Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2017/18 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 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
1	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 2016 - March 2017; In-house survey)	91570	100.00	100.00	NA	

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 2017/18)	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?
Continue to offer and track client satisfaction surveys. Look for creative ways to engage clients and increase the number of clients satisfaction surveys that are completed.	Yes	The focus this year was increasing the number of client satisfaction surveys that were completed. A policy was created which specifies the details for offering surveys and collecting results, making the process streamlined and part of our daily work and yearly plan. The survey was revised, making it more user friendly for clients. The survey was offered on paper as well as electronically. Links were added to our website as well. The CHC implemented two "focused" time periods however, the survey is available at all times for clients. The number of surveys completed more than doubled, making our sample size larger and results more realistic. The focus in the upcoming year will shift to incorporating a general survey focused question.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
2	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 2015 - March 2016; CIHI DAD)	91570	CB	CB	CB	

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1. Work with the local hospital to ensure they understand the role of SGBCHC including Nurse Practioners 2. Develop a system to track each time a hospital admission report is received 3. Communicate with our clients to better promote an awareness of the SGBCHC when they are in hospital 4. Track hospital admissions to collect baseline data 5. Develop a system for following up with clients after hospital discharge	Yes	This continues to be an area of improvement for the SGBCHC. The SGBCHC is still not receiving all hospital admission reports. This indicator will continue to be a focus for the coming year. Details can be found in the 2018/19 Quality Improvement Plan.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
3	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 2016 - March 2017; In-house survey)	91570	50.98	60.00	62.00	

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To increase the percentage of clients who reported they were able to see a doctor or nurse practitioner on the same day or next day, when needed	Yes	Schedules were reviewed and same day spots are allotted each day. Triage guidelines were reviewed and the clinical nurse is currently triaging calls, at times preventing an unnecessary visit to the clinic. We have also expanded the role of the clinical nurse which creates more appointment availability for the Nurse Practitioners and Physicians. This indicator is important and we feel there is still room for improvement with and therefore will keep this indicator on the 2018/19 Quality Improvement Plan.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
4	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)	91570	58.00	65.00	83.00	

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Increase the percentage of clients with diabetes, aged 40 and over, with two or more A1c tests within the past 12 months	Yes	A roster of diabetes patients was created. A Certified Diabetic Educator (CDE) was attached to each diabetic client. The two CDE's run searches weekly to monitor appointment dates as well as A1c levels. Focus in the upcoming year will shift to making the A1c searches automated at regular intervals using the EMR.

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5	Percentage of patients with medication reconciliation in the past year (%; All patients; Most recent 12 month period; EMR/Chart Review)	91570	CB	CB	NA	

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To begin to offer medication reconciliation to primary care clients	No	Charts were audited thoroughly this year. The clinic team met and discussed the necessity for medication reconciliations to be completed. The SGBCHC is in a unique situation due to our local EMR capability for e-prescription service. The clinical team, in consultation with management, has decided the medication reconciliation is not a priority for improvement at this time.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
6	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)	91570	70.00	80.00	89.00	

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To increase the percentage of eligible patients aged 50 to 74 who had a FOBT within the past two years, other investigations (sigmoidoscopy) within the past 10 years or a colonoscopy within the past 10 years	Yes	The process for tracking cancer care screening was reviewed. A focus was made on consistent documentation of offered/declined rates. Our screening rates are quite high at this time and focus in the next year will be on maintaining processes to keep these rates consistent.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
7	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)	91570	78.00	85.00	88.00	

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To increase the percentage of women aged 21 to 69 who had a PAP smear within the past three years	Yes	The process for tracking cancer care screening was reviewed. A focus was made on consistent documentation of offered/declined rates. Our screening rates are quite high at this time and focus in the next year will be on maintaining processes to keep these rates consistent