Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2014/15 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 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
1	Percent of patients/clients able to see a doctor or nurse practitioner on the same day or next day, when needed. % PC organization population (surveyed sample) TBD In-house survey	63.40	73.30	X	63.8% is the percent of respondents who agree or strongly agree that they can see the healthcare provider needed, when needed, the same day or next day. The performance increases to 85.1% when those who responded "neutral" to the statement are included. Questionnaire will be revised to match QIP format provided.

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 2014/15)	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?
1) review current booking and scheduling along with demand data to create guidelines for scheduling (number of appointments needed per day and week, overall and per provider) 2) evaluate use of same day appointments to determine number and types of appointments referred to hospital ED (conditions best managed in ED not primary care)		

3) balance out physician panel sizes so they correspond more closely to provider supply of appointments 4) continue effort to hire new NP to increase access to urgent/acute care appointments

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2	Percent of patients/clients who visited the ED for conditions best managed elsewhere (BME). % PC org population visiting ED (for conditions BME) TBD Ministry of Health Portal	5.59	4.40	4.19	2013/14 data. Represents 162/3870 rostered patients.

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1) review current booking and scheduling along with demand data to create guidelines for scheduling (number of appointments needed per day and week, overall and per provider) 2) balance out physician panel sizes so they correspond more closely to provider supply of appointments 3) continue effort to hire new NP to increase access to urgent/acute care appointments 4) Analyze CTAS level 4 and 5 visits from Wilson Memorial General Hospital (WMGH)to determine types of visits and ideas for change to decrease these visits. 5) Collaborate with WMGH to reduce wound care provided through ED, increase wound care provided at MFHT.	No	Wound care provided by MFHT has increased over the past year, off-loading the local hospital. Other change ideas will continue to be worked on over the next fiscal year as human resource capacity within the FHT permits.

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3	Patients able to contact the practice on the phone easily. % PC organization population (surveyed sample) sample once per quarter In-house survey	75.60	83.20	85.40	Current performance includes patients responding agree or strongly agree to statement "I can contact MFHT on the phone easily". Another 10.4% of patients responded neutral.

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Implement auto-attendant to better direct phone calls Review scheduling of phone appointments to minimize overloading of phone system	No	The decision was made to not implement auto-attendent system as previous survey results did not justify a change to the current system. Some changes were made to the telephone answering process over the past year to improve access e.g. phone being answered by side reception and front desk at times when main booking person is busy.

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4	% able to see usual provider or provider of choice % PC organization population (surveyed sample) 2014 In-house survey	63.40	70.00	63.40	This is the percent of respondents who agree or strongly agree that they can see their usual provider or provider of choice. The performance increases to 87.8% when those who responded "neutral" to the statement are included.

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1) review current booking and scheduling along with demand data to create guidelines for scheduling (number of appointments needed per day and week, overall and per provider) 2) balance out physician panel sizes so they correspond more closely to provider supply of appointments	No	Work has been done over the past year to look at approaches to reducing the panel sizes of some physicians but aside from closing practices to new patients and natural atrition, no other steps have been made to increase the rate of reduction in these panel sizes. This will be further reviewed in 2015/16. Flexibility in physician scheduling to meet demand will also be further reviewed this coming year.

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5	% high school clinic appointments booked % High school aged population quarterly EMR/Chart Review	33.60	37.00	56.30	Based on September to December 2014.

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1) work with high school Principal, staff and students to identify barriers to use of high school clinic and to identify ways to improve uptake	Yes	Questions related to high school clinic were included on high school student survey. Time of clinic changed to include lunch hour to improve access by students.

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6	Percent of patients/clients who saw their primary care provider within 7 days after discharge from hospital for selected conditions (based on CMGs). % PC org population discharged from hospital TBD Ministry of Health Portal	67.00	74.00	63.00	This is the value from the web portal. Internally we have a value of 77% representing the 22 patients for whom MFHT received a call from the hospital or an EMR message from the physician to book post discharge for the period from September 14 2014 to December 31 2014. 86.4 % of patients were booked for within 7 days but two cancelled and rescheduled for a later date.

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1) Improve discharge communication with hospitals most commonly involved with MFHT patient care (WMGH, TBRHSC), perhaps through access to MFHT EMR message system and/or nursing provider presence at weekly discharge rounds. 2) Improve discharge planning communication with local CCAC 3) Develop system to track patients who are in hospital, rehab or other settings and their discharge dates	Yes	Either calls to MFHT booking from the local hospital at discharge planning time or EMR msg from physician, as well as formal process for booking these patients has worked well. Efforts have not been made to improve communication with other, more distant hospitals commonly used by the local population for more serious issues.

