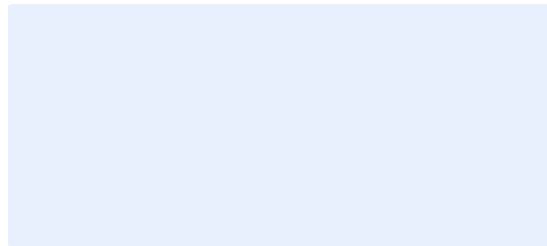


Let's Make Healthy
Change Happen.



Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario



3/30/2017

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

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Overview

The South East Grey Community Health Centre ("the Centre") opened its doors on October 1, 2011.

At the Centre, our vision is "Healthy people, vibrant communities". In order to achieve this goal, we have implemented our strategic directions which place the client in the center of all we do, which is then linked to our five strategic priorities:

Health Equity - Community - Innovation - Quality - Accountability

Placing the patient first in everything that we undertake helps to guide our actions and our decision-making. Our Mission is "High Quality, Equitable Healthcare for All".

Our 2017-2018 Quality Improvement Plan (QIP) will build upon previous years' work and will form the framework for how we measure our success and continuously improve our service offering. The dimensions of quality that will receive our primary focus include access, integration and patient-centeredness. Effectiveness and safety will also be integral elements of our quality plan and all of these quality elements align with our strategic directions and the SW LHIN IHSP. This year we will focus on achieving the following:

QIP - Primary Focus:

- Timely access to care when needed - we expect to achieve a 97% approval rating from patients who respond through a patient survey that they require same day or next day when needed.
- Timely access to primary care appointment post-discharge through coordination with hospitals - 92% of patients (with selected conditions) who are referred by hospitals to see a practitioner within 24 hours of discharge shall be seen.
- Receiving and utilizing feedback regarding patient/client experience with the primary care health organization - patients shall provide an approval rating of 97% when asked about patient involvement in care decisions, the opportunity to ask questions and having enough time with physician/nurse practitioner.

QIP Integral Elements:

- A balanced budget to ensure our organizational sustainability.
- A 99.2% approval rating from employees when asked whether SEGCHC is a good place to work.
- 98.5% of our clients willing to recommend the SEGCHC services to friends and family in a telephone survey.
- A 25% reduction in ED avoidable visits by CHC patients.
- An influenza screening rate of 57%
- A breast cancer screening rate of 80%.
- A colorectal screening rate of 80%.
- A cervical screening rate of 80%.
- A 100% completion rate of the semi-annual and the annual individual performance management program objectives.

We are confident that we will achieve the goals outlined in our QIP thanks to the dedication of our staff, and volunteers, the commitment of our Board of Directors and the support and collaboration with our community partners.

QI Achievements From the Past Year

As one of the strategic directions of the organization, accountability management is a first priority in everything that we undertake. To ensure that we are able to meet and monitor the objectives identified in our plan we engaged in the phase VI access to care initiative through HQO. We will continue with the work started by the team and roll out lessons learned to the rest of the organization.

Our Board Quality Committee was established in 2013. They meet semi-annually to monitor progress and the performance measures will be monitored monthly through the Board.

The SEGCHC received accreditation in August 2016. This process led to the development and implementation of clinical and administrative best practices, policies and procedures.

Annually, the Board approves the goals for the organization. The goals are subsequently cascaded to frontline staff. Each staff person has a Performance Management Program (PMP) which is customized to their specific role in the organization. The S.M.A.R.T. criteria are negotiated and agreed upon and the Supervisor meets with each staff person semi-annually to review their progress against the established performance goals.

A Balanced Score Card is used to track all quality and performance measures for the organization. The Executive Director has five percent (5%) at risk compensation dedicated to the achievement of the objectives.

In 2016-2017 the SEGCHC achieved the following Q3 results:

Cervical Cancer Screen Rate - 80.71%, target for 2016-2017 was 62%
Colorectal Cancer Screen Rate - 83.02%, target for 2016-2017 was 59%
Breast Cancer Screen Rate - 80.75%, target for 2016-2017 was 60%

All of these achievements were due to the implementation of a men's and women's wellness programs.

Additionally, the SEGCHC achieved:

Diabetes Inter-professional Referral Rate - 97.52%, target was 91%
Influenza Vaccination Rate - 80.04%, target was 45%

25,984 patient visits - target is 28,152
Lowest cost/patient visit in Ontario (CHCs)
Lowest cost/patient in Ontario (CHCs)
98.5% patient approval rating
99.2% employee engagement rating

SEGCHC held 116 OTN sessions last year which provides an increase access to service.

