2018/19 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

Unison Health & Community Services

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Effective transitions	Percentage of patients who have had a 7-day post hospital discharge follow-up	% / Discharged patients	See Tech Specs/Last consecutive 12 month period	91972*	38	40	A target has been entered because it is a required field. Resource	1)See Target Justification and Comments sections.	See Target Justification and Comments sections.	See Target Justification and Comments sections.	See Target Justification and Comments sections.	As Unison's priority project for QI is to improve access to primary care, we
		Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification	% / Discharged patients	EMR/Chart Review / Last consecutive 12 month period	91972*	CB	CB	Unison will not be working on a project for this indicator in 2018-19. Our	1)See Comments section.	See Comments section.	See Comments section.	See Comments section.	Unison will not be working on a project for this indicator in 2018-19. Our resources
Equitable	Population health - cervical cancer screening	Percentage of eligible female clients who received or were offered a Pap test in the previous three years either at the CHC or outside the CHC	% / PC organization population eligible for screening	In house data collection / 3-year look back for mean	91972*	75	80	Target is the quarterly mean from the KR site since the start of the WEQIC project (in Q4 2015-16). Although there are not yet 12 data points, we	1) Continue to optimize recall process at original (KR) site.	1. Implement workflow for recalls; 2. Monitor progress; 3. Tweak recall process as needed	# of clients due for screening who are successfully booked	To increase the number of clients screened	We are continuing to assess success of our recall process.
									2) Continue to update dashboard to monitor sustainability of improvements at original (KR) site.	1. Dashboard for monitoring; 2. Creating graphs of cancer screening rates, # of clients screened and due for screening for each provider every quarter, and the # of CS declines (to go into the dashboard); 3. # of eligible clients for screening on the recall list.	1. # of clients screened and due for screening for each provider every quarter 2. # of eligible clients for screening on the recall list	To monitor and take quick action if necessary to ensure CS rates at original site are	Current performance reported here is median, whereas from now on we
	Population health - colorectal cancer screening	Percentage of rostered CHC clients aged 50 to 74 who received or were offered a fecal occult blood test in the last 2 years	% / PC organization population eligible for screening	In house data collection / 3-year look back for mean	91972*	64	71	Target is the quarterly mean from the KR site since the start of the WEQIC project (in Q4 2015-16). Although there are not yet 12 data points, we	1) Continue to optimize recall process at original (KR) site.	1. Implement workflow for recalls; 2. Monitor progress; 3. Tweak recall process as needed	# of clients due for screening who are successfully booked	To increase the number of clients screened	We are continuing to assess success of our recall process.
									2) Continue to update dashboard to monitor sustainability of improvements at original (KR) site.	1. Dashboard for monitoring; 2. Creating graphs of cancer screening rates, # of clients screened and due for screening for each provider every quarter, and the # of CS declines (to go into the dashboard); 3. # of eligible clients for screening on the recall list.	1. # of clients screened and due for screening for each provider every quarter 2. # of eligible clients for screening on the recall list	To monitor and take quick action if necessary to ensure CS rates at original site are	Current performance reported here is median, whereas from now on we
	Equity	Identify equity factors that influence access to cancer screening based on each CHCs' analysis of equity data for the Q ending Sept. 30, 2017	Number / On going primary care clients	Analysis of in house data pulled from EMR / for quarter ending Sept. 30, 2017	91972*	CB	CB	We analyzed the client population of focus. Our aim is to improve screening for that population. We will set the target once we identify projects or interventions.	1) Share the analysis of intersectional SD factors (for CS screening) with the whole primary care team to illustrate the factors that	1) Hold a whole team meeting to share the analysis	# of underscreened/never screened clients who are now getting access to screening	To screen underscreened/never screened clients	This project is part of the common QIP of the WEQIC. At Unison, the
									2) identify approaches, based on results, at the provider or team level.	2) Identify projects or interventions, for the identified populations that do not receive equitable screening, to increase cancer screening rates	# of underscreened/never screened clients who are now getting access to screening	To screen underscreened/never screened clients	
									3) Evaluate the effectiveness of the selected approach to see if the identified client group has been screened (based on	3) Evaluate the level of success in targeting the clients who did not receive equitable screening	# of underscreened/never screened clients who are now getting access to screening	To screen underscreened/never screened clients	
Patient-centred	Person experience	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else	% / PC organization population (surveyed sample)	In-house survey / Annual, in fall	91972*	82.82	82.9	A target has been entered because this is a required field. This target is the	See Target Justification and Comments sections.	See Target Justification and Comments sections.	See Target Justification and Comments sections.	See Target Justification and Comments sections.	As we meet the TC-LHIN average for this measure, we have not planned any
		Percentage of clients who stated that they know how to make a suggestion or complaint	% / Clients	In house survey / annual, in fall	91972*	71	70	Since this is Unison's own question, we did not look for a benchmark in	1) To sustain improvements by continuing to promote telephone hotline and other mechanisms for giving feedback.	1) Telephone hotline usage sustained or increased.	1. # of clients who select telephone hotline option 2. # of clients who giving feedback via other means.	To sustain current level of awareness.	
Timely	Timely access to care/services	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)	In-house survey / Annual, in fall	91972*	23.73	39.00	Unison's 2016 performance across all sites has been kept as the target.	1) Add a 2nd provider to the A2C QI team.	Have the 2nd provider collect data about their practice for analysis.	# of additional staff who have been given QI training	Increase staff's QI capacity by end of March 2019	This project is the focus for year 3 for the WEQIC. Each CHC will have a
									2) Collect and understand 2nd provider's supply and demand data.	a. Apply supply and demand tool that was created the previous year in order to analyze and understand where to focus our improvement efforts for the 2nd provider. b. Manually collect supply and demand data for the 2nd provider on the QI team for a period of 6 to 8 weeks to understand the supply and demand patterns to inform	Collect supply and demand data for the 2nd provider.	Depending on each CHC's needs, based on collected supply and demand data, to balance supply and demand or	Each CHC will use HR, NOD and financial data in order to calculate supply and demand for the
									3i) Continue to monitor TNAA for 1st provider. 3ii) Collect and analyze TNAA for 2nd provider.	For change ideas 3i and 3ii: a. Apply the TNAA template for both providers b. Continue adding data to the run chart for the 1st provider and start a run chart for the 2nd provider in order to interpret TNAA data and determine best	# of days to TNAA	To improve the number of days to TNAA for each participating provider.	