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7	Percent of a primary care organization's patients/clients who are readmitted to hospital after they have been discharged with a specific condition (based on CMGs). % PC org population discharged from hospital TBD Ministry of Health Portal	8.00	6.00	20.20	This represents 19/94 admissions for 2013/14. Work on this indicator has been deferred to 2015/16.

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1) In collaboration with WMGH identify and review patients readmitted within 30 days for the selected case mix groups to identify factors contributing to readmission 2) Determine method to identify patients with admission and/or readmission involving TBRHSC or other facility other than WMGH.		

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8	% patients with complex needs in registry % Patients with complex needs 2014/2015 EMR/Chart Review	CB	100.00	0.00	No work was done towards creating a registry of patients with complex needs.

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1) Develop registry for patients with complex needs and process for maintaining registry.	No	

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9	% patients with complex needs having alert or flag on chart noting special needs % Patients with complex needs 2014/2015 EMR/Chart Review	CB	100.00	0.00	No work was done towards creating alerts for patients with complex needs.

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1) Establish criteria for designating patients as having complex needs and system for identifying these patients. 2) Establish process for adding alert/flag to chart indicating special needs of complex patients.	No	

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10	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) give them an opportunity to ask questions about recommended treatment? % PC organization population (surveyed sample) 2014/2015 In-house survey	100.00	100.00	X	93.3 % is the percent of respondents who agree or strongly agree that they are encouraged to ask questions about recommended treatment. The performance increases to 97.7% when those who responded "neutral" to the statement are included. The format of this question will be modified to match QIP format.

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Current value indicates patient satisfaction with opportunity to ask questions. There will be no changes to current practice. Include measure on patient survey to monitor satisfaction.		

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11	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) 2014/2015 In-house survey	90.20	93.00	X	95.6 % is the percent of respondents who agree or strongly agree that they are involved to the extent they want to be in decisions related to care and treatment. The performance increases to 100% when those who responded "neutral" to the statement are included. Format of question will be mofified to match QIP format.

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Include item on 2014/2015 patient survey that will help identify why/how patients do not feel adequately involved in decisions about their care, and how to improve that.		

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12	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) spend enough time with them? % PC organization population (surveyed sample) 2014/2015 In-house survey	95.00	95.00	X	95.6% is the percent of respondents who agree or strongly agree that their healthcare provider spends enough time with them. The performance increases to 98 % when those who responded "neutral" to the statement are included. Question format will be modified to match QIP format.

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Changes to address access may improve satisfaction with amount of time spent with provider as issues dealt with in a more timely fashion and so less issues per appointment. Otherwise, no changes as current satisfaction is high. Will monitor through annual patient survey.		

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
13	% patients with DM satisfied with MDC-MFHT shared care % Patients with DM Q3 In-house survey	CB	85.00	CB	Deferred to 2015/16

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1) conduct patient survey for patients with DM receiving care from Marathon Diabetes Clinic and MFHT		

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14	Percent of patient/client population over age 65 that received influenza immunizations. % PC organization population aged 65 and older TBD EMR/Chart Review	75.00	80.00	67.90	The newly created health promotion committee will work towards improving flu shot uptake in 2015/16.

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1) Identify reasons patients not refusing flu shot and develop flu immunization promotion plan addressing these issues	No	With the creation of a new health promotion committee late in 2014, efforts will be made to address this issue in 2015/16. Flu shot uptake seems to be somewhat affected by media around the quality of the match between the flu shot and flu strains as well as severity of flu i.e flu related deaths.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
15	Percent of eligible patients/clients who are up-to-date in screening for breast cancer. % PC organization population eligible for screening TBD EMR/Chart Review	65.00	75.00	68.80	Value as of December 2014. Represent % of eligible women who have ahd a mammogram in the past 30 months as per preventive care bonus calculations.

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1) Arrange for batch referral of women turning 50 in the current year to the OBSP for entry into their reminder system 2) Develop system to ensure patients newly ineligible for screening are entered into the preventions section of EMR so recall list and outcomes measures accurate 3) Refine calendar for reminder letter and phone list generation to improve efficiency and outcomes 4) Provide information re:alternate mammogram sites and referral process when unable to attend OBSP van	Yes	The process for charting and ensuring accurate data in the EMR has been refined over the past year and a process been developed for batch referral of women turning 50 to the OBSP so that they will be contacted about upcoming breast van visits to the community.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
16	Percent of eligible patients/clients who are up-to-date in screening for colorectal cancer. % PC organization population eligible for screening TBD EMR/Chart Review	50.00	60.00	59.00	This is the % of eligible enrolled patients who have had an FOBT in the past 30 months or colonoscopy in the past 10 years.