All NP's and a physician have been registered and trained for eConsults. eConsults is a secure, web-based tool that allows primary care providers quick access to specialty care for their patients, often avoiding the need for the patient to be referred for a face-to-face visit. Through eConsult, a primary care provider can submit a non-urgent, patient-specific question to a participating specialty. The

request is processed and assigned to an appropriate specialist, who is asked to respond within 7 days (average time to response = 2 days).

Population Health

SEGCHC provides services to residents in our catchment area who do not have access to primary care and who are in one or more of our priority populations. The following is a breakdown of our priority populations and how our organization is working to address the profile of these patients in our program planning and quality improvement activities:

Seniors (65 years of age or older) - Each year we pick a theme; this year's theme is bone health, which starts in April. We have added a 'BMD' indicator to our EMR track. In 2017/18 we are embarking on an osteoporosis strategy in partnership with Osteoporosis Canada. This will be rolled out through Bone Fit (strong bones and falls prevention) and staff and client education. We are providing ongoing sessions through Senior Safety Network. We are partnering with Home and Community Support Services to build a Friendly Visiting program in South-East Grey. SEGCHC is partnering with Alzheimer's Grey Bruce to offer Memory Clinics and Minds in Motion. We have also partnered with Diabetes Grey Bruce to offer the Sit and Get Fit program geared towards seniors. We are currently renovating our Centre's lower level to provide an opportunity to collaborate and co-design programs and services for the seniors of our area.

People who are economically disadvantaged (individuals involved with provincial and federal employment programs, families living in poverty and/or with housing or food securities) - We are active members on the Bruce Grey Poverty Task Force, Income Security Working Group, and Food Security Working Group. From these forums, we are able to determine community needs and establish programs accordingly i.e. our Income Tax Program, Gardening Program and Food Gleaning.

Children and Youth (Newborn to 19 years old) - We are the host agency for the Healthy Kids Community Challenge where we offer free programs and support to promote health and wellbeing for children. We are currently offering six after school programs which promote physical activity and provide nutritious snacks. We offer counselling, nutrition counselling and a Nurse Practitioner at our student clinic located in the local high school. We offer a number of fitness and nutrition class both at the high school and at our CHC. We also offer child psychology services on site.

Individuals and families experiencing mental health and addictions issues - We offer counselling services through the clinic at the local high school where a high number of clients experience mental health and addictions issues. As previously stated, we also offer child psychology services.

Pregnant women and families - SEGCHC offers prenatal care to pregnant women. Pregnant patients have the option to stay with us until being referred to their Obstetrician at 28-34 weeks or being referred to mid-wives around 12-16 weeks. In 2017/18 we are implementing a new mom strategy where our Nurse trained in lactation/breastfeeding and a Dietitian will visit the new mom to provide information on healthy eating and also to address any breastfeeding questions or concerns. Nurse trained in lactation/breastfeeding will also provide lactation and breastfeeding consultation at the clinic. We also refer patients to prenatal courses through Public Health. Babies return to the CHC for care after birth from the referred Obstetrician office or two months from the referred mid-wives for their immunization.

People with physical and mental disabilities - We have a partnership with Hope Haven, a therapeutic riding centre. Through Healthy Kids Community Challenge we will be working with Hope Haven around food security and gardening programs. We are currently developing partnerships with South East Grey Support Service and Participation Lodge.

Equity

In 2017-2018, SEGCHC will continue initiatives which ensure that Health Equity remains at the forefront of everything that we do.

In March 2016, staff were provided with Health Equity training and we have engaged the services of a researcher/consultant to assist with the development of indicators which will assist in driving our program and service offering.

Our goal for 2017-2018 will be to continue working towards improving access to services to marginalized people including the Amish and Mennonite communities.

In March, 2017, SEGCHC signed partnerships with two agencies, Participation Lodge and South East Grey Community Support Services. Both partners deliver services to developmentally handicapped adults. SEGCHC will provide primary care in the home for these two marginalized groups.

This year we began the journey of introducing the Canadian Index of Wellbeing (CIW) tool as a means to identify the current state assessment of the populations that we serve from a "community belonging" perspective. Based on the results of the survey, SEGCHC will devise actions that will improve the sense of belonging with a focus on marginalized populations.

Integration and Continuity of Care

The SEGCHC embraces our health system partners by collaborating to provide the safest, best quality and seamless care for patients. Our 2017-2018 QIP aligns with the SW LHIN, the Ministry of Health and Long Term Care and also with the priorities set by our community partners.

