

Quality Improvement Plans (QIP): Progress Report for 2016-17 Q3

Quality Dimension: Effective

Measure/Indicator	Performance in Q4 2015-16	Target on 16/17 QIP	Current Performance 2016-17	Comments
Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years	58.78%	65%	Q2: 66.3% Q3: 72% Median: 53%	Data reported is for Keele-Rogers (KR) site which has a QI team working on improving cancer screening rates. Targets established by KR QI team to be attained by March 31, 2017 (shown in the "Target on 16/17 QIP" column) have been reached. Next goal is to bring median of last 12 quarters, excluding highest and lowest quarters, to target. This will require sustaining improvements over the longer term.
Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years	69.58%	78%	Q2: 75.8% Q3: 79.7% Median: 69%	Notes: (1) We are using MSAA technical specifications to set our targets and measure our progress. (2) Plans and learning from KR were shared with other site managers, who initiated their own clean-up and QI processes, with positive results for Unison over all.
Percentage of women aged 50-74 years who received or were offered a mammogram in the previous two years.	55.15%	65%	Q2: 66.2% Q3: 74.6% Median: 41%	
Change Ideas	Was this change idea implemented as intended?		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?	
Conduct data clean-up	Yes		Data entry inadequacies have contributed to lower cancer screening rates. Frequent errors were identified for ineligible clients, clients who had the screening done elsewhere and clients who refused the screening.	
Bring together a QI team for cancer screening at 1 site, Keele-Rogers (KR).	Yes		QI team was established in March 2016 with site manager as team lead. QI team was 6-7 people; we learned 4-5 is a better number to maximize engagement and productivity. First QI team lead was a manager, who has left the	

		organization; successor is Data Coordinator, a non-management staff member. Other CHCs in the same project had great success with non-management leads.
Develop a current state process map for CS with Unison KR site QI team	Yes	QI projects take time and that includes time of providers who must be included in all steps and processes. The current state process map development, which was combined with some QI training, took the KR QI team 2.5 days. The future state process map in the Kaizen event took 2 days. It has not yet been implemented, which will require additional time and effort.
Create a list of all KR clients who are eligible for screening	Yes	This has been started. With the extent of data entry inaccuracies, clean-up is ongoing on a quarterly basis to create an accurate recall list.
Create a measurement plan	Not yet	A comprehensive common measurement plan for the CHC collaborative was developed, but CHCs had trouble choosing their own family of measures. A standardized dashboard with 4 common measures is being developed instead. A prototype has been shared with the KR QI team, and all CHCs in the collaborative have agreed to try using it in 2016-17.

Measure/Indicator	Performance in 2015-16	Target on 16/17 QIP	Current Performance 2016-17	Comments
Percentage of patients with diabetes, aged 40 or over, with two or more glycosylated hemoglobin (HbA1C) tests within the past 12 months	53.23%	Pending	60.32%	The project is focusing on 1 MD. Current performance is for this provider. Current performance, per technical specifications for this indicator, looks back 1 full year, so was calculated from Q3 2015-16 to Q3 2016-17. This project is being dropped from the QIP work plan since it is no longer a priority indicator. Nevertheless we plan to continue the project on a small scale.
Change Ideas	Was this change idea implemented as intended?		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?	

Bring together a primary care QI team for A1Cs	No	Primary care managers requested that this project look at all 4 sites simultaneously and the QI team was formed with representation from all sites. However, in terms of work processes, the MD on the team can only speak to her way of practising. Discussion is ongoing with QI team members about a way to involve other sites in the project. It may have been better to start with a site-specific team.
Create current state process map with A1C QI Team	Yes	Current state process map was developed by the QI team over the course of a few team meetings.
Create a list of all diabetic primary care clients aged 40 and over	Yes	This was prepared at the organization-wide and site-specific levels, as well as for the specific MD on the QI team. The organization-wide and site-specific information has not been used. We need to remember to keep the scope of our QI projects small initially.
Create a measurement plan	Not yet	Based on experience with the measurement plan in the cancer screening project, this change idea may be revised or dropped.

Quality Dimension: Equitable

Measure/Indicator	Performance in 2015-16	Target on 16/17 QIP	Current Performance 2016-17	Comments
% of clients with 1 or more health equity barriers to screening who are successfully screened	Collecting Baseline	Collecting Baseline		The CHC collaborative discussed and agreed to look at cancer screening and income levels, ethnocultural group, born in Canada (and # of years in Canada) and insurance status.
Change Ideas	Was this change idea implemented as intended?		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?	
Review CS rates for differences that may be attributable to key socio-demographic	Started		Data from all 5 CHCs in the collaborative was shared and reviewed. For Unison, the data was for KR site. It was noted	

indicators such as income or language		that there are lower screening rates for Paps for women born in Portugal in 4 of 5 participating CHCs. Lower income and non-insured clients appear to have good access to screening at these CHCs.
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Quality Dimension – Client Experience

Measure/Indicator	Performance in 2015-16	Target on 16/17 QIP	Current Performance 2015-16	Comments
Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) give them an opportunity to ask questions about recommended treatment?	88.13	88.13	91.00	Current performance is Unison's overall result from the past year's client experience survey, which was conducted at all four of our sites in Oct. 2016.