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1) Develop system to ensure patients newly ineligible for screening are entered into preventions section of EMR as ineligible 2) Refine calendar for reminder letter and phone list generation to improve efficiency and outcomes 3) Develop and implement promotion strategy to increase uptake of colorectal cancer screening	Yes	The system for tracking and recording FOBT and colonoscopies has been improved over the past year and students have worked to update the preventions section of the EMR resulting in more accurate data. Letters are no longer being sent as CCO has taken on this role. The promotion strategy will be developed over the next year.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
17	Percent of eligible patients/clients who are up-to-date in screening for cervical cancer. % PC organization population eligible for screening TBD EMR/Chart Review	71.00	75.00	81.90	This represents the % of enrolled eligible women who have had a pap in the past 40 months as per preventive care bonus calculation.

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1) Develop system to ensure patients newly ineligible for screening are entered into preventions section of EMR as ineligible 2) Refine calendar for reminder phone call list generation to improve efficiency and outcomes 3) Develop and implement promotion strategy to increase uptake of cervical cancer screening	Yes	Having the RNs review charts before making reminder calls has greatly increased the accuracy of the lists by identifying patients no longer eligible for Paps and ensuring correct follow up dates.

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18	% patients aged 65 or older with recorded pneumococcal vaccination % PC organization population aged 65 and older 2014/2015 EMR/Chart Review	CB	85.00	10.20	Names of patients receiving pneumovax vaccinations at this fall's community flu shot clinic were collected by FHT staff. Records for pneumovax vaccinations from previous years were not accessed from the health unit this past year due to time constraints. This will remain on our QIP for the next fiscal year.

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1) Contact local health unit to acquire list of patients with current pneumococcal vaccination and use this list to update preventions section of EMR 2) Develop and implement a plan to ensure pneumococcal vaccinations given at flu clinics are acquired by MFHT to update chart	No	Unfortunately, the health unit was not willing to share their flu and pneumovax vaccination lists with MFHT and so our staff had to attend the community clinic to collect names of those who attended. While we frequently call the health unit to determine vaccination status of individual patients and this information is provided to us at that time there is currently no mechanism to share this information in a bulk format i.e. for all patient 65+

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19	% patients with positive FOBT who receive referral within 2 weeks % All patients with + FOBT 2014/2015 EMR/Chart Review	90.00	95.00	80.00	Queries are now being run monthly to identfy patients with abnormal results in the previous month. Patient charts are then checked to verify date and completion of referral. In 2014 there were only 6 abnormal FOBTs, 5 of which were referred for colonscopy within 14 days.

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1) Develop and implement system for follow up of patients not receiving referrals in a timely manner (identification of patients overdue for referral, alert of healthcare provider) 2) Identify reasons for delayed referrals and make changes to overcome these reasons, if possible	Yes	Queries are now being run monthly to identfy patients with abnormal results in the previous month. Patient charts are then checked to verify date and completion of referral.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
20	% patients with diabetes with A1c test in the past 12 months % Patients with DM Q1, Q2, Q3, Q4 EMR/Chart Review	84.50	90.00	85.90	Further improvements in this value may be difficult to achieve as a certain proportion of the population is either difficult to contact and/or uninterested in follow up.

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1) Work with local First Nations to identify ways to improve DM follow up and management 2) Explore possibility of using point of care testing for off-site clinics in area First Nations communities	Yes	Point of care testing has proved to be helpful in getting A1c tests for patients at off-site clinics in Pic River and Pic Mobert.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
21	% DM patients with foot exam recorded in the past 12 months % Patients with DM Q1, Q2, Q3, Q4 EMR/Chart Review	33.00	60.00	45.40	Data from December 2014. Has been steadily increasing as patients are being seen for DM follow up.

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1) Assess reasons for low % patients with recorded foot exam in past 12 months (foot exam not done, or not recorded?) and identify ways to improve in this area 2) Complete new user-friendly DM flow sheet for EMR 3) Work with local First Nations to identify ways to improve DM follow up and management	No	Creation of new DM flow sheet in current EMR is difficult and costly so not feasible.
Process implemented whereby HCA staff verify date of last foot exam for patients having DM follow up. If last foot exam more than 9 months ago a reminder yellow foot is placed on exam room computer keyboard as physician prompt.	Yes	This process has worked well but reason for appointment needs to be clearly indicated in schedule to avoid missing patients. Consistent use of flow sheet still needed to ensure data accurate for HCA to implement process.

