Unison
Health & Community Services

2016/17 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	Improve rate of cancer screening.	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	% / PC organization population eligible for screening	See Tech Specs / Annually	91972*	CB	CB	Performance at this site is currently unavailable due to an error in the Business Intelligence Reporting Tool (BIRT). The error should be corrected by Q1. After the error is corrected, the target will be set.	1)Conduct data clean-up	Extract list of clients who are not up-to-date with FOBT and review charts to identify reasons and correct data entry errors	# of reasons identified for which one or more clients were not up-to-date with FOBT testing (i.e. types of errors)	Improve the accuracy of the list of KR clients who are eligible for screening	This will be done at all Unison sites. For KR site, it will be done prior to starting
									2)Bring together a QI team for cancer screening (CS) at 1 site, Keele-Rogers (KR)	Create a SIPOC (high level process map) to identify a QI team	# of staff who have been given training - in pursuit of qualitative improvement in QI knowledge	Team identified; members include a representative of all those who have a role in CS; QI	This process is the focus of the West End Quality Improvement Collaborative
									3)Develop a current state process map for CS with Unison KR site QI team	Develop current state process map	# of high impact gaps identified and reduced at KR site	Decrease the number of gaps in KR site's current state cancer screening process	Each CHC within the WEQIC will come up with its own process map, list of gaps
									4)Create a list of all KR clients who are eligible for screening	Criteria to pull a list from the EMR will be identified	# of KR clients who have been identified as eligible and offered an opportunity for screening	Identify KR clients who require screening	
									5)Create a measurement plan	Create a group of measures that are directly linked to CS; create an operational definition for each measure; identify the data source and method of collection	# of standardized data elements identified	Establish a consistent way of collecting and reporting on data	Individual CHCs in WEQIC will choose a group of measures that is appropriate to
		Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years	% / PC organization population eligible for screening	See Tech Specs / Annually	91972*	CB	CB	Performance at this site is currently unavailable due to an error in the Business Intelligence Reporting Tool (BIRT). The error should be corrected by Q1. After the error is corrected, the target will be set.	1)Conduct data clean-up	Extract list of clients who are not up-to-date with Paps and review charts to identify reasons and correct data entry errors	# of reasons identified for which one or more clients were not up-to-date with Pap tests (i.e. types of errors)	Improve the accuracy of the list of KR clients who are eligible for screening	This will be done at all Unison sites. For KR site, it will be done prior to starting
									2)Bring together a QI team for cancer screening (CS) at 1 site, Keele-Rogers (KR)	Create a SIPOC (high level process map) to identify a QI team	# of staff who have been given training - in pursuit of qualitative improvement in QI knowledge	Team identified; members include a representative of all those who have a role in CS; QI	This process is the focus of the West End Quality Improvement Collaborative
									3)Develop current state process map with Unison KR QI Team	Develop current state process map	# of high impact gaps identified and reduced at KR site	Decrease the number of gaps in KR site's current state cancer screening process	Each CHC within the WEQIC will come up with its own process map, list of gaps
									4)Create a list of all KR clients who are eligible for screening	Criteria to pull a list from the EMR will be identified	# of KR clients who have been identified as eligible and offered an opportunity for screening	Identify KR clients who require screening	
									5)Create a measurement plan	Create a group of measures that are directly linked to CS; create an operational definition for each measure; identify the data source and method of collection	# of standardized data elements identified	Establish a consistent way of collecting and reporting on data	Individual CHCs in WEQIC will choose a group of measures that is appropriate to

