Action Plan Examples

Activity 1: A practice-driven quality improvement (QI) activity using objective data

Project: Mammogram screening

	GOAL
1. What is the opportunity or gap?	Currently, 55 per cent of female patients aged 50 - 74 have completed mammograms in the past two years. Based on the current, updated guidelines, I would like to do outreach to female patients aged 45 - 74 who are due for mammograms with the goal of increasing my screening rate from 55 to 68 per cent (Calgary zone 2023 screening rate).
2. What is your SMART goal?	To improve mammogram screening rates from 55 to 68 per cent within the next six months.
3. Who will lead the change?	I, the physician, will lead the change with support from my Primary Care Network (PCN), Health Information Coordinator (HIC), and Patient Care Coordinator (PCC).
4. Who will help implement the change and how will they need help?	• The HIC will pull the list of patients due for screening. • The PCC will do outreach and book patients an appointment with me. • I will give the patient the requisition during their appointment.
5. How will you identify the root causes of the issue?	Female patients aged 45 and up are at increased risk of developing breast cancer. The recommended age for patients to get mammograms was once 50 years old, but now starts at 45 years old as per ASaP. Knowing this, I realize many patients are not aware they are now eligible for screening.
6. Considering root causes, what is a potential intervention	Outreach to eligible patients will let them know they are due for a mammogram and inform them that the recommended age of beginning mammogram screening has recently changed.

which may be tested to improve the challenge you are facing?	
7. What resources are needed?	• ASaP guidelines • EMR data • Netcare • The project team
8. What is the timeline?	Six months
9. What barriers may compromise success?	• Patients are unaware that they are due for a mammogram. • There may be a lack of knowledge regarding the importance of having regular mammograms done. • Patients may not know when to come in for an appointment.
10. What strategies will you employ to mitigate the barriers identified?	• Notify patients that are due for a screening • Educate patients on the importance of getting mammograms done regularly • Ensure a variety of appointment times are available, with both virtual and phone appointment options.
11. How will achieving the goal be identified or measured?	• The HIC will create a run chart which will be updated monthly. • The list of eligible patients will be updated on a quarterly basis.
12. What strategies will you employ to evaluate and sustain the change?	We will meet again in three months to review screening rates and ensure we are on track to reach our goal.

Activity 1: A practice-driven quality improvement (QI) activity using objective data

Project: Diabetes screening

	GOAL
1. What is the opportunity or gap?	I aim to increase diabetes screening rates in patients aged 40 - 74 to 85 per cent in the next six months. The provincial benchmark for diabetes screening is at 78 percent and my screening rates are currently at 75 per cent — I would like to see this number increased.
2. What is your SMART goal?	To improve diabetes screening rate for patients aged 40-74 from 75 to 85 per cent within the next six months.
3. Who will lead the change?	I will lead this change with support from the HIC.
4. Who will help implement the change and how will they need help?	• The HIC will pull a list of eligible patients who have not been screened for diabetes in the past five years by having either their fasting glucose or hemoglobin A1c's checked. • The HIC will add an EMR flag that I will use as a reminder to offer the screening when seeing patients during appointments.
5. How will you identify the root causes of the issue?	Upon reflection, I recognize often there are many items to discuss when a patient comes in to see me and blood work that should be checked periodically may be overlooked.
6. Considering root causes, what is a potential intervention which may be tested to	Adding a flag to the patient's chart will serve as a reminder that they need to have labs done and be screened for diabetes.

improve the challenge you are facing?	
7. What resources are needed?	• ASaP guidelines • EMR data • Netcare • The project team
8. What is the timeline?	Ongoing — check progress within three months, with a final completion goal within six months.
9. What barriers may compromise success?	• Some patients are not comfortable having blood work done. • Patients may not understand the importance of screening for diabetes. • Not all patients come into the clinic for regular appointments.
10. What strategies will you employ to mitigate the barriers identified?	• Educate patients on the importance of screening for diabetes. • Most patients come in annually for a check-up, making this an ongoing project.
11. How will achieving the goal be identified or measured?	• The HIC will run the list quarterly and update flags as required at that time. • The HIC will update the run-chart monthly and we will review our numbers in six months.
12. What strategies will you employ to evaluate and sustain the change?	We have decided to have another meeting in six months to assess our progress.

Activity 2: A CPSA Standards of Practice quality improvement activity

Project: Patient record content audit

	GOAL
1. What is the opportunity or gap?	50 per cent of 20 randomly selected charts have incomplete health context information and do not meet the CPSA standard of practice for patient record content.
2. What is your SMART goal?	To improve documentation of the cumulative patient profiles so that 75 per cent are complete in one year on repeat chart review.
3. Who will lead the change?	I will lead this change.
4. Who will help implement the change and how will they need help?	• Medical office assistants, receptionists, nurses, and patients will assist with this project. • They will need direction, documents, and time to complete the work.
5. How will you identify the root causes of the issue?	Upon examination of personal and system factors that can impact performance, I recognize that limited physician time is identified as a root cause for incomplete cumulative patient profiles.
6. Considering root causes, what is a potential intervention which may be tested to	I will involve the team in providing a questionnaire to patients in the waiting room to collect their health information and use it to update the patient record.

improve the challenge you are facing?	
7. What resources are needed?	• Patient questionnaire to update the cumulative patient profile • Receptionist, MOAs, RN, and physician time to collect and update the cumulative patient profile
8. What is the timeline?	Ongoing —check progress within three months, with a final completion goal within six months.
9. What barriers may compromise success?	• There may be limited time for staff to complete these tasks. • Patient disabilities that may impact completion of the questionnaire.
10. What strategies will you employ to mitigate the barriers identified?	• Encourage the use of the electronic patient portal to send and receive the questionnaire • Approach only a portion of all the patients seen in a day (50 per cent) to make the project more realistic and manageable • Engage the PCN to provide assistance
11. How will achieving the goal be identified or measured?	• Periodic chart audits will be completed to assess the completeness of the cumulative patient profile and last date updated.
12. What strategies will you employ to evaluate and sustain the change?	We will schedule regular assessments (i.e., 20 charts quarterly) to monitor performance.

