Case Study: West End Quality Improvement Collaboration

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Abstract

The West End Quality Improvement Collaboration is a partnership of six community health centres in Toronto that was established with the goal of increasing the efficiency and effectiveness of service delivery by working alongside one another on quality indicators. Community health centres are funded to serve the most marginalized populations, which include people living in poverty, homeless people, street-involved people, newcomers and lesbian, gay, bisexual, transgender, queer (or questioning) people. In year 1 of the initiative, we chose to focus on cancer screening rates. After the results were analyzed and we had started to see improvement in these rates, we overlaid an equity analysis to ensure that our marginalized populations were screened at similar rates. This case study will examine the steps taken to get to these outcomes and the lessons learned for collaborative practice for quality improvement. This includes understanding the importance of collaboration, including group dynamics and a culture of learning from each other, investing time and the role of expertise, all with the ultimate result of improved client care.

Background

The West End Quality Improvement Collaboration (WEQI Collaboration) was established in 2015. It includes six community health centres (CHCs) in Toronto's west end: Access Alliance Multicultural Health and Community Services, Davenport-Perth Neighbourhood and Community Health Centre, Parkdale Queen West Community Health Centre, The Four Villages Community Health Centre, Unison Health and Community Services (and, previously, Stonegate Community Health Centre). The overarching goal of the WEQI Collaboration has been to create shared quality improvement (QI) capacity for its members. At the outset, the WEQI Collaboration had several key objectives:

- to improve each participating CHC's performance and strengthen their internal QI capacities, processes and tools
- to jointly hire and fund a QI specialist to support the collaboration, while also working toward developing and documenting best practices for performance improvement
- to develop a shared change management culture so as to allow the CHCs to work toward having consistent improvement goals and to align mandatory reporting, such as the annual quality improvement plans that each CHC submits to Health Quality Ontario (HQO).

The WEQI Collaboration emerged from a long history of collaboration among the above-mentioned CHCs. This history, organizational nimbleness and a shared system of values and ethics enabled the formation of the collaboration. The catalyst for formalizing the collaboration was a growing governmental

interest in primary healthcare in Ontario, with a push toward data sharing among organizations for the purposes of comparison and improvement. Strong relationships enabled these CHCs to successfully weather the inevitable group dynamics involved in forming a new partnership with its own particular objectives and projects.

Description of the Work

Phase I: Cancer screening rates

In the first year of the WEQI Collaboration initiative, the teams agreed to focus on improving their cancer screening rates. Cancer screening rates are accountability indicators of Ontario CHCs within their accountability agreement with their Local Health Integration Networks. Cancer screening is also an equity issue. As HQO (2016) reported in *Income and Health: Opportunities to Achieve Health Equity in Ontario*, cervical cancer screening rates by neighbourhood correspond directly to income level. In the poorest neighbourhoods, only 54.3% of women had cervical cancer screening between 2011 and 2013, compared to 61.8% across Ontario and 66.7% in the wealthiest neighbourhoods. Because CHCs are mandated to serve people and populations who experience barriers to optimal health, it is essential that efforts to improve screening rates be grounded in addressing the social determinants of health (Rehel 2017).

The overarching goals for the WEQI Collaboration's year 1 cancer screening initiative were to gain an understanding of the barriers to cancer screening, improve clients' experience of care and increase the number of screened clients. During the first year of the initiative, each CHC developed a current state cancer screening process map of their existing screening programs for breast, colorectal and cervical cancer. There was a lot of work that went on internally at each CHC. Each team identified gaps and wastes in the process, created an aim statement and a project charter, developed a driver diagram and completed root cause analysis and a sustainability assessment. Teams at each CHC identified and tested change ideas and identified key processes for improvement. The collaboration then organized and held a kaizen learning event where the most promising practices and findings from each CHC were shared, and participants (including clinical providers, administrative staff and managers) from all CHCs developed a common future state process map. Another layer of analysis was to ensure that all of the populations served were screened at equitable rates. This is described in more detail later in this article.

Phase II: Access to care

The focus of the work starting in 2018 and continuing to the present is on access to primary care. This is a more intensive project than cancer screening because of the range and number of complex factors that impact on access to care, such as monitoring client flow to prevent bottlenecks and addressing attrition and no-show rates. During the first year, intensive work went into developing definitions and tools to accurately and consistently capture third-next-available appointments, as well as supply of appointments versus demand for appointments for clients. Each CHC formed a new team to learn about QI, to gather and review data and to begin to develop and test change ideas. As with cancer screening, teams at each CHC have identified potential improvements, such as group appointments, and implemented tests of change. Through monthly meetings between managers from all CHCs and between all CHCs' data specialists, each CHC is also learning from the efforts and experiences of the others to inform their own work. With increased knowledge from the cancer screening project about the time, effort and resources required to identify successful changes, spread them and make them stick, the WEQI Collaboration keeps the project moving forward through each organization's team work with the QI specialist and through regular monthly meetings and related follow-up.

