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

Ingersoll NPLC

AIM		Measure						
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop dow								
Effective	Coordinating care	Percentage of patients identified as meeting Health Link criteria who are offered access to	A	% / Patients meeting Health Link criteria	In house data collection / most recent 3 month period	91956*	CB	CB
	Effective transitions	Percentage of patients who have had a 7-day post hospital discharge follow up. (CHCs,	P	% / Discharged patients	See Tech Specs / Last consecutive 12 month period	91956*	60	75.00
		Percentage of patients who were discharged in a given period for a condition within selected	A	% / Discharged patients with selected HIG conditions	DAD, CAPE, CPDB / April 2016 - March 2017	91956*	CB	CB
		Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification	P	% / Discharged patients	EMR/Chart Review / Last consecutive 12 month period	91956*	60	100.00
	Wound Care	Percentage of patients with diabetes, age 18 or over, who have had a diabetic foot ulcer	A	% / patients with diabetes, aged 18 or older	EMR/Chart Review / Last consecutive 12 month period	91956*	CB	80.00
Efficient	Access	Number of requests for support from RPNs during clinical visits to provide essential non-	C	Count / All patients	In house data collection / March 1 2018- March 1 2019	91956*	CB	CB

Equitable	**Population health - cervical cancer screening**	Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least	A	% / PC organization population eligible for screening	CCO-SAR, EMR / Annually	91956*	75.6	80.00
	Population health - colorectal cancer screening	Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for	A	% / PC organization population eligible for screening	See Tech Specs / Annually	91956*	51	40.00
	Population health - diabetes	Percentage of patients with diabetes, aged 40 or over, with two or more glycated	A	% / patients with diabetes, aged 40 or over	ODD, OHIP-CHDB,RPDB / Annually	91956*	100	100.00
Patient-centred	**Person experience**	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	91956*	98.3	100.00
		% of patients who receive self management support and treatment strategies to manage	C	% / All patients	EMR/Chart Review / April 1 2018-March 31-2019	91956*	CB	CB
		% of patients who receive self management support and treatment to manage insomnia	C	% / All patients	EMR/Chart Review / April 1 2018-March 31-2019	91956*	CB	CB
		% patients/clients who receive mental health or addiction care that perceive the Ingersoll NPLS as a	C	% / Mental health patients	In house data collection / April 1 2018-March 31 2019	91956*	CB	95.00
Safe	**Medication safety**	Percentage of patients with medication reconciliation in the past year	A	% / All patients	EMR/Chart Review / Most recent 12 month period	91956*	CB	CB

		% of patients with chronic non-cancer pain who are offered opioid alternatives for pain management	C	% / All patients	EMR/Chart Review / April 1 2018-March 31-2019	91956*	CB	CB
Timely	**Timely access to care/services**	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	91956*	37.8	98.00

	Change			
Target justification	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**

n menu if you are not working on this indicator) C = custom (add any other indicators you are working on)

Oxford HL became operational in April 2017. There was limited data	1)Refer those patients/clients who have complex health and social issues that are not being addressed by the in-house	Determine the number of patients who meet HL criteria who are currently having their complex health needs addressed by our interdisciplinary team. Refer patients meeting the criteria for HL who are not having their complex health and social needs met by the in-house	# of patients meeting the criteria for HL # of patients identified that are referred to HL	CB
Communication from hospitals is improving through use of HRM and SPIRE.	1)Develop a social media campaign directed at patients to encourage them to arrange follow up following discharge from	Develop an Ingersoll NPLC Facebook page Post information regarding groups, seasonal health issues, health promotion campaigns, clinic closure alerts and information about community partners	# of Facebook pages developed	1
NPLCs do not have access to the DAD, CAPE, or DPDB.	1)Collect baseline data of patients who are re-admitted to hospital within 30 days of discharge for selected HIGs.	Collect in-house data via HRM, SPIRE and Clinical Connect on patients who are re-admitted to hospital within 30 days who have one of the following HIGs: Acute MI (age 45+), cardiac conditions (excluding MI and CHF, age 40+), CHF (age 45+), COPD (age 45+),	# of patients re-admitted within 30 days for one or more the selected HIGs	CB
With availability of same day and next day appointments, it is reasonable	1)NPs will alert the RPNs when a discharge summary is received so that follow up can be completed within 7 days.	NPs will review HRM and SPIRE reports daily. NPs will inform the RPN that a patient has been admitted to hospital RPNs will seek out discharge summary on Clinical Connect. Receptionists will request discharge summaries from hospitals if not available through HRM,	# of patients for whom a discharge summary was received within 48 hours after discharge #w of patients who had follow up by the most appropriate provider within 7 days after discharge from hospital.	75%
Patients with DM are assessed at least 4 times/year by the NP, Chronic	1)All clinicians who provide DM related care will complete INLOW's 60 Sec Diabetic Foot Screen as part of their standard	Complete training with all DM care providers on INLOW's 60-sec Diabetic Foot Screen).	# of patient appointments when diabetes was addressed # of INLOW's 60 sec Diabetic Foot Screens completed ("Footcare Screening Diabetes" custom form).	80%
Care that is provided by the interdisciplinary team is essential, yet rarely	1)Gain a baseline understanding of the impact that RPN essential non-scheduled care has on patient care access and	RPNs will collect in-house data on requests for assistance	# of requests for RPN assistance # of request for RPN assistance per week day	CB