Change Ideas	Was this change idea implemented as intended?	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?
Maintain performance.	Yes.	

Measure/Indicator	Performance in 2015-16	Target on 16/17 QIP	Current Performance 2016-17	Comments
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?	82.25	86	83.17	Current performance is Unison's overall result from the past year's client experience survey, which was conducted at all four of our sites in Oct. 2016.

Change Ideas	Was this change idea implemented as intended?	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?
Explore best practices for client self-management that could be tested as change ideas	No	The proposed change ideas were not implemented because the overall number of change ideas in our 2016-17 work plan exceeded what we could reasonably do. From our experience of implementing this work plan, we learned to be more realistic about the total number/scope of QI projects that we take on, given

		current resources. This learning was used in developing our 2017-18 QIP work plan.
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Measure/Indicator	Performance in 2015-16	Target on 16/17 QIP	Current Performance 2016-17	Comments
Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) spend enough time with them?	87.19	87.19	87.83	Current Performance is from client experience survey, which was conducted in Oct. 2016.

Change Ideas	Was this change idea implemented as intended?	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?
Maintain performance.	Yes	

Measure/Indicator	Performance in 2015-16	Target on 16/17 QIP	Current Performance 2016-17	Comments
Percent of clients who stated that they know how to make a suggestion or complaint	60.35	70	65.64	Current performance is Unison's overall result from the past year's client experience survey, which was conducted at all four of our sites in Oct. 2016.

Change Ideas	Was this change idea implemented as intended?	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?
Bring together a QI team (with client members) on suggestions and complaints	No	In January 2016, we held 3 focus groups involving 10 clients and community members. At these focus groups, we discussed our results on this indicator from the 2015 client survey.
Brainstorm and develop change ideas to test	Yes	An action plan was developed based on the input given in the above focus groups. The action plan articulated change ideas that were tested including: Suggestion Spotlight prepared and posted at 4 sites – to show a suggestion that was received and Unison's implementation of it or response to it, telephone hotline (voice mail option) set up at LH site, white board option set up at JT site, and outreach done to groups during client experience survey. One idea from action plan (installation of 1 suggestion box/floor at LH) is not yet implemented.

Quality Dimension: Timely

Measure/Indicator	Performance in 2015-16	Target on 16/17 QIP	Current Performance 2016-17	Comments
Percent of patients/clients who saw their primary care provider within 7 days after discharge from hospital for selected conditions (based on CMGs).	Q4: 46% Q3: 32%	40%	35.4%	Out of 65 reports received in Q1-Q3, 23 were seen within 7 days. Notes: (1) Target for 2016-17 was set before Q4 results for 2015-16 were known; (2) It is difficult to accurately calculate performance on this measure. An external report of our results is published twice annually, but it does not provide information that can be used to actually do QI.

Change Ideas	Was this change idea implemented as intended?	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?
Require Medical Secretary to book follow-up appointment immediately upon receipt of discharge report from hospital	No	The change was communicated to relevant Medical Secretaries at the beginning of the year. It was not successfully implemented by all of them - probably they are uncomfortable proceeding without consulting the client's provider. It was communicated again recently. For this to be successful, providers must be informed of the reasons for it, and buy in.
Give business cards of provider to each client; ask them to let us know if they are admitted/discharged from hospital	No	Two (of four) sites reported that providers regularly give out business cards. We do not track progress because we do not want to burden providers with this request, given all their other responsibilities. For us to know if this is successful, we must be able to track it.
Provide feedback to hospitals on late discharge reports	Yes	Senior Director Primary Health Care is provided with information to follow up with hospitals. One of the hospitals whose reports are frequently late says it only requires providers to send discharge reports within 14 days. This is out of our control and hopefully hospitals will eventually align with health

		system expectations.
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Measure/Indicator	Performance in 2015-16	Target on 16/17 QIP	Current Performance 2016-17	Comments
Percent of patients/clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	Unison: 40% BF: 33%	70.00	Unison: 39% BF: 26%	Current performance is the site-specific result from the Bathurst-Finch (BF) site on the past year's client experience survey, which was conducted in Oct. 2016 at all sites. The result across all 4 sites was somewhat better, at 39%. From this same survey, 79% of all Unison clients got appointments in 2 to 20+ days got an appointment when they wanted it, even though they waited longer than same/next day.

Change Ideas	Was this change idea implemented as intended?	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?
Improve booking procedures for primary care appointments at BF site based on feedback from special client experience survey	Yes	List of reasons for visit for a prebooked appointment was shortened/ simplified in discussion with BF QI team. There was a staffing shortage during the time that the Oct. 2016 survey was conducted that seems to have negatively affected BF client's satisfaction.