Common Standards of Practice (SOP) to consider:

- Patient Record Content SOP – (e.g., Section 2.a.c. that requires a detailed cumulative patient profile (CPP))
- Patient Record Retention SOP – (e.g., Section 2. requires policies and procedures be in place in accordance with the *Health Information Act;* Section 3. related to ensuring there is an Information Sharing Agreement in place.)
- Episodic Care SOP (e.g., Section 2. includes several requirements including establishing whether a patient has a primary care provider (PCP) and, if so, provide the PCP with a record of the encounter.)
- Responsibility For A Medical Practice (SOP) – (e.g., Section 2.h. requires both regulated and non-regulated healthcare providers are clearly identified to patients and the public.)
- Infection Prevention and Control (IPAC) SOP - (e.g., Section 1.1. ensure there are written IPAC policies and procedures in place; Section 4.0 regarding management of medical sharps, e.g., 4.1.6. Sharps containers must be single use. They cannot be emptied and reused.; Section 7.0 Medical and Vaccine Injection Safety includes requirements for safe storage.)

Activity 3: A personal development activity (improve non-medical expert roles of the CANMEDS roles)

Project: Impact Bias

	GOAL
1. What is the opportunity or gap?	I would like to complete implicit bias training modules to improve awareness of how implicit bias may affect decisions and medical outcomes affecting my practice.
2. What is your SMART goal?	To create awareness and measure implicit bias which may be impacting my practice.
3. Who will lead the change?	Myself and my team.
4. Who will help implement the change and how will they need help?	Each team member will assess and support in this area.
5. How will you identify the root causes of the issue?	These may be different for each team member — this would be achieved through the implicit bias training, scoring, and personal reflection which can then be discussed in our team approach.
6. Considering root causes, what is a potential intervention which may be tested to	I could consider patient initiatives that specifically address bias or its perception by the patients.

improve the challenge you are facing?	
7. What resources are needed?	• Implicit bias training modules for all team members • Dedicated time for individual reflection • Scheduling group meeting time (perhaps during staff meetings?) to consider issues
8. What is the timeline?	Start immediately with the plan to reevaluate at six months
9. What barriers may compromise success?	• Time may be a concern—perhaps there is a need for ongoing facilitation if difficult conversations occur.
10. What strategies will you employ to mitigate the barriers identified?	• Be open to coaching as required
11. How will achieving the goal be identified or measured?	We can re-evaluate by completing further implicit bias scoring as well as considering adding patient feedback as above.
12. What strategies will you employ to evaluate and sustain the change?	Implicit bias testing on a six-month basis may help to sustain changes over time, as well as adding questions regarding patient perceived bias to our patient feedback questions periodically.

Activity 3: A personal development activity (improve non-medical expert roles of the CANMEDS roles)

Project: Burnout Assessment

	GOAL
1. What is the opportunity or gap?	There are increasing demands with the changing primary care landscape, and burnout is common. I want to objectively assess my own personal and professional burnout to integrate strategies that will ultimately support my practice and ability to succeed in all CanMEDS roles.
2. What is your SMART goal?	Objectively assess how burnout may be affecting myself and my practice and reflect on opportunities that may support my personal wellness and professional practice.
3. Who will lead the change?	I, the physician, will lead the change. Our group of physicians at the clinic are all completing this simultaneously.
4. Who will help implement the change and how will they need help?	I will be leading the change. I will utilize my PMH team (Quality Improvement Coordinator and Health Information Coordinator) to support in the facilitation of my initial data results to objectively assess areas where I can improve. Having the team to support will allow objectivity as I consider my own behaviors.
5. How will you identify the root causes of the issue?	Through the baseline data collection using a burnout survey, and reflection and review of my results with my colleagues and the PCN team.
6. Considering root causes, what is a potential intervention which may be tested to	Utilize resources available through the AMA or from the survey to reflect on burnout in the workplace, specifically for a physician.

improve the challenge you are facing?	I plan to complete the survey, then reflect with my colleagues to identify an area for change, awareness, and/or improvement. I will then implement my intervention and reassess to see if anything has changed.
7. What resources are needed?	Access to the survey, information from AMA and CPSA for resources, time
8. What is the timeline?	Will implement changes in the 6 months following baseline data, at which point I will repeat the survey to see progress.
9. What barriers may compromise success?	Lack of time, pressing and unchangeable priorities that may compete with my resolution to burnout (e.g., patient demand).
10. What strategies will you employ to mitigate the barriers identified?	Schedule specific time to learn more about preventing burnout, so it is prioritized. Participating at the same time as my colleagues will allow us to hold one another accountable to our goals.
11. How will achieving the goal be identified or measured?	Reflection at the six-month mark, using the same burnout survey again to assess and reflect on changes that were made or that could continue to support. I will reflect with my team for objectivity in assessing my results.
12. What strategies will you employ to evaluate and sustain the change?	Reflect with colleagues about our respective changes, continue to practice techniques adopted, and seek out opportunities for support. Revisiting with the same survey tool will allow for a comparison of progress.