Timmins Family Health Team
Équipe de Santé Familiale

TFHT QI Dashboard

2014/2015 - Q1-Q4

Ontario

Reference Documents and Legend: 1) TFHT 2013/2014 to 2017/2018 Strategic Plan 2) TFHT 2014/2015 Quality Improvement Plan 3) TFHT 2014/2015 Service Plan - Schedule A 4) Currently Unavailable 5) Indicator Target
afhto -> AFTHO D2D 1.0 Indicator

Strategic Direction	Outcome and Performance Measure	Strategic Plan Success Measure	*Target*	*Q1*	*Q2*	*Q3*	*Q4*	*Data Source(s)*
1. Access and Care Transitions	80% of patients will be able to see a doctor or nurse practitioner on the same or next day. afhto		80%					Staff Portal, ED Board Report, EMR
	Patients without a PCP will decrease by 20% in Timmins, based on the number of patients registered with Health Care Connect.		20%					
	50% of TFHT patients discharged from hospital will be assessed by their PCP within 7 days of discharge.		50%					
	70% of patient population over age 65 will receive influenza immunization. afhto		70%					
	50% of patients identified as high users of the health care system and those who are high risk will be assessed by their PCP and care team within 7 days of identification.		50%					
	Patients seen by TFHT IHP's will increase by 10%.		10%					
	Number of OTN clinicals will increase by 10%. Otn.		10%					Quarterly Report
2. Quality Outcome Based Services and Programs	75% of patients will state that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) give them the opportunity to ask questions about recommended treatment. afhto		75%					Patient Experience Survey
	85% of patients will state that when they see their 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. afhto		85%					
	90% of patients will state that when they see their doctor or nurse practitioner, they or someone else in the office (always/often) spend enough time with them. afhto		90%					
Asthma	50% of patients with Asthma will have documented self-management goals in the EMR.		50%					Create & develop EMR tool
	80% of patients over the age of 18 with asthma will report that they are not currently smoking at their most recent visit.		80%					
	Number of Asthma encounters will increase by 10%.		10%					Quarterly Report
CHF	50% of patients with CHF will have documented self-management goals in the EMR.		50%					EMR
	Number of encounters will increase by 10%.		10%					Quarterly Report

COPD	80% of patients over the age of 18 with COPD will report that they are not currently smoking at their most recent visit.		80%					EMR
	80% of patients over the age of 18 with COPD will have influenza vaccine in the past 365 days.		80%					
	60% of patients over the age of 18 with COPD will receive pneumococcal vaccine.		60%					
	50% of patients over the age of 18 with COPD will have a documented chronic disease management plan that includes self-management.		50%					
	Number of encounters will increase by 10%.		10%					Quarterly Report
Diabetes	0% of patients age 50-74 with diabetes will have an acute MI in the past 12 months.		0%					EMR - search to be det
	0% of patients age 50-74 with diabetes will have an above or below-knee amputation in the past 12 months.		0%					
	0% of patients age 50-74 with diabetes will begin chronic dialysis in the past 12 months.		0%					
	0% of patients 50-74 with diabetes will be diagnosed with retinopathy in the past 12 months.		0%					
	0% pf patients age 50-74 with diabetes will have one of the following: acute MI, amputation, begin dialysis, retinopathy, in the past 12 months.		0%					
	75% of patients 20 or older with diabetes will report having an eye exam in the past 24 months.		75%					
	80% of patients 20 or older with diabetes will have at least two HbA1C in the past 12 months.		80%					
	80% of patients age 20 or older with diabetes will have cholesterol screening in the past 36 months.		80%					
	80% of patients 20 or older with diabetes will have a foot exam in the past 12 months.		80%					
	Number of encounters will increase by 10%.		10%					Quarterly Report
Geriatric Dementia	15% of patients between 75 and 80 will be screened using MMSE.		15%					EMR
	20% patients in the geriatric dementia program will be reviewed through the interdisciplinary care management clinic.		20%					
	Number of encounters will increase by 10%.		10%					Quarterly Report
Hypertension	50% of patients 18 or older will have BP measured in past 15 months		50%					EMR
	90% of patients 18 or older with hypertension will have BP recorded in the past 12 months.		90%					
	50% of non-diabetic patients 20 or older with hypertension, will have a BP less than 140/90.		50%					
	Number of encounters will increase by 10%.		10%					Quarterly Report
Anticoagulation	100% of RNs will implement the anticoagulation program who have attended training; in adherence to medical directive		100%					EMR
	Number of encounters will increase by 10%.		10%					Quarterly Report