		Percentage of women aged 50-74 years who received or were offered a mammogram in the previous two years.	% / PC organization population eligible for screening	See Tech Specs / Annually	91972*	CB	CB	Performance at this site is currently unavailable due to an error in the Business Intelligence Reporting Tool (BIRT). The error should be corrected by Q1. After the error is corrected, the target will be set.	1)Conduct data clean-up	Extract list of clients who are not up-to-date with mammograms and review charts to identify reasons and correct data entry errors	# of reasons identified for which one or more clients were not up-to-date with mammograms (i.e. types of errors)	Improve the accuracy of the list of KR clients who are eligible for screening	This will be done at all Unison sites. For KR site, it will be done prior to starting
									2)Bring together a QI team for cancer screening (CS) at 1 site, Keele-Rogers (KR)	Create a SIPOC (high level process map) to identify a QI team	# of staff who have been given training - in pursuit of qualitative improvement in QI knowledge	Team identified; members include a representative of all those who have a role in CS; QI	This process is the focus of the West End Quality Improvement Collaborative.
									3)Develop current state process map with Unison KR QI Team	Develop current state process map	# of high impact gaps identified and reduced at KR site	Decrease the number of gaps in KR site's current state cancer screening process	Each CHC within the WEQIC will come up with its own process map, list of gaps
									4)Create a list of all KR clients who are eligible for screening	Criteria to pull a list from the EMR will be identified	# of KR clients who have been identified as eligible and offered an opportunity for screening	Identify KR clients who require screening	
									5)Create a measurement plan	Create a group of measures that are directly linked to CS; create an operational definition for each measure; identify the data source and method of collection	# of standardized data elements identified	Establish a consistent way of collecting and reporting on data	Individual CHCs in WEQIC will choose a group of measures that is appropriate to
	Improve rate of HbA1C testing for diabetics	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months	% / All patients with diabetes	Ontario Diabetes Database, OHIP / Annually	91972*	CB	CB	This indicator is new. Prior to setting a target, we would like to run a report, analyze the results and assess where we are at with HbA1Cs for primary care clients.	1)Bring together a primary care QI team for HbA1Cs	Create a SIPOC (high level process map) to identify a QI team	scope of QI project; # of staff on QI team	Scope determined: Unison-wide or single site or single provider(s); team identified;	
									2)Create current state process map with HbA1C QI Team	Develop current state process map	# of high impact gaps identified and reduced	Decrease the # of gaps in work processes related to HbA1Cs by end of Q3	
									3)Create a list of all diabetic primary care clients aged 40 and over	Criteria to pull a list from the EMR will be identified	# of primary care clients identified as part of the denominator of this measure, who have not had 2 or more tests in the past 12 months	Identify diabetic primary care clients who require tests	Consider whether primary care clients who are also DEP clients are more likely to
									4)Create a measurement plan	Create a group of measures that are directly linked to HbA1Cs; create an operational definition for each measure; identify the data source and method of collection	# of standardized data elements identified	Establish a consistent way of collecting and reporting on data	
Equitable	**Improve Rate of Cancer Screening**	% of clients with 1 or more health equity barriers to screening who are successfully screened	Number / PC organization population eligible for screening	See Tech Specs / April 1, 2017 - March 31, 2018	91972*	CB	CB	Tech Specs will have to be developed. Given the state of Unison's socio	1)Review CS rates for differences that may be attributable to key socio-demographic indicators such as income or language	Pull lists of eligible clients who have declined or accepted but not completed screening; analyze the lists for trends in socio-demographic indicators; identify potential activities to counter access barriers	% of records of eligible clients who have declined or accepted but not completed screening that were analyzed from a health equity perspective	Improve CS rates for clients identified	This will be the first year we assess our CS data from a health equity
Patient Experience	**Improve Patient Experience: Opportunity to ask questions**	Percent of respondents who responded positively to the question: "When you see your	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91972*	88.13	88.13	Maintain performance. In 2014, performance on a similar	1)Maintain performance	Maintain performance	Maintain performance	Maintain performance	Maintain performance
	Improve Patient Experience: Patient involvement in decisions about care	Percent of patients who stated that when they see the doctor or nurse practitioner, they or	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91972*	82.25	86.00	Source of this target is Measuring Up 2015.	1)Explore best practices for client self-management that could be tested as change ideas	Managers will create list of practices by Unison providers in Q1; IPSP team will obtain information from other organizations in Q1; identify ideas to test; design tests of change;	# of primary care organizations and individual providers consulted; # of change ideas identified	2-4 change ideas selected	

	Improve Patient Experience: Primary care providers spending enough time with patients	Percent of patients who responded positively to the question: "When you see your doctor or	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91972*	87.19	87.19	Maintain performance. In 2014, performance on a similar	1)Maintain performance.	Maintain performance.	Maintain performance.	Maintain performance.	Unison recently standardized the duration of primary care appointments
	Receiving and utilizing feedback regarding patient/client experience with the primary health care organization	Percent of clients who stated that they know how to make a suggestion or a complaint	% / Clients	In-house survey / 2016-17	91972*	60.35	70.00	Since this is Unison's own question, we did not look for a benchmark in setting our target.	1)Bring together a QI team (with client members) on suggestions and complaints	Create a SIPOC (high level process map) to identify a QI team	Team identified; # of staff on team; # of clients on team	Team identified; members include both staff and clients; QI capacity of team members	
									2)Brainstorm and develop change ideas to test	Brainstorm ideas; analyze and choose most feasible ideas	# of change ideas identified; 2-4 change ideas tested	Expand ways for clients to give suggestions and complaints; improve	
Timely	**Improve 7 day post hospital discharge follow-up rate for selected conditions**	Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions.	% / PC org population discharged from hospital	DAD, CIHI / April 2014 – March 2015	91972*	30.56	40.00	Our change idea for this indicator is aimed at improving Unison's performance. If we can reduce our delays by 50%, assuming other causes of delays are constant, we can achieve the target.	1)Require admin staff person to book follow-up appointment immediately upon receipt of discharge report from hospital	Revise internal tracking database; revise work process for responsible admin staff; train and monitor work of responsible admin staff; analyze quarterly reports from internal tracking database	# of follow-up appointments successfully booked within 7 days; # of follow-up appointments successfully booked within 7 days that actually occurred (client did not no show, reschedule, etc.); Reasons (types and #s of each type) why follow-up appointments could not be	Increase in # of appointments booked within 7 days of the date that the report is	
									2)Give business cards of provider to each client; ask them to let us know if they are admitted/discharged from hospital	Manager schedules and gives reminders to providers in team meetings. Manager ensures all providers have business cards	# of reminders per team/site	Written evidence (i.e. team minutes) document that team received reminder at least 2	
									3)Provide feedback to hospitals on late discharge reports	Quarterly report produced by IPSP team for Senior Director Primary Health Care, who will follow up with hospitals	# of late discharge reports per hospital per quarter; # of hospitals receiving a report of late discharge reports from Unison	Hospitals examine and improve their own systems/processes for discharge	
	Improve timely access to primary care when needed	Percent of patients/clients who responded positively to the question: "The last time you were	% / PC organization population (surveyed sample)	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period available)	91972*	33.33	40.00	Many BF clients are seniors, frequently accessing care, who have	1)Improve booking procedures for primary care appointments at BF site based on feedback from special client experience	Conduct special client experience survey during Q1; analyze results and identify/make changes to booking procedures with aim to increase satisfaction; conduct special client experience survey again during Q3	% of all clients booked for a "within 48 hours appointment" who report having made their appointment "earlier today" or "1 day ago" and who are 'very satisfied' or 'somewhat satisfied'	70% of all clients booked for a "within 48 hours appointment" who report having	BF site's advanced access system is a hybrid, with a percentage of