Access and Flow

Measure - Dimension: Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Patient/client perception of timely access to care: percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted	O	% / PC organization population (surveyed sample) Primary care clients	In-house survey / Most recent consecutive 12-month period	65.00	70.00	In 2019, 74% of clients responded 'yes' to this question on our annual client experience survey. In our most recent client survey in 2022, this had declined to 65%. In the interim there was the pandemic. We aim to go back up to levels of positive client experience from 2019 or even exceed them, but will need to do this in steps.	

Change Ideas

Change Idea #1 Spread ENCODE prompts to encourage and remind providers to refer their clients to group programs that can intensify support to them with mental health, chronic disease, etc. (thereby potentially reducing number of primary care appointments needed/requested).

Methods	Process measures	Target for process measure	Comments
Implement PDSA using ENCODE prompts that refer to Diabetes Education Program groups	# of referrals from primary health care providers to group program(s) of DEP before/after implementation of ENCODE prompt; # of primary care appointments of referred clients before/after referral to DEP group program(s)	Referrals from primary health care providers to DEP group(s) are doubled compared to before implementation of ENCODE prompt PDSA	Although there is no guarantee that a client will accept a referral to a group, we know from the literature that clients are more likely to accept a recommendation from their primary care provider. The 2nd process measure has been selected for insight into the impact of the PDSA on primary care access but it will take some effort and time (one year or more) to obtain enough data to be analyzed.

Change Idea #2 Facilitate access to appointments for existing primary care clients

Methods	Process measures	Target for process measure	Comments
Collect, review and analyze relevant data; share findings with providers/team; work with providers to comb schedules and make adjustments if possible to benefit access	Third Next Available Appointment (TNAA) rates; appointment wastage measures; client experience survey rates; # of access-related concerns/complaints received from clients	Maintenance of existing rates of access-related concerns/complaints to less than 1, on average, per quarter; maintenance of or reduction to existing median TNAA rates; appointment wastage minimized; increase in positive client experience in response to standardized question	This is a balancing measure for the other measure/project under Access/Flow/. The Bathurst-Finch site has been identified to implement this change idea. When we conduct our 2024 client experience survey, we will survey more clients compared to 2022, and we expect that a bigger survey sample, in addition to being 2 more years out of the pandemic, will increase the positive feedback rate from clients.

Measure - Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Panel Size (as per "2023-24 MSAA Indicator Technical Specifications") as follows: Numerator: Number of clients that have had an encounter with a Physician, Nurse Practitioner, Registered Nurse, Registered Practical Nurse, or Physician Assistant within the last 3 years AND have had an encounter with a Physician or Nurse Practitioner anytime. Denominator: Target Adjusted Panel Size for the member organization = 1137.5/ member organization specific Standardized ACG Morbidity Index (SAMI) x FTE primary care providers (Physicians + Nurse Practitioners).	C	% / PC patients/clients See Numerator description under Measure / Indicator. Note: This is in place of suggested optional indicator "# of new clients/patients/enrolment"	Local data collection / April 1 to March 31	82.00	85.00	Although Unison's performance overall on this indicator was 93.46% as of Q3 2023-24, 2 of our 5 sites are below Unison's 85% MSAA target. We will focus on one of these sites, with the aim that they will take in enough additional new clients to be able to meet the Unison target. (There is also a balancing measure for this project/site around TNAA that is elsewhere in the Access and Flow section of this work plan.)	

Change Ideas

Change Idea #1 Implement planning session with the team at the site to discuss how they will intake additional new clients to move closer to target and prevent attrition.

Methods	Process measures	Target for process measure	Comments
Decision Support Specialist will create monthly panel and attrition reports for each of this site's providers.	Manager to review and discuss individual panel size and attrition with providers monthly, assessing if the plan is proceeding well or needs any changes.	New client intake net of attrition closes gap between current panel size and target panel size.	The Bathurst-Finch site will implement this change idea.

Change Idea #2 Prevent attrition at the site by prioritizing cancer screening recalls for clients who are due to fall off of panel in the coming year.

Methods	Process measures	Target for process measure	Comments
Use MSAA recall list from Decision Support Specialist to identify clients due to fall off panel in next quarter and due for one or more types of cancer screening; prioritize these clients for more attention in terms of recalls process (exact process TBD)	# of clients lost to attrition per month and per quarter.	Quarterly attrition rates for the team/site are below the average/median attrition rates of the previous 12 quarters (Q3 2020-21 to Q4 2023-24).	The Bathurst-Finch site will implement this change idea.

