Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 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 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	% current smokers with smoking cessation counseling recorded in the past year (%; current smokers; 2016; EMR/Chart Review)	92288	CB	CB	89.50	This indicator will be dropped from the next QIP until there is a higher percentage of people with smoking status documented in the chart, so as to make this measure more accurate.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Standardize charting of smoking cessation counseling.	Yes	A measurement group was created for charting of smoking status and counseling of smoking cessation. It could still be more consistently used across the various providers.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
2	% patients 65 and older with pneumoccocal vaccination recorded in preventions section of the chart. (%; PC organization population aged 65 and older; 2016; EMR/Chart Review)	92288	CB	CB	48.30	Value increased from 39% in June after update from Health Unit completed.

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Update pneumovax measurement in EMR with data from Health Unit	Yes	Lists of patients having appointments at the clinic and with no pneumovx recorded in the EMR were sent to the Health Unit on a weekly basis. Later in the process, in order to update everyone in the target group, patients were added to the lists who were not presenting at the clinic. This process would have worked better had it been possible to acquire a full list electronically of FHT patients in the target group with the pneumovax information from the Health Unit rather than them having to look up each patient individually.
Develop process with health unit to share information when pneumovax administered at annual flu clinic.	Yes	For the 2017/18 flu shot season the health unit is going to be adding a check box to their vaccination consent for pneumovax and flu vaccine information to be shared with MFHT.
Patients in the target age group presenting at the clinic for flu shots were offered pneumovax at the same time. Pneumovax status was also added to flu shot call lists so patients could be asked about having pneumovax at same time as flu shot.	Yes	A number of patients had pneumovax administered at the same time as their annual flu shot. This process will be refined for 2017/18.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
3	% patients aged 12 and over with smoking status recorded in measurements (%; patients aged 12 and over; 2016; EMR/Chart Review)	92288	14.60	80.00	59.30	Significant progress was made with this indicator but target was overly optimistic. New target will be 70%.

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Update smoking status measurement in EMR for active patient population.	Yes	This was a good student project in which data from the social history section of the EMR was queried to create a list of patients who had smoking status information. This list was used by the student to update the smoking status measurement.
Smoking status was added to the vitals measurement group and the Health Care Assistant has started to update this measure when patients are brought to the exam room for physician, NP and PA appointments.	Yes	After 1 month of including smoking status in the vitals measurement group an additional 1 % of rostered patients 12 and over had smoking status updated in the chart.

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4	% patients with CHF with evidence based flow chart completed in the past 12 months (%; CHF QBP Cohort; 2016; EMR/Chart Review)	92288	10.50	40.00	12.50	This indicator has not been a priority for MFHT this past year. Although efforts will be made to progress with this indicator next year, it will not be included on the 2017/18 QIP.

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Revise the current flow sheet	No	This was not completed due to lack of time. Flow sheets from elsewhere will be reviewed this coming year in hopes of finding one that will work for MFHT.
Revise process for flowsheet completion with admin or other providers completing initial entries en eform.	No	Not completed this past year as other initiatives were of higher priority.

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5	% patients with COPD having pneumovax vaccination (%; COPD QBP Cohort; 2016; EMR/Chart Review)	92288	22.30	40.00	52.10	The target for this indicator was surpassed. Will be included on 2017/18 plan with target of 60%.

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Add alert in EMR for patients due for pneumovax	No	The alert for a number of the vaccinations is not currently working in our EMR. This still needs to be resolved.
Contact patients with COPD due for pneumovax vaccination	Yes	A list of patients with COPD due for penumovax was generated. Come of these patients have been contacted. Process is on-going.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
6	% patients with DM with foot exam in the past 12 months (%; patients with diabetes, aged 40 or over; 2016; EMR/Chart Review)	92288	46.20	50.00	49.10	The current performance nears the target value. A new target of 53% will be set for 2017/18.