In 2012-2013 SEGCHC began accepting referrals from external clinics for our allied health professionals. This first step led to the creation of a group of local physicians that meets semi-annually to discuss issues associated with primary care. Additionally, we have established partnerships with mental health agencies and school boards to provide care in the area high school and at two satellite clinics to ensure no clients are missed and continuity is maintained. Chart updates are fed to all external providers within 48 hours of SEGCHC providing an encounter for a non-rostered patient.

As stated above, SEGCHC will provide local hospitals with access to our EMR for SEGCHC patients that show up at the ER.

The SEGCHC actively informs, interacts and has established links with the corporations and councils of the three municipal townships included in our catchment area. An example of this collaborative integration has been related to the Ministry of Health and Long Term Care's Healthy Kids initiative and a Health Equity Steering Committee established in 2016-17.

Our allied health professionals have assisted in reducing the wait time for physiotherapy and dietitian services provided by GBHS. Patients referred to the Diabetes Program at GBHS receive treatment from our dietitian, chiroprapist and recreational therapist in a seamless manner.

On April 1, 2014 we successfully integrated a sole practitioner clinic into our Centre with more than 2,000 patients coming on board. All of these patients will have access to our allied health team and we fully expect to see improved health outcomes and a reduction in ER visits at the two referring hospitals.

Our goal in 2017-2018 is to build upon our success to-date and to further integrate services currently offered by the acute care hospitals into our program offering. The current Patient's First policy paper will provide for further opportunities for SEGCHC to become a regional leader in case management, system navigation and palliative care. All of these elements pose exciting opportunities for SEGCHC to further enhance their service offering.

SEGCHC will continue to work towards the establishment of an integrated rural health hub.

Access to the Right Level of Care - Addressing ALC Issues

In December 2014, SEGCHC signed a Service Agreement with South Bruce Grey Health Centre that will guarantee access for rostered patients of the CHC who are admitted to an area hospital.

Current best clinical practices suggest that a patient that is being discharged from hospital, see their family practitioner within seven (7) days. The visits to the family doctor or nurse practitioner are designed to ensure that there is a good transition of service from the hospital to the primary care provider. This helps to reduce the number of patients readmitted to the hospital with complications arising from their hospital stay. The SEGCHC - SBGHC agreement will guarantee a visit to a rostered patient being discharged from a SBGHC hospital within 24 hours or one business day.

Engagement of Clinicians, Leadership & Staff

In 2015 the SEGCHC conducted an employee engagement survey along with forty-five other CHCs. Talent Map facilitated the independent survey. The SEGCHC scored 99.2% in employee engagement - a new Talent Map score.

Internally - The South East Grey CHC is committed to employee engagement at every level. Monthly meetings are held with all staff and a primary care sub-group meets to discuss ongoing issues bi-weekly. Daily rounds have been constituted and a clinical director continues to manage primary care issues.

Externally - The SEGCHC is part of the Grey Bruce Health Integration Coalition. The GBHIC is comprised of health leaders from all facets of healthcare - acute care, home care, primary care, public health and long term care. Mental health and addictions are also members of the coalition. Leaders from the group meet monthly to focus on improving the health of the residents of Grey Bruce through their actions. Our clinical lead is an integral member of this group.

Our Executive Director meets quarterly with his acute care counterparts to review ongoing opportunities and issues. Our Executive Director is also part of a SW LHIN

CHC ED Network who meets monthly to review sector issues and to look at ways to improve healthcare within our LHIN.

As previously stated, SEGCHC meets semi-annually with local sole practitioners to identify areas of concern and opportunities to improve patient care.

Resident, Patient, Client Engagement

The SEGCHC Board of Directors approved the 2016-2020 Strategic Plan in November 2016. Key elements of this planning are to engage regional partners, patients and area residents to determine needs and to identify opportunities for improvement and to increase awareness. Public input is essential to this planning exercise.

SEGCHC is committed to engaging with patients through a patient survey. Our engagement rate this coming year is set at 15% or at least 750 patients surveyed from our 5,000 patient roster.

The SEGCHC has established a Community Engagement Committee to ensure that our operations are guided by the community in which we serve.

Our Community Board represents members of the broader community that we serve.

Staff Safety & Workplace Violence

In 2016, SEGCHC provided staff with Code White training (Mental Health and Crisis Intervention training). The course provides staff with self-awareness, communication strategies, escalation processes, non-verbal and verbal intervention strategies. Staff engages in role playing and practice using communication techniques. All staff are trained in first aid and CPR. Frontline staff is also trained regarding using the defibrillator.

Our Health and Safety Committee meets quarterly and perform monthly inspections.

Contact Information

For more information please contact Executive Director, Allan Madden at allan.madden@segchc.ca

Other

N/A

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair
Quality Committee Chair or delegate
Executive Director / Administrative Lead
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)

