Quality Improvement (QI)

Panel Support Program

P S E C

This program is available to Pediatrician, Standard, Enhanced, and Comprehensive members.

The **Panel Support Program** is tailored to your practice and preferences to identify patients with a confirmed, ongoing patient-provider relationship and establish ongoing processes to maintain your patient list (a.k.a. panel) in the clinic EMR.

An accurate panel is the **first step** to participating in Community Information Integration/Central Patient Attachment Registry (CII/CPAR) and identifying additional QI projects or goals. A **Discovery Report** that describes your panel is provided as part of this process.

QI goals

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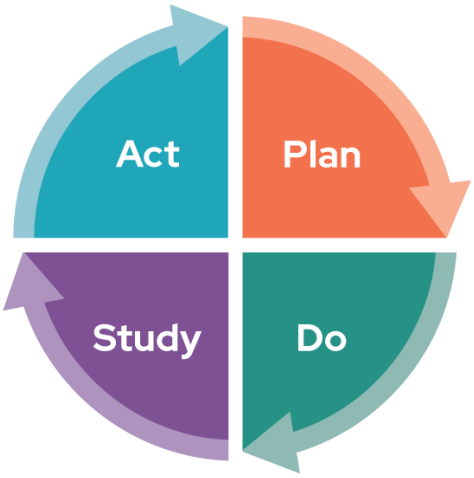

This program is available to Enhanced and Comprehensive members.

The Patient Medical Home (PMH) team can support **identifying**, **contacting**, and **providing care** to patient groups eligible for proactive screening, chronic disease management, and/or mental health management. QI goals can also identify opportunities for EMR or clinic process improvements.

QI activities supported by your PMH team are recorded on your **Monday.com physician QI board**. The board serves as a central and collaborative location for an easy glance at project progress and documentation.

Physician Practice Improvement Program (PPIP)

The PCN's approach to QI and the support that PMH team members offer is aligned with the **CPSA's PPIP**. Ongoing improvement goals using data and facilitated with your team could fulfill one or more of the PPIP activity areas. Your team will **document** your ongoing QI activities on your Monday.com QI physician board, designed to mirror the CPSA PPIP Action Plan.

Contact your Physician Liaison or Health Information Coordinator if you have questions or want to learn more.

Example: QI goal with PMH team support

Step	Details	Example
Plan	It all starts with a question, an idea, or an observation. The PMH team will plan with you who will do what and when.	Purpose: Identify the opportunity to improve support for patients with diabetes due for annual diabetic foot exams. Patients will also benefit from additional education and lifestyle and goal support. Goal: 90 per cent of patients with diagnosed diabetes have had a diabetic foot exam completed within the last 12 months by X date.
Do	Carry out the plan, gather data, and review the data. The PMH team will support with patient coordination and care, data collection, and analysis.	Health Information Coordinator (HIC) pulls a list of diabetic patients that are due for a foot exam from the EMR, and the list is prioritized based on physician discussion (e.g., by time since completed, additional risk factors, lab values, etc.); Patient Care Coordinator (PCC) calls patients and books them in with the Primary Care Registered Nurse (PCRN); PCRN completes the diabetic foot exam and provides additional condition support for patient during appointment.
Study	Compare the data to what you expected. Document what you learned.	HIC tracks progress toward the goal over time to see improvement (i.e., per cent of patients with a completed foot exam within the last 12 months). Are they improving? Will the goal be met? Does the process need to be changed?
Act	Decide if you want to keep this change (Adopt), modify the change (Adapt), or decide that the change didn't improve anything, and you want to try something else (Archive).	Reflect and communicate the plan going forward. The process may be repeated at regular intervals to maintain goal achievement or adjusted to better reach the improvement goal.