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Key Factors Enabling Collaboration

Data quality

Early on, the WEQI Collaboration leadership recognized that the participating CHCs would need to develop a shared understanding of data elements and reporting. Technical specifications had been interpreted and applied differently among them, making comparison difficult. This meant that a process had to be undertaken whereby language and definitions were tightened. Lengthy, detailed discussions involving the QI specialist, managers and data specialists were required to develop a measurement plan for the cancer screening project. As there were also documentation errors, data had to be cleaned up at each CHC for all clinical providers who conduct and document cancer screening. This intensive work enabled the collaboration to eventually get to a place where they could look at each CHC's data and have confidence in their accuracy and an understanding of their comparability to other collaboration CHCs' data.

Health equity

Health equity is an important consideration for CHCs, which are mandated to serve people and populations who experience barriers to health and well-being. Once the cancer screening project was well under way, the WEQI Collaboration started working with existing sociodemographic data to understand differences in cancer screening based on particular demographic characteristics as well as gaps or successes in cancer screening in relation to equity. Analysis was done based on the indicators CHCs had the most confidence in, including income, education, insurance status and place of birth. The data

analysis showed that many CHC clients are undergoing cancer screening, regardless of their sociodemographic complexity.

Places where improvements needed to be made were identified – both at individual CHCs and among all of the CHCs. The largest CHC in the collaboration had statistically significant findings that suggested areas for improvement that were shared to help inform and guide the other CHCs. Some CHCs identified and tested Plan–Do–Study–Act processes (PDSAs) based on this equity analysis. One of these PDSAs explored whether a more personal invitation for screening or an offer to cover transportation costs would increase cervical and colorectal cancer screening by lower-income women. The change ideas and the results of tests were shared. The in-depth analysis also enabled some individual providers to identify practice improvements, such as taking extra care to check cancer screening status of their clients from particular racial/ethnic groups with lower than targeted rates of screening. As part of the access to care project, the WEQI Collaboration is continuing to apply a health equity lens to our QI projects.

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Lessons learned

There were several factors that enabled successful collaboration and played a key role in the success of the WEQI Collaboration:

1. *Expertise.* An important ingredient in the group's success was bringing in a QI expert to build each team's QI knowledge and skills. The QI specialist also facilitated shared insights, ideas and information between CHCs and kept the various stakeholders moving forward in a thoughtful, organized way.
2. *Standardization.* To collectively improve, collaborators need to know that they are measuring the same things in the same way, working toward the same goals and applying the same tools. It is essential that they standardize their measures, their data and their definitions. Standardized knowledge, data, measures and definitions were crucial and took significant time and effort to establish. Even in cases where the WEQI Collaboration started with a technical specification that was created specifically for the CHC sector, differences in interpretation had to be discussed and aligned.
3. *Culture.* For QI efforts to be successful, a team needs to foster a culture of knowledge sharing and QI both internally and externally. In individual CHCs, the QI specialist helped to support a work culture of "learning by doing" – by supporting project teams to do real QI projects. At the WEQI Collaboration tables, the CHCs were able to share learnings from their individual project teams. This gave them greater confidence in identifying gaps, a stronger base for a culture of learning and a set of strengths to build on. Being comfortable and willing to share challenges, frustrations, failures and untested ideas is an important feature of creating a productive QI culture within a partnership, which requires trust as a condition that must either already exist or be developed. The WEQI Collaboration has learned as much or more from ideas that were not feasible or unsuccessful.
4. *Whole-team involvement.* Effective collaboration happens at all levels, including managers, data specialists and front-line staff. It also includes linkages across these levels, which are important to establish and maintain forward momentum. Whole-team involvement enabled a number of different staff within each CHC to develop QI skills. This built excitement for QI within each CHC. In addition, some CHCs have also been able to apply QI skills gained through the collaboration to projects in other parts of their organizations.
5. *Leadership.* Involving clinical directors (managers) meant that strategic considerations were always at the forefront. Although buy-in and support at the most senior levels of each CHC have been essential to establishing, setting the overall direction for and sustaining the collaboration, having the clinical directors at the forefront with their particular blend of strategic and operational knowledge has been essential to driving the QI work within their CHCs and within the collaboration.

Discussion

A collaboration can be more than the sum of its parts. By building on strengths, collaboration among teams can increase each one's capacity for QI, so they see better results from their QI efforts. Harmonizing their approaches to care is a means of scaling up and spreading best practices to benefit a larger number of patients. Improving data quality and standardizing measurement allow teams to compare themselves to their peers in meaningful ways so they can accurately identify their strengths and opportunities for improvement.

QI can and should be grounded in equity. Gaps in care are most profound for individuals and groups who experience barriers to care. Understanding which barriers are most relevant to a particular health outcome allows interventions to be targeted in a way that addresses those barriers. Again, measurement and data quality are essential: collecting demographic and equity data in a thorough and consistent way makes it possible for teams – individually and collectively – to better understand and amend the ways in which inequity affects health. HQ

References

Health Quality Ontario (HQO). 2016. *Income and Health: Opportunities to Achieve Health Equity in Ontario*. Toronto, ON: Queen's Printer for Ontario. Retrieved March 5, 2019. <http://www.hqontario.ca/Portals/0/documents/system-performance/health-equity-report-en.pdf>.

Rehel, J. 2017, May 23. Spotlight on Health Equity: Improving Cancer Screening Rates by Focusing on the Social Determinants of Health. Toronto, ON: Alliance Ontario. Retrieved March 5, 2019. <https://www.allianceon.org/blog/Spotlight-Health-Equity-Improving-cancer-screening-rates-focusing-social-determinants-health>.

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