2017/18 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**	Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions.	% / Discharged patients with selected HIG conditions	CIHI DAD / April 2015 - March 2016	91972*	35.4	40.00	A target has been entered because it is a required field. Resource limitations do not permit Unison to continue to maintain its own database and workflow for tracking process measures. We will use Practice Profile data received from ICES. However, this data is lagging, hence, it cannot appropriately be used for QI. Target setting for this item makes less sense to us in this context.	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 appointments at the smallest of 4 sites, we may see minor improvements in the 7-day post hospital discharge follow-up rate for selected conditions. As we improve access to primary care we expect this rate to improve.
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 median	91972*	69	77.00	Based on "best in class" median from Q3 2016-17 from other CHCs participating in WEQIC. This median was achieved by Davenport Perth Neighbourhood Centre.	1)Identify optimal recall process	1. Develop recall list for Paps (to be done with/by QuIcKeR QI Team, and then spread within the KR Team); 2. Develop workflow for Paps (to be done with/by QuIcKeR QI Team, and then spread within the KR Team)	# of clients due for screening who are successfully booked	To increase the number of clients screened	A PDSA was done last year, and results looked promising, but there were some problems with data collection.
									2)Take history at 1st medical appointment.	1. Set documentation standards and train RPNs/RNs (to be done by KR MDs); 2. Revise schedules to allow back-to-back appointments (to be done by KR Admin Assistant based on approval/direction from Manager).	% of new clients eligible for screening that had screening history taken at 1st visit before/after methods implemented	1. Improve documentation of CS that is up to date. 2. Improve efficiency of appointments through delegation.	Process measure requires collection of baseline data.

									3)Develop and share a dashboard to monitor sustainability of improvements.	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 continued performance or increase in CS rates.	Unison will collect the data for the providers.
	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 median	91972*	53	63.00	Based on "best in class" median from Q3 2016-17 from other CHCs participating in WEQIC. This median was achieved by Four Villages CHC.	1)Identify optimal recall process	1. Develop recall list for FOBTs (to be done with/by QuIcKeR QI Team, and then spread within the KR Team); 2. Develop workflow for FOBTs (to be done with/by QuIcKeR QI Team, and then spread within the KR Team)	# of clients due for screening who are successfully booked	To increase the number of clients screened	A PDSA was done last year, and results looked promising, but there were some problems with data collection.
									2)Take history at 1st medical appointment.	1. Set documentation standards and train RPNs/RNs (to be done by KR MDs); 2. Revise schedules to allow back-to-back appointments (to be done by KR Admin Assistant based on approval/direction from Manager).	% of new clients eligible for screening that had screening history taken at 1st visit before/after methods implemented	1. Improve documentation of CS that is up to date. 2. Improve efficiency of appointments through delegation.	Process measure requires collection of baseline data.
									3)Develop and share a dashboard to monitor sustainability of improvements.	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 continued performance or increase in CS rates	Unison will collect the data for the providers.
Equitable	**Equity**	Identify equity factors that influence access to cancer screening based on each CHCs' analysis of equity data for the Q ending Sept. 30, 2016	Number / On going primary care clients	Analysis of in house data pulled from LMIS / July 1 2016 to Sept. 30 2016	91972*	CB	CB	Qualitative analysis to understand the data. We already collected baseline.	1)Further analyze equity data (from Q ending Sept. 30, 2016) to determine equity factors that prevent people from accesing screening.	Better understand which population, in each participating CHC, is vulnerable to not being screened and why they are not being screened.	Findings/themes from qualitative analysis of identified barriers.	Better understand barriers to screening.	In last year's workplan we collected baseline (based on our population). We will further analyze this to understand barriers.
									2)Identify projects based on results of change idea # 1.	Identify a project, for the population identified above, to increase cancer screening rates.	Findings/themes from qualitative analysis of identified barriers.	Determine a project to address identified barriers.	

Patient-centred	**Person experience**	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?	% / PC organization population (surveyed sample)	In-house survey / April 2016 - March 2017	91972*	83.17	85.90	Source of this target is Measuring Up, 2016	1)Create a flyer or poster to communicate a message to clients, such as "You have a right to participate in and make decisions about your healthcare."	Plain language flyer or poster with translation into common languages Development process to include review and input by primary care teams	Flyer developed with teams input # of flyers posted	To take a small initial step towards increased awareness of this right that clients have	
		Percentage of clients who stated that they know how to make a suggestion or complaint	% / Clients	In house data collection / April 1 2016 - March 31 2017	91972*	65.64	70.00	Since this is Unison's own question, we did not look for a benchmark in setting our target.	1)Spread learning from 2016-17 QI project	Telephone hotline spread to all sites	1. # of clients who take paper slip with telephone hotline number 2. # of clients who select new telephone hotline option 3. # of appointment cards distributed with telephone hotline number	To spread a change idea that seemed successful in one site to other sites.	Unison will get a new phone system in mid 2017. As the new system is set up at each site, the telephone hotline will be set up and promoted.
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 / April 2016 - March 2017	91972*	26.09	39.00	Unison's current performance across all sites has been used as the target.	1)Bring together an Access to Care (A2C) QI team.	Create a SIPOC (high-level process map) to identify a QI team	# of people who have been given QI training	Increase staff's QI capacity by end of May 2017	This project is the focus for year two for the West End (WE) QI Collaborative. Each CHC will have a customized QI team based on each CHC's needs and resources. At Unison the project will focus on one site, Bathurst-Finch.
									2)Collect and understand MD/NP supply and demand data.	1. Create and apply supply and demand tool in order to analyze and understand where to focus our improvement efforts. 2. Manually collect supply and demand data for the provider on the QI team for a period of four to six weeks to understand the supply and demand patterns to inform improvement to the schedule.	Collect supply and demand data for each MD/NP in the clinic.	To balance supply and demand for MD/NPs.	Each CHC will use HR, NOD and financial data in order to calculate supply and demand for the MD/NPs.

									3)Collect TNAA data and analyze.	1. Create a common understanding of TNAA definition. 2. Create a template to collect TNAA. 3. Create run charts to understand TNAA data over time, in order to interpret TNAA data and determine best possible target for providers in the practice.	Number of days to TNAA	To improve the number of days to TNAA for each MD/NP	
									4)Increase MD/NP supply of appointments.	1. Test change ideas on the schedule of the MD/NPs on the QI team. 2. Apply the learning to other MD/NPs as appropriate.	Number of available appointments	To increase the number of available appintments for the clients.	The driving force behind WEQIC's common QIP in year 2 of the collaboration is to focus on A2C to address the need for each CHC within the WEQIC to meet and maintain panel targets in an environment where we are facing increased demand for our services.
									5)Appropriate use of MD/NPs' time	1. Analyze and understand pressures from internal and external demand on the QI provider's schedule to determine changes for improvements. 2. Test change ideas for improvements. 3. Apply the learnings to other MD/NPs as appropriate. 4. Measure revisit rate based on client context.	Revisit rate	To optimize the use of MD/NPs time.	Same comment as in change idea # 4 above.