									4) Free up/increase the participating providers' supply of appointments	a. Monitor the progress of the 1st provider. b. Reduce the bad backlog of the 2nd provider. c. Test change ideas on the schedule of the 2nd provider on the QI team. d. Apply the learning to other MD/NPs as appropriate.	TNAA for each participating provider is at target (based on best possible performance considering FTE and scheduling)	To improve TNAA appointment based on each provider's target.	The driving force behind WEQIC's common QIP in year 3 of the collaboration is
									5) Appropriate use of both participating providers' time	a. Analyze and understand pressures from internal and external demand on the QI providers' schedules to determine changes for improvements. b. Test change ideas for improvements. c. Measure revisit rates for both providers based on client context.	Revisit rate	To optimize the use of both providers' time.	Same comment as in change idea # 4 above.
		Percent of patients								d. Apply the learning to other MD/NP as appropriate.		1. To understand the % of clients who are getting an appointment when they want/need it for the primary care team 2. To determine baseline among CHCs participating	This question was chosen as a balancing measure to the "same day/next day" priority of our QIP. It is important that clients get an appointment on
						61	70	70% was the overall result for Unison based on the fall 2016 client experience survey.	2) Crosstabulate the results of the client experience survey questions to understand if clients are getting appointments when they want/need an appointment.	a. Continue with the practice of comparing the results of "same day/next day" and "when I want/need it" to understand if clients are getting appropriate access to primary care	1. Cross tabulate: Same day Next day 2-19 days 20 or more days With: % of people who got an appointment when they wanted/needed it		