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Flag patients due or overdue for DM foot exams when presenting for non-DM appointments with MD.	No	This has not yet been implemented. It is hoped that this can be achieved in 2017/18.
Trial a foot exam clinic.	No	This has not yet been implemented. It is hoped that this can be achieved in 2017/18.
Marathon Diabetes Centre adding DM foot exams completed by the DM footcare nurse to the EMR DM flowsheet.	Yes	All DM foot exams done by DM footcare RN are being added to the EMR.

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7	% people with COPD with at least one spirometry recorded in EMR (%; COPD QBP Cohort; 2016; EMR/Chart Review)	92288	77.70	85.00	92.10	Target surpassed. Will continue to monitor this indicator but will be removed from QIP.

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Recall patients with COPD having no spirometry on record.	Yes	A list of patients with COPD having no spirometry was generated through a query of measurements. Charts were updated with spirometry tests in chart but not in measurements then a summer student called patients identified as physically able to complete the spirometry test.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
8	Number of patients having a documented SMART goal, HealtheSteps measures or weight self-management goal in the past 12 months (Number; All patients; 2016; EMR/Chart Review)	92288	27.00	100.00	63.00	As the health promoter has become trained over the past year for various interventions, the number of patients with health promotion related measures has increased but not yet reached the target. This indicator will be retired for 2017/18 and a more global indicator for health promotion added.

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Actively promote availability of SMART goal setting and HealtheSteps programs	Yes	Both of these programs were promoted through physicians and the health promoter doing presentations at a local First Nation community, health fairs and high school.
Track and provide feedback to providers re: referral of patients interested in improving lifestyle as per Health Promotion tool	No	While this was done a couple of times it was a labour intensive process so was discontinued.

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9	Number of people residing in local First Nations communities with visits for well woman/pap, HealtheSteps, SMART goals or smoking cessation (Counts; Residents of Biigtigong and Pic Mobert First Nations; 2016; EMR/Chart Review)	92288	CB	CB	103.00	This indicator will not be included on the 2017/18 QIP. More discussion will be undertaken before deciding on future equity measures.

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Provide on-site smoking cessation counseling, HealtheSteps, SMART goal and well woman/Pap appointments to Biigtigong Nishnaabeg and Pic Mobert First Nation.	Yes	Some on-site services have been provided at Biigtigong. These services have not been extended to Pic Mobert at this time.
Provide on-site smoking cessation counseling, HealtheSteps, SMART goal and well woman/Pap appointments to Biigtigong Nishnaabeg and Pic Mobert First Nation.		

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
10	Percent of patients on opioids enrolled in addictions and chronic pain program (%; Non cancer patients taking opioid medications; 2016/17; EMR/Chart Review)	92288	CB	100.00	83.40	This is up from 76.6% in June 2016. The target was overly optimistic and will set a more conservative target of 90% for 2017/18 as patients are prescribed and discontinue opioid medications there will likely always be some patients not yet in the program.

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Identify patients eligible for addictions and chronic pain program (on opioid medication)	Yes	A query of medications was created to use in generating lists of patients on opioid medications.
Develop and implement strategy for enrolment of eligible patients into addictions and chronic pain program.	Yes	Lists of potential candidates are distributed to physicians as a reminder of who still needs to be enrolled. Further process improvements are needed to increase uptake.

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11	Percent of patients or clients who visited the emergency department (ED) for conditions "best managed elsewhere" (%; PC org population visiting ED (for conditions BME); April 2014 – March 2015; DAD, CAPE, CPDB)	92288	4.24	4.03	4.40	There has been no statistically significant change in this measure over the past three year.

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Improve access to same day appointments.	No	In the past year an NP was hired which has helped to improve access to same day appointments.

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12	Percent of patients who responded positively to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office spend enough time with you?" (%; PC organization population (surveyed sample); April 2015 - March 2016 ; In-house survey)	92288	88.00	90.00	91.50	This value surpasses the target. There has been no statistically significant change in this indicator over the past three years.

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13	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 2015 - March 2016 ; In-house survey)	92288	87.76	90.00	89.72	This value approaches the target. It is not statistically significant from past values.

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14	Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions. (%; Discharged patients with selected HIG conditions; April 2014 – March 2015; CIHI DAD)	92288	52.00	57.00	80.00	Error in last years entry. Actual value that should be reported as last year's current performance is 76%. Current value shows improvement.

