Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	% of eligible patients/clients who are up-to-date in screening for using Cancer Care Ontario letters. CCO-SAR, EMR) (%; PC organization population eligible for screening; April 2018 - March 2019; CCO-SAR, EMR)	92309	62.80	70.00	63.90	

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Better use data and the EMR to identify overdue patients	Yes	Instead of using reminder reporting, we installed OntarioMD Dashboard, as it also included a chronic disease component. This data is updated daily to ensure current screening status.
Create a woman’s health program	Yes	Revisions to the program changed it to Woman's Screening Program to include all relevant cancer screening as well as immunization and risk screening, including smoking status and BMI for patients that may not often be seen. This is a first step towards a full Woman's Health Program. A custom form was created to allow for data extraction as needed.
Reach out to overdue patients during scheduled appointments	Yes	The Ontario MD toolbar showing current status of a patient's relevant cancer screening is now available to clinicians.
Call overdue patients	Yes	Using the OntarioMD Dashboard and the relevant custom form, clerical staff were able to call patients who were overdue for screening, the custom form displayed the status of all relevant cancer screening and provided a place to record patient response. As the dashboard is

refreshed each night, it is current. This is a great improvement over our previous method of printing lists. We have asked OntarioMD to create a similar form for Flu immunization.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
2	Improve screening and identification of cognitive impairment and dementia (%; PC organization population aged 65 and older; April 2018 - March 2019; EMR/Chart Review)	92309	CB	CB	CB	

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Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Establish a Memory Clinic	Yes	Feedback from patients and families has been positive about the assessments. Caregivers appreciate the opportunity to express their concerns about the patient. Because of the comprehensive assessments of memory, function and mood, Memory Clinic physicians came away with a deeper understanding of the patients and their issues. Clinic is very human resource heavy hence can only do 2 or 3 intake appointments each half-day session. As nurse intake assessments are lengthy; physicians now schedule follow-ups between intakes to maximize clinic time.
Better identification of patients for referral to specialists	Yes	Previously all patients with dementia diagnosis were referred to specialist. Vast majority of patients who were seen in the Memory Clinic did not require outside referral and could be managed in-house. Only a few complex needs patients required referral.
Better follow-up	Yes	Able to manage the follow-up on the vast majority of patients in-house, without waiting for referral for specialists. This meant less delays for patients and their caregivers and caring for them in their “medical home”.

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3	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? (%; PC organization population (surveyed sample); April 2017 - March 2018; In-house survey)	92309	92.60	95.00	94.52	

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Continue to offer high quality health care	Yes	
Continue to to ask the question “When you see your doctor or nurse practitioner, how often do they or someone else in the office involve you as much as you want to be in decisions about your care and treatment?”	Yes	In response to the socio-economic characteristics of our patient population, we rewrote the patient experience survey in plain language, shortened it and re-ordered the questions to lessen the impact of drop out rates.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
4	Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for colorectal screening in each calendar year (%; PC organization population eligible for screening; Annually; See Tech Specs)	92309	38.00	35.00	37.60	

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Better use data and the EMR to identify overdue patients	Yes	All colonoscopies were searched for past 10 years to ensure they were properly identified. Instead of using reminder reporting, we installed OntarioMD Dashboard, as it also included a chronic disease component. This data is updated daily to ensure current screening status.
Reach out to overdue patients during scheduled appointments	Yes	The Ontario MD toolbar showing current status of a patient's relevant cancer screening is now available to clinicians.
Call overdue patients	Yes	Using the OntarioMD Dashboard and the relevant custom form, clerical staff were able to call patients who were overdue for screening, the custom form displayed the status of all relevant cancer screening and provided a place to record patient response. As the dashboard is refreshed each night, it is current. This is a great improvement over our previous method of printing lists. We have asked OntarioMD to create a similar form for Flu immunization.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
5	Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period. (%; PC organization population eligible for screening; Annually; CCO-SAR, EMR)	92309	62.30	70.00	64.70	

