Excellent Care for All

**Quality Improvement Plans (QIP): Progress Report for 2019/2020 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.

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| **ID** | **Measure/Indicator from 2019/20** | **Org Id** | **Current Performance as stated on QIP2019/20** | **Target as stated on QIP 2019/20** | **Current Performance 2020** | **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 2018 - March 2019; In-house survey) | 91486 | 88.78 | 90.00 | Dec 31/19 - 86.71% | Client satisfaction data collection started in August 2019 for the current fiscal. The results are now collected through an online survey administered by volunteers in the waiting room at NorWest. Since the fall Norwest has collected approximately 50 surveys per month, an amount which will ensure a confidents rate of 95% +/- 5%. The increased statistical confidence results in better data quality, which is likely the cause of the reduction in results. |

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| 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. |

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| **Change Ideas from Last Years QIP (QIP 2019/20)** | **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?** |
| Enable providers to promote health literary activities to empower client for decision-making on their health and engage in self-care. | Y | A ‘Client appointment guide’ pilot project was conducted and clients were given an info-graph providing tips and guidance on how to get the most out of their primary care visit and engage their primary care provider in their care plan. As well clients are now provided with calendars to keep track of their appointments and their personal health information in order to ensure they are aware of their health plan.  NorWest operates a number of Chronic Disease Self-manage Programs, such as “Health Choices”, which focus on information for self-management on a monthly basis. As well the Health Links program helps to identify client’s with multiple chronic disease issues and social determinants of health; and then aligns these clients with additional supports. |

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| 2 | Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system within a 6-month reporting period. ( %; Patients; Six months reporting period ending at the most recent data point; CAPE, CIHI, OHIP, RPDB, NMS) | 91486 | CB | CB | Q1 – 176  Q2 – 137  Q3 – 176 | As a result of our inability to receive the MyPractise report from HQO, we have been forced to develop a custom internal indicator to replace the current measure.  The new proposed indicator is ‘total number of prescribed opioid for all providers’. This new indicator will allow us to monitor all opioid dispensing on site each month and allow for the ability to drill down by provider. This information can now be included on our internal corporate balance scorecard and our quarterly physician scorecards, which will allow for us to engage with our providers on any change initiatives. |

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| New Indicator Implementation Project: - Develop and map data collection process - Provide training to Providers/Staff - Implement the indicator within corporate planning | Y | While the original proposed data collection process was not possible, a new proposed indicator will provider NorWest CHC with reliable data on opioid prescribing patterns, which can be used for targeted improvement plans in 2020/21. |

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| 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 2019 - March 2020; In-house survey) | 91486 | 37.37 | 45.00 | 22.75 | Client satisfaction data collection started in August 2019 for the current fiscal. The results are now collected through an online survey administered by volunteers in the waiting room at NorWest. Since the fall Norwest has collected approximately 50 surveys per month, an amount which will ensure a confidents rate of 95% +/- 5%.  Current results are well below target, which is directly related to the volume of appointments booked and a high no-show rate for the facility (14.46% in Q3). |

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| Improve booking processes in order to: reduce no-shows, increase booking/re-booking rates for cancelled spots, assure full capacity is being used. | Y | Reminder calls to clients are completed for all appointments the day before their scheduled appointments.  A new phone tree system was implemented in April 2019 to address issues with missed calls. The new system ensures that Norwest is aware when a client needs to cancel an appointment and has been successful in reducing the no-show rates. |
| Increase capacity by hiring new staff |  | Primary Care is currently fully staffed with physicians and NP’s. |
| Develop process of capacity analysis in order to support a change idea for next QIP cycle. |  |  |

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| 4 | Percentage of patients who have had a 7-day post hospital discharge follow up, by a community care provider for selected conditions- CHCs. ( %; Discharged patients ; Last consecutive 12-month period.; See Tech Specs) | 91486 | CB | CB | Q1 – 22.2%  Q2 – 23.1%  Q3 – 14.8% | Baseline data is currently collected by the RN at NWCHC. Patients are identified as requiring a follow-up visit within 7 days, reception in notified and the client is booked for the next available appointment with their provider. |

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| Implement a new process to manage post-discharge information in order to improve data accuracy and access to timely clinical follow-up. Expected Deliverables: - New process map - Master feeder spreadsheet - Operational report (Excel), weekly, cumulative - Case management record sheet - Staff training - Program Guidelines for staff (Timely Clinical Follow-up) | Y | While results are now being collected and reported on quarterly for NorWest, there trending is showing that there is currently access issues with getting clients into see a provider within 7-days post discharge from the hospital. Part of the issue is that NorWest currently does not have a way to access discharge data in a timely and reliable fashion and therefor may not be aware of a discharge until several days later.  Future improvement opportunities for this indicator should focus on investigating the use of HRM automated messaging through our new EMR PS Suite to receive discharge notices from the regional hospital and the inclusion of discharge tracking for all cases within the EMR to improve timely reporting of results. Once complete the process of protecting time for discharge follow-up within a provider’s schedule can be reviewed for efficiencies. |

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| 5 | 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) | 91486 | CB | CB | Q3 – 13.25% | Baseline data is currently collected through a chart audit for all clients discharged from the hospital. The chart audit revealed that only 30.9% of clients had a documented follow-up (appointment or call) once discharged from hospital. |

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| 6 | Proportion of patients with a progressive, life-limiting illness who were identified to benefit from palliative care who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment. ( Proportion; All patients; Most recent 6 month period; Local data collection) | 91486 | CB | CB | n/a | Data collection process has been developed and will be implemented with new Integrated Palliative Care Clinical Program at the start of next fiscal. |

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| New Indicator Implementation Project: - Develop and map data collection process - Provide training to Providers/Staff - Implement the indicator within corporate planning | Y | By the end of 2019/20, not only will the indicator and data collection process be implemented but a new Integrated Palliative Care Clinical program will be available for rostered patients. During this fiscal, plans for the implementation of the integrated model were approved and planning for indicators and data collection needed to be aligned to the new program implementation.  The newly established IPCCP has established targets as part of the funding agreement that will help monitor and evaluate the success of the program in 2020/21 and further. |