Health Quality Ontario - Quality Improvement Plan (QIP):

Progress Report for 2017-18 Q3 (Revised March 20, 2018)

Quality Dimension: Equity

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	We have decided to focus this project at the Keele-Rogers site initially. Analysis has been updated using data from Q ending Sept. 30, 2017.
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?
Further analyze equity data (from Q ending Sept. 30, 2017) to determine equity factors that prevent people from accessing screening.	Yes. Statistically significant findings were found among clients as follows: ▪ cervical cancer screening (Pap tests) – born outside Canada, income levels, age groups; ▪ colorectal cancer screening (FOBT) – sex, income levels.	Findings will be shared with the primary care team in Feb. 2018. Highlights, based on statistical significance, to be shared are as follows: • Pap tests: Highest # of unscreened clients are in the following groups: aged 31-35, income level ≤ $14,999, not born in Canada • FOBT: Highest # of unscreened clients

		are males, income level ≤ $14,999.
Identify projects based on results of change idea # 1.	No. This change idea will be carried over into 2018-19 work plan.	

Dimension: Client-centred

Measure/Indicator	Performance in 2016-17	Target on 2017-18 QIP	Current Performance	Comments
Percent of clients who stated that they know how to make a suggestion or complaint	65.64%	70%	71%	Current performance is from the fall 2017 client experience survey. Target met.
Note: Client Experience Survey is conducted once annually. The most recent survey was conducted in fall 2017 (Oct. 16 to Nov. 3, 2017).				

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?
Spread learning from 2016-17 QI project	Yes.	Complaint voice mail box was implemented with new phone system and promoted (in Q2). 10 messages were collected so far. Increasing the range of options for giving feedback, and actively promoting the voice mail box has enabled us to reach our target after several years of trying.

Measure/Indicator	Performance in 2016-17	Target on 2017-18 QIP	Current Performance	Comments
Percent of clients who	83.17%	85.90%	82.82%	Current performance is

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?				from the fall 2017 client experience survey.

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?**
Create poster to communicate a message to clients: "You have a right to participate in and make decisions about your healthcare."	Yes.	Poster was translated into most common languages used at each sites and posted during Q2. This communication effort was likely too little and/or too late to make a difference. The fall 2017 client experience survey was conducted a few weeks after the posters went up.

Quality Dimension: Effective (includes effective transitions and cancer screening)

Measure/Indicator	**Performance in 2016-17**	**Target on 2017-18 QIP**	**Current Performance**	**Comments**
Percent of patients/clients who see their provider within 7 days after discharge from hospital for selected conditions.	39%	40%	38%	Our reported performance is not current because it is taken from CHC Practice Profile April 1, 2013 –

				March 31 2015 (most recent data available).

Notes:

1. Performance in 2016-17 was tracked at Unison. Data is Unison's own. Data was collected using a technical specification that only included physician data and only included certain conditions. Data of non-insured clients was included.
2. As of 2017-18, Unison no longer tracks its own data as this was resource intensive. Practice Profile does not include non-insured. Interpret with caution (limited data).

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?
See target justification and comments sections of 2017-18 work plan.	Yes.	We did not have any change ideas for this indicator because Unison's priority project for QI was to improve access to appointments at 1 of 4 sites. In the long-term, as we improve access to primary care, we expect this indicator to improve.

Measure/Indicator	Performance in 2016-17	Target on 2017-18 QIP (See Note 2)	Current Performance (See Note 3)	Comments
Percent of patients aged 50-74 who received or were offered a fecal occult blood test within past two years, sigmoidoscopy or barium enema within	53.5%	63%	64%	Targets/measures are specific to Keele-Rogers site. Target is for median of 12 quarters (dropping highest and lowest). Target for 2017-18 was met as of Q3.

five years, or a colonoscopy within the past 10 years				
Percent of women aged 21 to 69 who received or were offered a Papanicolaou (Pap) smear within the past three years	69%	77%	75%	Targets/measures are specific to Keele-Rogers site. Target is for median of 12 quarters (dropping highest and lowest).

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?**
Identify optimal recall process	Yes. Test # 1 completed (in Q1): 22.1% of clients due for screening and called once made an appointment. Test # 1, with some modifications, was repeated (in Q2) with 28% success rate. The success rate of tests completed for those called in Q1 was 19% by Q3. From Q1-Q3, the number of clients on recall list has declined by 15% (74) for Paps and by 19% (71) for FOBTs.	The lag between the reminder phone call and the resulting appointment can be lengthy. The appointment may be rescheduled, sometimes more than once. The 19% success rate of completed tests is not necessarily final.
Take history at 1st medical appointment	Not yet. Keele-Rogers site has been closed to new primary care clients. However, a new Medical Directive makes it possible for RNs and RPNs to do or order screening for existing clients.	Medical Directives are not 'one size fits all' for every site/team. Even though another site already had a Medical Directive, the MDs at KR site had to go through the process of developing their own.

