Health Quality Ontario- Quality Improvement Plan (QIP): Progress Report for 2018-19 Q3

7-Day Hospital Discharge Follow-up

Measure/Indicator	Performance in 2017-18	Target on 2018-19 QIP	Current Performance	Comments
Percent of patients/clients who see their provider within 7 days after discharge from hospital for selected conditions.	38%	40%	41.7%	Our reported performance is from CHC Practice Profile April 1, 2015 – March 31, 2017 (latest available data).
Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.	CB	CB	33%	Baseline was calculated for the Lawrence Heights site, as this is where we will focus improvement efforts in 2019-20.
Note: For the 2019-20 work plan, HQO has enabled us to select which of the two above indicators is most suitable to our situation. We have selected the 2nd of the two above indicators.				

Change Ideas (2nd Measure/Indicator)	Was this change idea implemented as intended?	Lessons Learned: 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?
Not applicable. Collecting baseline.	Not applicable	Not applicable

Access to Primary Care (Client Experience)

Measure/Indicator	Performance in 2017-18	Target on 2018-19 QIP	Current Performance	Comments
Percent of clients able to see a doctor or nurse practitioner on the same day or next day, when needed	23.73%	39%	33.77%	Client experience survey was conducted Oct. 29 – Nov. 16, 2018. Current performance is for Unison as a whole. This is a change. Earlier reports (including 2017-18 performance, as shown) was only for Bathurst-Finch.

Measure/Indicator	Performance in 2017-18	Target on 2018-19 QIP	Current Performance	Comments
Percent of clients who responded "yes" to: “the last time you were sick or were concerned you had a health	71%	78.5%	73.9%	Client experience survey was conducted Oct. 29 – Nov. 16, 2018. All data is for Unison as a whole.

problem did you get an appointment on the date you wanted?"				
Note: This is intended as a balancing measure for the other access question immediately above. We will continue to ask this question in future client surveys.				

Measure/Indicator	Performance in 2017-18	Target on 2018-19 QIP	Current Performance	Comments
Cross tab of two above A2C indicators: percent of clients who didn't get an appointment on the same day or next day, when needed, but who nevertheless responded "yes" they got an appointment on the date they wanted it.	61%	70%	62%	Client experience survey was conducted Oct. 29 – Nov. 16, 2018. Data is for Unison as a whole.
Note: This is intended as a balancing measure for the same day/next day access question, above. As we continue our efforts to improve access to primary care in 2019-20, we will continue to use this crosstab as a balancing measure that gives a fuller picture of access than the HQO priority indicator alone.				

Change Ideas	Was this change idea implemented as intended?	Lessons Learned: 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?
Continue to ask the "date that you wanted" question on the fall 2018 client experience survey. (Unison has been	Yes.	We interpret our improvement on this indicator as evidence of some limited

asking this question on our client survey for the past 5 years, but other CHCs in the collaboration added it more recently.)		progress made in improving access at some of our sites.
Cross tabulate the results of the above two access questions (from the client experience survey) to understand if clients are getting appointments when they want/need an appointment.	Yes	There are many clients who are getting appointments when they want one, even though it is not same or next day. Advice to others is to ask clients about their ability to get an appointment when wanted - which will enable this crosstab to be generated
Add a 2nd provider to the A2C QI Team (at BF)	Yes. 1 NP was added. Team consists of: 1 MD, 1 NP, 1 Medical Secretary and the Site Manager. (North Hamilton Decision Support Specialist is consulted as needed.)	The 2nd provider provides encouragement and support to the 1st provider. However, the small size of the team makes it challenging to move forward quickly.
Collect and understand 2nd provider's supply and demand data (at BF)	Done. However, bad backlog for the NP has not been identified.	This NP reported that she already does a number of good practices, such as (1) checking her schedule to combine appointments with the same client, or cancel them if unneeded, and (2) booking clients' Pap tests with the RPN.
Continue to monitor TNAA for 1st provider (at BF). Collect and analyze TNAA for 2nd provider (at BF).	Yes. This is ongoing weekly since Jan. 17, 2017. As of Dec. 31, 2018, M.D.'s Median TNAA is 20 and N.P.'s Median TNAA is 14.	Compared with Q2, M.D.'s TNAA is slightly up and NP's TNAA is slightly down. TNAA for both providers has not changed significantly since tracking began.
Free up/increase the participating providers' supply of appointments (at BF)	A new PDSA, aimed at reducing no shows to first medical appointments, was developed at a meeting in Dec. 2018. The 'do' step of the PDSA was implemented in Jan. 2019.	The no show rate for 1 MD dropped to 20% from a baseline of 33.33%. With a few tweaks, a second PDSA is being conducted with new clients of the MD and 1 NP.

Appropriate use of both participating providers' time (at BF)	Revisit rate is being monitored 3 times per year. Industry benchmark is 3.19. Revisit rate to end of Q3 was 4.15 (M.D.) and 3.11 (N.P.). Revisit rates of both providers declined slightly from Q2 to Q3.	M.D. started to implement a PDSA to reduce average time for check-up appointments from 40 to 30 minutes. N.P. started to look at ways to work down her bad backlog which might have led to unarticulated practice changes. Positive results may be connected to these occurrences.
Definition: Third Next Available Appointment, or TNAA, measures the length of time in days between the day a patient makes a request for an appointment with a physician and the third open appointment. The "3rd next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, one appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability.		