Mental Health	250 patients referred by PCP will receive psychometric and psychological testing through NEOFACS.		250					Staff Portal
	75% of patients referred to MH program will receive a SW visit within 1 month of referral.		75%					
	No more than 10% of patients will be no-shows.		10%					
	Number of encounters will increase by 10%.		10%					Quarterly Report
Periodic Health/Cancer Screening	80% of female patients 18 to 69 who have not had a hysterectomy will have a Pap test in the past 36 months. afhto		80%					EMR
	75% of female patients 50 to 74 who have not had a mastectomy will have a mammogram in the past 24 months.		75%					
	70% of patients 50 to 74 will have FOBT testing in the past 24 months OR a colonoscopy/sigmoidoscopy in the past 10 years. afhto		70%					
	Number of encounters will increase by 10%.		10%					Quarterly Report
Healthy Lifestyle Sessions	90% of patients will indicate a high level of satisfaction with healthy lifestyle sessions.		90%					Staff Portal, HP Report
	10 daytime healthy lifestyles sessions will be offered		10					
	10 evening sessions will be offered.		10					
Immunizations	70% of patients 65 or older will have flu shot in past 12 months.		70%					EMR
	70% of patients 65 or older will have pneumococcal immunization.		70%					
Nutrional Counselling	Less than 60% of patients 18 and older will be overweight or obese according to BMI.		60%					EMR
	60% of patients seen for weight management will have a decrease in BMI.		60%					
	60% of patients 12 or older, seen by the RD will report consuming fruits & vegetables five or more times daily.		60%					
	60% of patients 12 or older, seen by the RD will report moderate activity level.		60%					
	85% of patients 12 or older, seen by the RD will have self-management goals identified.		85%					
	Number of encounters will increase by 10%.		10%					Quarterly Report
Smoking	100% of patients over 18 will have smoking status documented in the EMR.		100%					EMR
	50% of patients will have self-management goals documented in the EMR.		50%					
	Number of encounters will increase by 10%.		10%					Quarterly Report
Well Baby, Well Child	100% of patients age 7 will have received recommended primary childhood immunizations.		100%					Staff Portal, EMR
	100% of patients 6 or younger will have a completed Nipissing Development Screen.		100%					
	100% of patients age 6 or younger will have completed Rourke Baby Record.		100%					
	Number of encounters will increase by 10%.		10%					
3. Organizational Capacity		# of components of HR Downloads utilized						

	# of consultation sessions with HR lawyer						
	# of HR outcome measures developed						
	# of vacancies in TFHT positions						
	# of staff hired						
	# of staff left						
	Annual rate of turnover						
	% of staff who can provided services in French						
	# of staff who claimed STD						
	# of staff who claimed LTD						
	# of staff with WSIB claims						
	# of staff on maternity leaves						
	# of job descriptions reviewed and revised						
	# of positions for which salary was reviewed						
	# of activities undertaken in order to advocate for salary equity						
	# of positions for which hours and/or workload was adjusted						
	Date of completion of human resource plan that includes succession planning						
	Date of completion of professional development plan						
	# of performance appraisals completed						
	# of performance appraisals for which the contribution of individual staff members to the achievement of the strategic plan is identified						
	% of staff who submitted their orientation evaluation						
	% of students who submitted their orientation evaluation						
	% of staff who have been invited to complete an exit interview or form						
	# of exit forms received						
	# of functioning committees/groups						
	# of functioning committees with terms of reference reviewed within the past year						
	# of staff newsletters circulated						
	# of staff meetings held						
	# of FHT Days held						
	# of sites represented at IT Committee by an IT lead						
	# of PSS upgrades completed						
	# if IT training sessions held						
	# of staff registered for one-mail						
	Document changes made to address privacy at all sites						