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Continue to work in collaboration with local hospital to facilitate improvement in number of patients being booked for appointments within 7 days of discharge as needed.	Yes	The process in which the local hospital calls the clinic or MFHT receives EMR messages to book patients being discharged from hospital works well. The appointments are booked into urgent care appointments that are available with all physicians when they are in clinic.
Work with Thunder Bay Regional Health Sciences Centre (TBRHSC) to improve booking of appointments within 7 days post discharge.	No	There has not been sufficient time to work on this initiative. It will hopefully be achieved in 2017/18.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
15	Percent of respondents who responded positively to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office give you an opportunity to ask questions about recommended treatment?" (%; PC organization population (surveyed sample); April 2015 - March 2016 ; In-house survey)	92288	89.80	90.00	84.90	Although this value has decreased since last year, the difference is not statistically significant. Larger sample size for this years and hopefully in future years will permit detection of smaller statistically significant differences.

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16	Percentage of acute hospital inpatients discharged with selected HIGs that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission, by primary care practice model. (%; Discharged patients with selected HIG conditions; April 2014 – March 2015; CIHI DAD)	92288	14.00	14.00	18.00	The 2013/14 value was 20.2. The relatively small number of patients admitted for these conditions leads to high variability in this measure.

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17	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); Apr 2015 – Mar 2016 (or most recent 12-month period available); In-house survey)	92288	40.91	44.00	49.53	While the current performance exceeds the target the sample size for the 2015/16 patient survey was too small for a statistically significant difference to be detected. As with this year's survey, larger sample sizes will be used for all future surveys.

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Review provider practice style/approach and identify any ways to reduce demand for physician appointments.	No	This process has been started but is still at the data collections and presentation stage.

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18	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months (%; patients with diabetes, aged 40 or over; Annually; ODD, OHIP-CHDB,RPDB)	92288	47.30	49.70	39.70	Patients continue to be contacted when they have not had an A1c test in over 12 months. This measure will be reviewed in 2017/18 to assess reasons for the decline.

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Identify patients overdue for A1c at time of any appointment in clinic and provide DM lab requisition at that time.	No	This process was not started this year. It has been started for cancer screening and hopefully other tests and screenings will be added this coming fiscal year.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
19	Percentage of people/patients who report having a seasonal flu shot in the past year (%; PC organization population eligible for screening; Annually; EMR/Chart Review)	92288	64.80	68.00	64.00	Patient phone calls, letters, public awareness and opportunistic administration of flu shots has not resulted in any change in this indicator.

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Will continue reminder letters, phone calls and opportunistic flu shot administration as per last year.	Yes	Same approaches were used to promote flu shots as in previous years.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
20	Percentage of screen eligible patients aged 50 to 74 years who had a FOBT within the past two years, other investigations (i.e., flexible sigmoidoscopy) within the past 10 years or a colonoscopy within the past 10 years. (%; PC organization population eligible for screening; Annually; See Tech Specs)	92288	57.20	66.00	60.60	Value based on CCO SAR. An underestimate as hospital FOBTs are not included. EMR data not used for this measure as does not contain sigmoidoscopy or barium enema data.

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Update cancer screening status in EMR through cross referencing with SAR.	Yes	This process was undertaken at fiscal year end preventive care bonus time last year. Still determining process for on-going updates in a more efficient manner.
Increase promotion of CRCS	Yes	Health promoter has started to identify patients due for screening the day before they arrive for an appointment. Kits are readied for theses patients and left for the provider in the exam room (PD, PA, NP only).

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21	Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years (%; PC organization population eligible for screening; Annually; See Tech Specs)	92288	70.00	74.00	71.00	Target not achieved. MFHT performance remains above provincial level of 64% as per Jan 2017 SAR.

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Review and update pap booking process for improved access.	Yes	Process reviewed and continues largely as previously.
Review trial Pap clinics at local First Nation communities to determine direction in 2016/17	Yes	On-site screening provided at one FN community in past fiscal year.