Client Experience

Measure/Indicator	Performance in 2017-18	Target on 2017-18 QIP	Current Performance	Comments
Percent of clients who stated that they know how to make a suggestion or complaint	71%	70%	72%	We are in the phase of sustaining our performance on this indicator by sustaining current activities. Item is not on the 2019-20 QIP work plan.
Note: Client Experience Survey is conducted once annually. In 2018, it was conducted from Oct. 29 to Nov. 16.				

Change Ideas	Was this change idea implemented as intended?	Lessons Learned: 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?
To sustain improvements by continuing to promote telephone hotline and other mechanisms for giving feedback.	Yes.	Telephone hotline promotion has continued. YTD, 9 complaints received by this method, which is close to the 2017-18 rate (10). One site (BF) is lagging the others on awareness levels. It could be a language issue. This could be an area for further investigation. However, since results have been sustained since 2017, we have put a hold on creating other mechanisms for feedback.

Measure/Indicator	Performance in 2017-18	Target on 2018-19 QIP	Current Performance	Comments
Percent of clients 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?	82.82%	82.9%	83.83%	Client experience survey was conducted Oct. 29 – Nov. 16, 2018. Item is not on the 2019-20 QIP work plan.

Change Ideas	Was this change idea implemented as intended?	Lessons Learned: What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact?
Not applicable. As Unison meets the TC-LHIN average for this measure, we have not planned to test any changes this year.	Not applicable.	Not applicable. As we had indicated, we did not implement any change ideas in 2018-19 because Unison already met the TC-LHIN average for this measure.

Population Health: Cancer Screening

Measure/Indicator	Performance in 2017-18 (as of Q3)	Target on 2018-19 QIP	Current Performance	Comments
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	75%	80%	83%	2017-18 performance was a median. Current performance is the mean of 11 quarters from Q1 2016-17 to Q3 2018-19. Target was set based on mean on CS dashboard in Q3 2017-18.
Percentage of rostered CHC clients aged 50 to 74 who received or were offered a fecal occult blood test in the last 2 years	64%	71%	76%	Same comment as above.

Notes:

1. The project was focused at KR site and the data reported is only for this site.
2. The performance in 2017-18 given on earlier progress reports for 2018-19 Q1-Q2 and Q3 has been revised/corrected here.

Change Ideas	Was this change idea implemented as intended?	Lessons Learned: 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?
Continue to optimize recall process at original (KR) site.	Yes.	KR site has intensified their recall process based on the successful process used at another site. Effective Q3, KR site sends a recall letter to a client after 2 unsuccessful phone calls. Spreading improvements from KR to other sites was chaotic and overwhelming earlier in the project. However, it is now showing pay offs as sites share learning and improvements that seem to be working. Sites push each other to improve.
Continue to update dashboard to monitor sustainability of improvements at original (KR) site.	Yes.	The dashboard is a valuable reminder to managers and staff about the project.

Equity: Cancer Screening

Measure/Indicator	Performance in 2016-17	Target on 2017-18 QIP	Current Performance	Comments
Identify equity factors that influence access to cancer screening based on each CHCs' analysis of equity data for the Q ending Sept. 30, 2016	Collecting Baseline	Collecting Baseline	Collecting Baseline	This project was at the KR site. Collecting baseline was chosen as the target because, when we were developing the QIP work plan for 2018-19, we didn't know what change idea we would be testing.
Note: The measure refers to 'each CHC' because this item is part of the shared work plan of all the CHCs in the QI collaborative.				

Change Ideas	Was this change idea implemented as intended?	Lessons Learned: 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?
Share the analysis of intersectional SD factors (for CS screening) with the whole primary care team to illustrate the factors that prevent people from accessing screening.	Yes.	In other CHCs in the WEQI collaborative, the QI Specialist presented and facilitated a discussion. It would have been useful to do this at Unison (KR site). The information is most relevant to the primary care team, but not all primary care providers were present. Rather, the entire primary health care team attended the presentation.
Identify approaches, based on results, at the provider or team level.	Yes.	The team came up with a few change ideas at the team level. A PDSA for one

		change idea was developed and tested – targeting low income women to get their Paps and FOBTs using high intensity recalls (sending a letter to a client due for both Pap and FOBT after 3 attempted phone calls) or an offer of free TTC tokens.
Evaluate the effectiveness of the selected approach to see if the identified client group has been screened (based on each site's decision to focus on clinical or statistical significance).	Yes.	Drilling down further on the data revealed no inequity: 2/8 clients were not due for both tests (data extraction issues); 2/8 became inactive while the PDSA was being implemented and 2/8 were actually ineligible/declined but not correctly recorded. The remaining 2/8 were sent a letter and have not replied. We think our unsuccessful PDSA reinforces an earlier finding from our cancer screening (CS) QI project, indicating that CS rates are actually higher than reported. This is due to data entry errors, which probably cannot be eliminated, but we do have good processes in place to catch such issues.