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of ongoing primary care clients aged 50 to 74 who received a FIT test in the previous 2 years, or a flexible sigmoidoscopy within the last ten (10) years, or a colonoscopy in the last ten (10) years.	C	% / PC organization population eligible for screening Screen eligible clients aged 50 to 74 in all WEQI CHCs	Local data collection / January 1 - December 31	50.00	55.00	Based on efforts to improve colorectal cancer screening completion rates that Unison began in 2023-24, we know that it will be challenging to increase these rates. In 2023-24, we increased our rates from 48.2% in Q1 to 49.97 in Q3, an increase of 1.77%. We don't have enough quarters of data to confirm if the 1.77% increase is a sustainable shift in the median. Therefore a 5% increase for 2024-25 is a stretch target. Please note: This is a WEQI project and WEQI has set a 5% increase as our overall target for our CHCs combined. In keeping with this Unison has set a 5% target for improvement.	Davenport-Perth Neighbourhood & CHC, Access Alliance Multicultural Health and Community Services, Parkdale Queen West CHC, Regent Park CHC

Change Ideas

Change Idea #1 Develop a measurement plan that will aggregate colorectal cancer screening done rates for the 5 WEQI CHCs			
Methods	Process measures	Target for process measure	Comments
Create aggregate measures that are directly linked to colorectal cancer screening; create an operational definition for each measure; identify the data source and method of collection	# of standardized data elements identified	Create a consistent way of collecting and reporting on data	Support for this change idea will be provided through WEQI Project Manager and WEQI Planning Table; Unison has 5 sites offering primary care; for this project with WEQI we will involve our Keele-Rogers and Jane-Trethewey sites in 2024-25.

Change Idea #2 Stratify aggregated data of all 5 CHCs in WEQI, by health equity variables			
Methods	Process measures	Target for process measure	Comments
Data extraction and presentation of findings to be assigned to Decision Support Specialists/Data Management Coordinators for each CHC for completion and sharing with WEQI in Q3 2024-25; better understand which populations are vulnerable to not being screened	Findings/themes from qualitative analysis of identified barriers.	Better understand barriers to screening.	Same as Change Idea # 1

Change Idea #3 Bring together a QI team with representation from across the 5 WEQI CHCs			
Methods	Process measures	Target for process measure	Comments
Project leads and participants identified from two Unison sites, with development of communication plan for Unison as whole; kick-off WEQI team meeting planned/held; plan created for ongoing WEQI coordination to share information, strategize and discuss learnings	Kick-off meeting implemented; # of provider/staff types at Unison/per CHC/overall on the WEQI team; attendance data at WEQI meetings	At least 2 staff per CHC participate actively on the WEQI team, including 1 healthcare provider per CHC; WEQI team meets as appropriate	Same as Change Idea # 1

Change Idea #4 Conduct 3 tests of change			
Methods	Process measures	Target for process measure	Comments
Share information with WEQI team including 2023-24 data and PDSAs, best practices, etc.; by use of QI tools, processes and conversations, identify and write up 3 tests of change; assign 1 test of change to each WEQI CHC; implement PDSAs within QI teams at each CHC/site, implementing huddles as needed	3 'great ideas' identified and written up as 3 PDSAs; each WEQI CHC implements 1 of 3 PDSAs; findings of PDSAs shared with WEQI team	At least 1 of 3 great ideas tested results in improved colorectal screening completion rates at CHC(s) where it is tried	Same as change idea # 1

Change Idea #5 Scale up most successful change(s)			
Methods	Process measures	Target for process measure	Comments
Share experiences and learnings from PDSAs at WEQI table; spread most successful change idea(s) to one or more other CHCs	# of completed tests of change deemed successful (and unsuccessful); # of meetings held for learning exchange about PDSAs; other CHCs in WEQI adopt successful change(s)	# and type of successful change idea(s) identified; # of other CHCs in WEQI that proceed to adapt/adopt successful change idea(s)	Same as change idea # 1

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	O	% / PC organization population (surveyed sample) Primary care clients	In-house survey / Most recent consecutive 12-month period	79.44	82.00	In 2019, our performance on the indicator was 84% on our client experience survey. In our most recent survey, this declined to 79%. In the interim was the pandemic. We would like to look at our performance in 2024 and then select Change Ideas / decide on Action Plans.	

Change Ideas

Change Idea #1 Increase number of clients surveyed as part of 2024 Unison client experience survey.

Methods	Process measures	Target for process measure	Comments
Recruit, orient and hire staff to coordinate work of surveyors; recruit, orient and hire 4 full-time surveyors (to collect data over 3 weeks); monitor total # of surveys collected by site daily/weekly and adjust locations/schedules as appropriate; identify Administrative Assistants to input survey data.	# of surveyors hired; # of hours of surveying time; # of surveys collected per site per day; # of valid surveys obtained	A greater number of surveyors and surveying time compared to 2022 client experience survey, combined with the return to normal services post-pandemic, will increase number of surveys collected to at least 400	Total Surveys Initiated: 214 Surveying takes place over a 3-week period in waiting rooms and groups. Clients will have the option to complete the survey electronically on tablets, but we have found in the past that many clients prefer paper.

Change Idea #2 Review and analyze responses to this question/indicator from the 2024 client experience survey

Methods	Process measures	Target for process measure	Comments
Contracted staff to be hired to coordinate client experience survey, which will include review, analysis and reporting on the survey results	# of surveys (overall and by site) collected from clients who have seen their MD or NP in the past year	At least 400 valid surveys collected overall from clients who have seen their MD or NP in the past year	212 valid surveys were collected in 2022 from clients who have seen their MD or NP in the past year. We think that a larger survey sample size in 2024, when we will be 2 more years out of the pandemic, will show increased positive response. After the survey, we will develop appropriate change ideas/action plans.