The Ingersoll NPLC is taking on 500 new patients in 2018-2019. Women who	1)Offer cervical screening to all female new patients who are screen-eligible, aged 21-69 at their initial visit or physical exam.	NPs will determine what patients are due for cervical screening at initial appointment by accessing cervical screening history from the patient or OLIS. NPs will complete cervical screening for new female patients who have not had a Pap test in the previous 42 month	# of new female patients who are cervical screen eligible, age 21-69 # of screen-eligible women who complete cervical screening	80%
The Ingersoll NPLC is taking on an additional 500 patients during 2018-2019. The	1)Promote colorectal screening with all new patients who are screen-eligible at initial assessment.	Determine last colorectal screening by reviewing previous records, OLIS and Clinical Connect	# of new patients in 2018-2019 # of new patients in 2018-2019 who are overdue for colorectal screening	25%
The Ingersoll NPLC will strive to maintain the same high level performance as	1)NPs and the CDC will order an HbA1C at least twice annually with patients who are aged 40 or over and diagnosed with DM or pre-	HbA1C will be ordered every 3 months in conjunction with quarterly or semi-annually DM focused appointments.	# of patients aged 40 or over with a diagnosis of DM # f HbA1Cs ordered	100%
The Ingersoll NPLC provides care within a patient-centred self management	1)Establish a Patient and Family Advisory Committee (PFAC).	Recruit PFAC members during June and July through social media, our webpage, the waiting room TV. Screen applicants during August and September.	# of PFAC's established	1
The Ingersoll NPLC is currently implementing the CEP guidelines on	1)Support and treat insomnia using self management strategies outlined in the CEP Guideline for Chronic Non-	Provide education to counsellors and NPs on the CEP Guideline for Chronic Non-Cancer Pain Management. Provide patients living with chronic pain resources to implement evidence-based self management strategies for chronic pain.	# of patients receiving care for chronic non-cancer pain # of resources provided to patients on self management strategies for chronic pain	80%
The Ingersoll NPLC is currently implementing CEP's Guidelines for Management	1)Support and treat insomnia using self management strategies outlined in the CEP Guideline for Insomnia.	Provide training to counsellors and NPs on self management strategies to treat insomnia outlined in the CEP Guideline for Insomnia. Provide patients with resources on evidence-based self management strategies for insomnia	# of patients seeking care for insomnia # of patients with insomnia who receive resources on evidence-based self management strategies for insomnia.	80%
The Ingersoll NPLC began using the OPOC tool in 2017 to develop an	1)Increase competence of staff to manage patients presenting with challenging behaviours and cultural differences.	Provide training for staff on cultural sensitivity and managing challenging behaviours.	# of professional development activities completed by staff	2
the Ingersoll NPLC is implementing medication reconciliation by	1)Medication Reconciliation will be completed with patients scheduled for a physical exam, following discharge from hospital	NPs will complete the Med Rec custom form to guide and document medication reconciliation with patients scheduled for a physical exam, following discharge from hospital discharge, or after seeing a specialist.	# of patients scheduled to have a physical exam, # of patients discharged from hospital # of patients seen by a specialist # of Med Red custom forms completed	75%

Access to opioid alternatives, such as onsite physiotherapy, exercise and	1)NPs will use the CEP's Guidelines for Managing Chronic Non-Cancer Pain to provide patients with alternatives to opioid	NPs will use the Chronic Non-Cancer Pain Baseline Assessment custom form to guide practice and document the initial visit with patients seeking care for chronic pain. NPs will use the Chronic Non-Cancer Pain Follow-Up Assessment custom form to guide practice	# of patient visits for pain management # of CNCP baseline assessments completed # of CNCP follow up assessments completed	80%
Our in-house data reflects an outcome that exponentially exceeds the	1)N/A	N/A	N/A	N/A

Comments
Our interdisciplinary model addresses many of the same challenges that
Social media is a new endeavor for the Ingersoll NPLC. The entire staff will be
The Indicator is based on data sources NPLCs do not have access to. Therefore the
HRM and SPIRE have increased the percentage of discharge summaries
Clinicians completing diabetes care are using a variety of assessment tools,
Collecting data on the # of requests for assistance from the RPNs and stratifying

The initial appointment and first physical provide excellent opportunities to
The Initial visit with the NP provides an opportunity to review the
In 2017-2018 the Ingersoll NPLC measured HbA1Cs twice annually with 100
In addition to involving patients in their direct care, research suggests that
The IDEAS quality improvement project on MDD provided foundational
The IDEAS project on MDD provided the clinic with a foundation to support
All staff play a role in the perception of care, whether they are directly
Medication safety in increased when a "Best Possible Medication History" is

the CEP Guideline for Managing Chronic Non-Cancer Pain is an evidence-based	
	The Ingersoll NPLC collects this data manually. The question on the Patient