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Better use data and the EMR to identify overdue patients	Yes	Instead of using reminder reporting, we installed OntarioMD Dashboard, as it also included a chronic disease component. This data is updated daily to ensure current screening status.
Create a Woman's Health program	Yes	Revisions to the program changed it to Woman's Screening Program to include all relevant cancer screening as well as immunization and risk screening, including smoking status and BMI for patients that may not often be seen. This is a first step towards a full Woman's Health Program. A custom form was created to allow for data extraction as needed.
Reach out to overdue patients during other scheduled appointments	Yes	The Ontario MD toolbar showing current status of a patient's relevant cancer screening is now available to clinicians.
Call overdue patients	Yes	Using the OntarioMD Dashboard and the relevant custom form, clerical staff were able to call patients who were overdue for screening, the custom form displayed the status of all relevant cancer screening and provided a place to record patient response. As the dashboard is refreshed each night, it is current. This is a great improvement over our previous method of printing lists. We have asked OntarioMD to create a similar form for Flu immunization.
Installed OntarioMD Dashboard, Toolbar and patient phone call custom form	Yes	

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6	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed. (%; PC organization population (surveyed sample); April 2018 - March 2019; In-house survey)	92309	63.50	70.00	85.37	

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Balance appointment supply & demand	Yes	Providers have added same day appointments to end of morning and afternoons to see their own patients rather than our previous model of wait time reduction clinics, (10 minute one problem appointments) open to all patients. As many of our patients are older with chronic diseases, the wait time reduction clinics did not address the complications from these chronic diseases and led to follow-up appointments with own provider, thereby not lessening the appointment load.
Continue to offer best appointment options for patients	Yes	82.2% of our patients received the appointment when they wanted it.
Continue to ask the question “The last time you were sick or were concerned you had a health problem, were you offered a same or next day appointment?”	Yes	Not all our patients are able to use same day appointments as they have transportation issues. In response to the socio-economic characteristics of our patient population, we rewrote the patient experience survey in plain language, shortened it and re-ordered the questions to lessen the impact of drop out rates.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
7	Percentage of patients who have had a 7-day post hospital discharge follow up for selected conditions. (CHCs, AHACs,NPLCs) (%; Discharged patients ; Last consecutive 12 month period; See Tech Specs)	92309	57.00	75.00	57.00	

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Fully implement nurse phone triage for post discharge pts from CMH, adapting to CMH PODS	No	Nurse phone triage custom form and protocol were created for CMH discharged patients. Nurse reviews a faxed list of discharged patients and calls to triage need for appointment. Nurse also updates prescriptions in the patients' profile. Custom form required several revisions due to process changes and nurse training. Completed a successful pilot in the main site. Now ready to expand to include satellite offices.
Track appointments with any provider	No	While able to track outcomes from hospital discharge appointments, i.e. nurse triage phone calls, provider appointments, isolating the hospital discharge summaries in the EMR has been unexpectedly challenging. We are currently working with the OntarioMD Practice Enhancement Consultant and Telus PSS to solve the issue.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
8	Percentage of patients with diabetes up-to-date with glycated hemoglobin (HbA1C) tests (%; patients with diabetes, aged 40 or over; April 2018 - March 2019; EMR/Chart Review)	92309	61.30	90.00	73.00	

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Create an electronic diabetic registry	Yes	Work with OntarioMD Practice Enhancement Consultant diabetic patients were identified and coded with IC9 code. The OntarioMD Dashboard shows HBA1C screening for coded diabetic patients. As well, a diabetic program cohort was created to be able to compare data between diabetic patients within the program and those who do not participate.
Create protocol for reminder and recall	No	The OntarioMD dashboard updates the diabetic HBA1C screening daily and will provide valuable information for a formal protocol. Our diabetic program is undergoing an overhaul and the reminder and recall protocol will be considered.
Created custom forms foraAnnual nurse and quarterly physician appointments	Yes	These custom forms will streamline and standardize both the annual and quarterly appointments within the family health team. These custom forms will be launched in April 2019.

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9	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. (%; Discharged patients ; Last consecutive 12 month period; EMR/Chart Review)	92309	CB	75.00	CB	

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