Team:

Meeting Date:

Team members present:

2019 Quality Check

01-07-2019

Care Team Representative

Cervical Cancer Screening	Goal:	75%
	Agency Result:	
	Our Result:	

WCHC Clinical Priorities Dash / Cervical CA Tab

Well Child Exams	Goal:	83%
	Agency Result:	
	Our Result:	

WCHC Clinical Priorities Dash / WCE Tab

Care Team Behavioral Health

Depression Screening	Goal:	50%
	Agency Result:	
	Our Result:	

BH Team / Depression 12 Months Tab

Care Team Medical Assistant

Tobacco Screening	Goal:	75%
	Agency Result:	
	Our Result:	

CTMA Dash / Tobacco Screen 12 Months Tab

Cessation Counseling	Goal:	75%
	Agency Result:	
	Our Result:	

CTMA Dash / Cessation 12 Months Tab

Care Team Provider

Colorectal Cancer Screening	Goal:	50%
	Agency Result:	
	Our Result:	

WCHC Clinical Priorities Dash / Colorectal Tab

Breast Cancer Screening	Goal:	60%
	Agency Result:	
	Our Result:	

WCHC Clinical Priorities Dash / WCE Tab

Hypertension Blood Pressure Control	Goal:	75%
	Agency Result:	
	Our Result:	

WCHC Clinical Priorities Dash / HTN Tab

Care Team Nurse

PHASE not at goal Case Management Complete	Goal:	75%
	Agency Result:	
	Our Result:	

PHASE Dash / Case Management Tab FILTER: At Goal='No'

A1C Poor Control	Goal:	16%
	Agency Result:	
	Our Result:	

Diabetes Dash / A1C Poor Control Tab

Review last month's Action Plan — STUDY and ACT

What did we conclude from testing our plan? What did we learn? (what worked, what didn't and why) Do we **adopt, adapt** or **abandon** our plan?

Example: FO was successful prepping charts to find out who needed a SDOH survey and it was helpful to discuss in our huddle! We struggled with getting the forms to the patient at check in. We will **adapt** our plan and focus on the check in process.

Our Team's SMART Goal — What are we trying to accomplish?

We will improve _____

by _____
(What is the action ? Reducing, decreasing, increasing, etc.)

from _____ to _____ by _____.
(What is our baseline result?) (How much) (When? Pick a date.)

Example: We will improve our Depression screening rates by increasing the number of SDOH surveys handed out from 38 to 100 by October 31, 2019.

Specific

Measurable

Ambitious

Relevant

Time bound

Make a new or adapt our old Action Plan — PLAN

What small change can we make that will result in an improvement? What are the EXACT steps needed to carry it out? WHO? WHAT? WHEN? WHERE?

Example: This month we will try having our FO prep SDOH surveys by filling out the patient's name at the top for each patient that is due and have ready at the check in desk. FO will notify the team in huddle which patients are due so the CTMA and provider are informed.

Do we need any additional info or support? (data, workflows, etc.)

QI Action Plan

Example: We need to measure the number of SDOH surveys scanned in for our team in addition to the depression screening measure. Can we get data on the number of surveys scanned ?