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22	% patients with hypertension with record of lifestyle intervention discussion % Patients with hypertension 2014/2015 EMR/Chart Review	CB	40.00	NA	This has been deferred to 2015/16 as we work towards establishing a standard way to record this information in the EMR.

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1) RPN to use hypertension flow sheet for charting of lifestyle intervention discussion. 2) Evaluate satisfaction with flowsheet and possibility of expanding its use to other healthcare providers.	No	The flowsheet has not been consistently used over the past year and the process for charting this information will be reviewed and modified if possible to make it more user friendly.

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23	% of active patient charts with complete and current problem list % PC organization population (surveyed sample) 2014/2015 EMR/Chart Review	CB	100.00	80.00	Summer student updated medical history section of EMR chart based on old paper charts. Physicians were also provided lists of patients entered into disease registries who did not have the corresponding condition listed under the medical history section of their EMR chart. Diagnosis was verified and added to medical history or removed from disease registry accordingly. As some disease registries have been added recently, not all conditions have been verified in this manner as the disease registry is not yet current for everyone.

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1) Develop strategy for ensuring active patient problem lists are complete and updated as new conditions arise, as well as method of charting date last updated.	Yes	Disease registries and medical history sections of charts will be cross checked using EMR queries on an annual basis to verify accuracy of key diagnoses.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
24	The practice maintains lists of patients with asthma and COPD. % patients with asthma or COPD in medical history in asthma or COPD disease registry % Patients with asthma or COPD 2014/2015 EMR/Chart Review	60.00	100.00	100.00	Disease registry for COPD and asthma was updated by summer student based on information in medical history section of EMR. Billing staff now update disease registry from billing section of EMR based on billing codes on day sheets.

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Change Ideas from Last Years QIP (QIP 2014/15)	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?
1) Develop a system for healthcare providers to communicate new diagnosis of asthma or COPD on billing sheets for entry into disease registry by billing staff. 2) Generate list of patients with ashma or COPD in medical history section of chart but not in disease registry so registry can be updated	Yes	Use of the function within the billing module of OSCAR "add to Dx registry" is very helpful for keeping registries current when a set list of codes is selected and physicians are all using these codes only when the patient has a disgnosis for the code (vs being investigated for the condition).

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
25	% patients with asthma or COPD with diagnosis confirmed by spirometry % Patients with asthma or COPD Q1, Q2, Q3, Q4 EMR/Chart Review	CB	65.00	74.70	This is the measure for COPD. 47.2% of patients with asthma have recorded spriometry in chart.

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Change Ideas from Last Years QIP (QIP 2014/15)	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?
1) develop and implement system to have spirometry results recorded in measurements/flow sheets in EMR 2) complete manual chart review of patients in asthma and COPD registries to update spirometry in EMR measurements/flow sheet	Yes	A measurement had to be created within the EMR to record when spirometry test had been completed. All respiratory program related measures were grouped together under EMR measurements for easy entry by our nurse responsible for spriometry and respiratory program.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
26	% patients with hypertension in medical history also added to disease registry % Patients with hypertension Q1, Q2, Q3, Q4 EMR/Chart Review	CB	100.00	100.00	Disease registry for HTN was updated by summer student based on information in medical history section of EMR. Billing staff now update disease registry from billing section of EMR based on billing codes on day sheets.

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Change Ideas from Last Years QIP (QIP 2014/15)	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?
1) Develop a system for healthcare providers to communicate new diagnosis of hypertension on billing sheets for entry into disease registry by billing staff. 2) Generate list of patients with hypertension in medical history section of chart but not in disease registry so registry can be updated	Yes	Use of the function within the billing module of OSCAR "add to Dx registry" is very helpful for keeping registries current when a set list of codes is selected and physicians are all using these codes only when the patient has a disgnosis for the code (vs being investigated for the condition).

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
27	% patients with valid BP measured in the past 12 months % Patients with hypertension Q1, Q2, Q3, Q4 EMR/Chart Review	CB	85.00	NA	Still working on effective method of tracking only valid BP measures (as opposed to some valid and others invalid or high because pt has not rested adequate time).

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Change Ideas from Last Years QIP (QIP 2014/15)	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?
1) Establish criteria for use of the BP measurement in the EMR so that measures input are valid (Currently, everyone who has a visit has BP taken at beginning of appointment by HCA. This value may not be valid as patient has just arrived, not resting adequate amount of time)	No	Having MDs and PA enter BP measures taken later on in appointment following a high HCA value were not consistently entered into EMR measurements. Issues for other providers as hard to find measures only recorded in notes. Process currently under further consideration for improvement.