4. Education & Excellence		# of students supported through the TFHT; identify disciplines						
		# of education sessions attended by IHPs						
		% of staff who participate in professional development						
		# of patients seen through Health Link Initiative						
		# of HL patients seen by TFHT staff						
		# of referrals received from TADH of high user patients						
		# of these patients who received in-depth assessment and case management by TFHT staff						
		# of meetings that included review of the practices implemented at different sites						
		# of initiatives that will reduce PCP paperwork						
		# of patients for whom system navigation was provided by IHPs						
		# of issues of Monthly Measure distributed						
		# of reports produced and distributed to staff						
		# of repots produced and distributed externally to health partners						
5. Collaboration & Advocacy		# of meetings held of HL partners						
		# of primary care education days held						
		# of participants at primary care education days						
		# of committees/groups attended on behalf of primary care						

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D2D 1.0 Indicators

Indicator	**Specific Measurement**	**Data Access Notes**	***Target***	***Q1***	***Q2***	***Q3***	***Q4***	***Data Source(s)***
Same/Next Day Appointments	Patient Experience Survey Question: How many days did it take from when you first tried to see your family doctor to when you actually saw him/her or someone else in the office?	Compile results from patient experience surveys, including the number of same/next day responses as well as those number of responses (ie. numerator and denominator for this measure).						Existing Patient Experience Surveys
Patient Experience: Time Spent	Patient Experience Survey Question: When you see your (family doctor, nurse practitioner) or someone else in their office, how often do they spend enough time with you?	Compile results from patient experience surveys, including the number of same/next day responses as well as those number of responses (ie. numerator and denominator for this measure).						
Patient Experience: Experience Involved	Patient Experience Survey Question: When you see your (family doctor, nurse practitioner) or someone else in their office, how often do they spend enough time with you?							
Patient Experience: Ask Questions	Patient Experience Survey Question: When you see your (family doctor, nurse practitioner) or someone else in their office, how often do they give you an opportunity to ask questions about recommended treatment?							

Regular Primary Care Provider	Number of primary care visits for a core service that are made to the physician to whom the patient is rostered or virtually rostered. Based on series of primary care and paediatric codes outlines in the full technical specification of the Primary Care Physician Practice Reports.	Submit data request to ICES for data for specific FHOs within FHT. Request must include FHT ED and Medical lead signature and assurance of full consultation of all physicians in group.						Primary Care Physician Practice Report
Colorectal Cancer Screening	Percentage of patients aged 50 to 74 (52-69 in Primary Care Practice Report) who had a fecal occult blood test (FOBT) within past two years, other investigations within five years, or a colonoscopy within the past 10 years.							
Cervical Cancer Screening	Percentage of female patients aged 23 to 69 who had a Papanicolaou (Pap) smear within the past three years.							
Cost	To be detailed in technical specification on receipt of data from ICES.							
Readmissions to Hospital	Percentage of patients who were re-admitted to a hospital following their initial hospitalization within 30 days of discharge, within one year of discharge (for specific conditions, to be detailed in technical specificaion on recipt of data from ICES).							
Influenza Immunization	Percentage of patients 65 and over who had a seasonal fly shot in the past year.	Extract number of people 65 and over with influenza immunization and the number of people 65 and over at the time of measurement (ie. numerator and denominator for this measure).						EMR
Childhood Immunizations	Percentage of 2 year old children who are up-to-date for immunization coverage (the recommended 3 doses and 1 booster of diptheria-polio-tetanus-pertussis/Haemophilus influenza type b vaccine and 1 dose of measles-mumps-rubella vaccine).							