Develop and share a dashboard to monitor sustainability of improvements	Yes. Number of clients due for screening is now ≤ 29% of eligible clients for all KR providers for all 3 types of screening (= green flag).	The dashboard is a valuable reminder to managers and staff about the project.
Notes: 1. The phone reminders data is aggregated for all 3 types of cancer screening (cervical, colorectal, breast). 2. The 19% success rate of completed tests is not necessarily final. The lag between the reminder phone call and the resulting appointment can be lengthy. The appointment may be rescheduled, sometimes more than once.		

Dimension: Timely

Measure/Indicator	Performance in 2016-17	Target on 2017-18 QIP	Current Performance	Comments
Percent of clients able to see a doctor or nurse practitioner on the same day or next day, when needed	26.09%	39%	23.73%	Targets and performance are specific to Bathurst-Finch site. Current performance is from the fall 2017 client experience survey.

Measure/Indicator	Performance in 2016-17	Target on 2017-18 QIP	Current Performance	Comments
Percent of clients who responded "yes" to: "the last time you were sick or were concerned you had a health problem did you get an appointment on the date you wanted?"	83%	83%	69%	Targets and performance are specific to Bathurst-Finch site. Current performance is from the fall 2017 client experience survey.

Note: This is a balancing measure for the other access question immediately above.				
Measure/Indicator	**Performance in 2016-17**	**Target on 2017-18 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.	79%	80%	59%	Current performance is from the fall 2017 client experience survey. The A2C project progressed slower than originally anticipated, while the team had fewer MD/NP hours than in 2016-17. Also, the survey was conducted fairly soon after a lengthy vacation of a 1 FTE MD.
Note: This is a balancing measure for the other access question immediately above.				

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?**
Bring together an Access to Care (A2C) QI team	Yes.	Team consists of: 1 MD, 1 Medical Secretary, 1 Data Management Coordinator and the Site Manager.
Collect and understand MD/NP supply and demand data	Yes. Data for all MDs/NPs at the site was analyzed in terms of supply and demand, continuity of care for clients and client revisit rate. The data was used to confirm the provider that would participate in the QI team. Then, 10 weeks of "real time"	It took more than 10 weeks to collect enough "real time" data. When the data was summarized and shared, the findings yielded some surprises for the physician, and time for reflection was needed before moving to action. The data

	data for that physician were collected and reviewed.	enabled a deep analysis of the MD's current practices and the need for change.
Collect TNAA data and analyze	Yes. This is ongoing weekly since Jan. 17, 2017. On Nov. 1, 2017, when data was presented at an A2C team meeting, the physician's median TNAA was 22 days. As of Dec. 27, 2017, the median TNAA was 20 days.	The TNAA of 22 days for a pre-booked appointment indicated a need to improve the provider's schedule by working down her bad backlog. Strategies in process for this during Jan. 2018 are: 1. Assigning work to a new MD (i.e. forms) 2. Assigning work to RPN (i.e. normal labs f/u, cancer screening) 3. Combining appointments booked for the same client close together.
Increase MD/NP supply of appointments	The A2C team will identify and try out practice and system changes after the physician has worked down the bad backlog. This is probably going to take a few more months to complete. (Provider is also going on vacation in February.)	Approaches 2 and 3 (above), if sustained, could also help keep the physician's supply of appointments open for those who want to be seen in 1-2 days. Approach # 1 may be time limited. Provider has 6 weeks of vacation entitlement and we will have to identify ways to sustain access given this reality.
Appropriate use of MD/NPs' time	The team has identified several potential ways to do this, such as: • Assigning work to the RPN (i.e. normal labs f/u, cancer screening) • Increasing effectiveness of referrals to Mental Health Nurse, Social Worker. The A2C team will identify and try out practice and system changes after the physician has worked down the bad	Revisit rate to end of Q3 was 4.2, which is above industry benchmark of 3.19. This will be measured quarterly going forward as a process indicator.

	backlog.	

Definitions:

1. 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.
2. Bad back log consists of all appointments booked by clients into the future due to lack of availability of earlier appointments.