aged 50-74. The reminder system in EMR as well as searches conducted by staff are used to call patients when they become due.	

Change Ideas

Change Idea #1 1)Increase percentage of patients, who are up to date with colorectal screening when in office for other reasons. 2)Increase 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 in order 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 screening or needing followup 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 EMR and keep updated. 4)Percentage of patients up to date with with colorectal cancer screening will be compared to our EMR searches to ensure all patients are being accounted for. Our measures we feel our working well, since the percentage of eligible patient who are screened for colon cancer steadily keeps improving.	Keeping the percentage of patients up to date with screening of 80% by March 31, 2023.	We would be making calls in followup to the letter mailed out by CCO/MOHLTC.

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #6	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 2021 – March 2022	97.72	98.00	We have improved for this category from the last QIP and feel confident that it continues to be excellent over the next fiscal year. Our staff is reminded annually and they are naturally diligent about involving the patient in their own care.	

Change Ideas

Change Idea #1 Maintain 450 + survey collection to ensure continual feedback. 2)Increase percentage of positive patient feedback about feeling they are being involved in decisions about their care and treatment by reminding staff and discuss importance of being patient centered at the Board level and Annual Staff meeting. 3)Continue to offer on-line option to do survey to collect feedback from patients.

Methods	Process measures	Target for process measure	Comments
1)Research Assistant to conduct, disperse and analyze surveys equally amongst all physician populations to get an accurate representation. 2) Physicians to ensure patients feel involved in decisions about their care and treatment. 3) Collect on-line surveys through our website.	1)Collection of data through MOH survey % of patient involved in care. 2) Staff will be informed of the results and encouraged to ensure that patients feel they are involved in decisions about their care and treatment. 3)Collection of data through standardized MOH survey.	percentage of patients feeling they are being involved in decisions about their care and treatment our target goal is 98% by March 31, 2023.	Total Surveys Initiated: 450 We have improved for this category from the last QIP and feel confident that it continue to be excellent over the next fiscal year.

Measure

Dimension: Patient-centred

Indicator #7	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	% / PC organization population (surveyed sample)	In-house survey / April 2020 - March 2021	40.60	100.00	Misrepresented in survey. In fact, the previous question on the survey asks, "Did you get the appointment date that you wanted?". In our surveys, only 14 % of patients stated that they didn't receive the appointment they wanted so perhaps this survey question needs to be revisited.	

Change Ideas

Change Idea #1 1) Collect more surveys to analyze patient's feedback. 2) Utilize our own 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 own poll 2x's 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 survey after the third quarter this year is 98.8% 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.	

Measure

Dimension: Patient-centred

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of patients 65 years of age or older who have been immunized with Pneumovax	C	% / PC organization population aged 65 and older	EMR/Chart Review / April 2020 - March 2021	71.40	75.00	Due to covid, we did not actively call patients to educate and inform them. The reminder system in the EMR was our main focus for this indicator.	

Change Ideas

Change Idea #1 1) Search will be performed by researcher to identify population. 2) Calls made to each patient on list to inform them of importance of pneumovax vaccine and appointment offered. 3) Quarterly searches conducted to see rate of change. 4) Reminders used in Telus EMR when patients come into clinic for appt.

Methods	Process measures	Target for process measure	Comments
Due to covid, we did not actively call patients to educate and inform them. The reminder system in the EMR was our main focus for this indicator. Slightly lower results most likely due to covid.	% of rostered patients who received pneumovax vaccine.	75% of patients 65 years of age or older will have been vaccinated with pneumovax	We will consider options but will continue to use the reminder in the EMR. (% of clinics rostered population of people 65 years of age or older 2021/22; EMR/Chart Review)

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #9	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.	C	% / All patients	Local data collection / April 2020 - March 2021	20.70	25.00	Each physician was given a list of patients who potentially could have palliative care needs over the subsequent year. The physician was asked to identify which patients they wouldn't be surprised if they were deceased within 1 year. This, we thought, would be our denominator for this metric. Of the 174 patients identified by physicians, 36 patients had a palliative care assessment done on them during the year.	

Change Ideas

Change Idea #1 1) Physicians will be given a list of patients with identified diseases or above a certain age. 2) The physicians will be asked which patients they wouldn't be surprised if they were deceased in the next year. 3) This will be our denominator for this metric. 4) Physicians will be encouraged to consider a palliative care assessment for these patients

Methods	Process measures	Target for process measure	Comments
Each physician was given a list of patients who potentially could have palliative care needs over the subsequent year. The physician was asked to identify which patients they wouldn't be surprised if they were deceased within 1 year. This, we thought, would be our denominator for this metric. Of the 174 patients identified by physicians, 36 patients had a palliative care assessment done on them during the year.	Physicians will be encouraged to consider a palliative care assessment for these patients. After the year, we will tally what percentage of the identified patients had a palliative care consult during this time. As a new metric that started with our previous QIP, we did improve this metric substantially. It is known that earlier palliative care in identified patients improves both quality of life and quantity of life in palliative patients.	25% of identified patients will have had a palliative care assessment	We feel we have developed a good system of identifying patients who may have palliative care needs. We will continue with our annual search and surprise question.

Measure

Dimension: Safe

Indicator #10	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 / March 31, 2021	3.30	3.00	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, surgeons).	

Change Ideas

Change Idea #1 Investigate opioid prescribing in our practice including searching methods of current physician practices when prescribing opioids. 2)Determine 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 search to indicate how many patients have been prescribed opioids in the past 6 month. Search is run for each physician practice to determine baseline of narcotic users in each practice using EMR meds profile. 2. The Lead reviews chart to see how each doctor manages their opioid population. Doctors are then given list to eliminate short term patients who have not been taken out. 3. Research Assistant runs search of all patients prescribed opioids in past 6 months as well as which of these patients have had random urine drug screening. 4. Physicians will be asked to use Telus Opioid Initial Assessment custom form and Opioid Risk Tool, including opioid contract when initiating opioids. Physicians to discuss and agree on process at Board meetings.	1) Percentage of patients prescribed opioids on Primary care 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 percentage of standardized methods being used.	1) Target to equal or better provincial percentage. 2) Increase in number of urine drug screens by 100% of physicians. Greater than present % is 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 to providers to keep them aware of their list and 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. Lhin %: 3.3% Prov: 2.8%