Let's Make Healthy Change Happen.

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

Grand Bend Area Community Health Centre
Every One Matters.

3/28/2017

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.

Overview

The Grand Bend Area CHC has developed a QIP, which continues to align with our strategic plan 2015-2020. Our Mission is to empower the health and well-being of the people in our communities together. The QIP will focus on our vision of health and well-being for all. It reflects our values of people centred, respect and inclusion, compassionate care, interconnectedness and integrity, responsibility and accountability.

The Centre continues to develop and evaluate strategic approaches with a focus on mental health in Primary Care, preventative health and wellbeing, programs and services, outreach to those most in need to improve access, remove barriers and communicate effectively.

Focus: The objective of our QIP is to improve our effectiveness, equitable treatment of persons, and improving patient experience in a safe and timely manner.

QI Achievements from the Past Year

- Wellbeing Summit with Agencies and Community, which further identified mental health gaps and solutions for change
- Collective Impact Workshop with focus on Social Isolation
- Hensall Renovations to improve privacy and workflow
- Erie St Clair and Southwest CCAC community nursing now on site weekly
- CMHA is now providing service on site weekly
- Physician Assistant hired and medical directives developed
- Elimination of Physiotherapy wait list due to a more efficient use of resources
- Establishment of a Physio clinic in Hensall
- Establishment of Cardiac Rehab program with Physio and PA

Population Health

The Centre's majority of clients are senior so we have focused on preventative health and wellness programming such as exercise, mental health programs and healthy eating with that in mind.

Part of our strategy this year will be to include mental health programming as part of the framework of every program we offer in 2017-2018. This will have a collective effect across the organization.

We are in year three of Healthy Kids Community partnership with Health Units, municipality and other agencies. The focus for this stage we will be healthy snacks and meals for children ages 6-12.

Equity

The centre will be exploring ageism, and weight bias in our community as identified in our Be Well survey. Once reasons for biases are identified, we will work towards addressing them.

Integration and Continuity of Care

The community partners of Sarnia-Lambton are actively seeking opportunities through partnership, between various healthcare sectors to fully realize the potential of integrated care. This is being accomplished via the development of a local Collaborative Quality Committee. Currently, partners include: Bluewater Health hospital, Central Lambton Family Health Team (FHT), Rapids FHT, Grand Bend Area Community Health Centre (CHC), North Lambton CHC, Erie St. Clair Community Care Access Centre (CCAC), Vision Nursing home, Twin Bridges Nurse Practitioner Led Clinic, Canadian Mental Health Association, Lambton Elderly Outreach, Erie St. Clair Local Health Integration Network, Health Quality Ontario, and a patient experience partner, and a common commitment to quality care has been developed: seeking to improve the patient journey during transitions of care. The identification of a common goal has been established to i) improve communication between all providers at point of transition, ii) increase patient education and information, and iii) develop and share consistent and thorough discharge summaries for primary and long-term care. Continued work is underway to further establish the newly developed committee and identify targeted action items to improve transitions of care for the people of Sarnia-Lambton.

The Centre also works with:
- Local pharmacies who have access to our EMR of shared patients.
- Choices for Change Drug and Gambling Addictions
- STOP STUDY for smoking cessation NRT
- South Huron Hospital Association, In Patient and Emergency Departments
- CMHA
- Parkwood Hospital Acquired Brain Injury Program
- Alzheimer's Society of Huron
- CNIB low vision clinics
- Visiting specialist to address cardiology, endocrine and diabetes

Access to the Right Level of Care - Addressing ALC Issues

Work with South Huron Hospital inpatient department so that, upon discharge an appointment with family doctor will be arranged within seven days for CHF patients. We will provide a easy method of communication between hospital and the centre.
We are exploring ways to help CHF patients utilize the CCAC Telehomecare program for improved self-management of their chronic disease.

Engagement of Clinicians, Leadership & Staff

We have a QIP committee that includes clinicians, administration, and patient representation. The QIP is discussed at our Quality Utilization Committee meetings quarterly, shared with board and staff for input and discussion at board and staff meetings.

Resident, Patient, Client Engagement

We have designed our client survey to include relevant QIP questions to monitor our performance in effective transition, person experience, and timely access. This survey is offered to the community as well as clients through our website. We have a client serving on our QIP committee to provide us with their perspective. Program evaluations are designed to gather feedback from participants to make sure we are meeting their needs.

Staff Safety & Workplace Violence

A new anti-harassment statement was shared with staff with a new easily accessible form on our staff drive. Increased number of panic buttons in areas of high risk. Our Joint Health and Safety committee continues to monitor and mitigate possible dangers.

Contact Information

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2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

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	Coordinating care	Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach	% / Patients meeting Health Link criteria	In house data collection / Most recent 3 month period	92233*	CB	75.00	Best estimate at this time	1)RPN Nurse Navigator work with Southwest and Erie ST Clair LHIN CCAC Nurse coordinators to identify high needs patients (greater than 5 ER visits per year, chronic disease and reasons for visits to ER and use of CCAC). Health Links approach using Coordinated care plan to be offered to any high needs individual who does not currently have a coordinated care plan.	Weekly Data analysis with CCAC clinic visits along with quarterly reporting by our RPN navigator	Number of health Links coordinated care plans /identified high needs patients	75% of identified high needs patients will be offered the Health Links approach.	This goal will be achievable as long as we have our Navigator position and CCAC support from community nurses.
	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	92233*	68	75.00	We adjusted our target to be more reflective of our goal. New process will be started with local hospital	1)Provide training and support for additional RPN to be able to access LENS to insure that patients are seen within seven days for selective conditions. Work with discharge nurse at South Huron Hospital Association who will be telephoning GBACHC for every CHF patient that is discharged to obtain appointment with Primary Care Provider within 7 days	The RPN Navigator tracks each discharge and date of appointment with Primary Care provider.	# of appointments within seven days/ # of discharges for certain conditions	75 % of patients discharged with certain conditions will have an appointment with Primary care provider within seven days	Our RPN navigator has had two quarters using LENS and striving to reach goals.
									2)Patients discharged with respiratory illness indicated in LENS will be referred to Better breathing team (BBT)by RPN navigator	RPN will fill out internal referral and submit to BBT in NOD	Number of patients with respiratory illness discharged and referred to BBT over the number of patients discharged with respiratory illness	75 % of people with respiratory illness upon discharge will have been referred to BBT	
									3)Patients will be encouraged to enrol in the CCAC Telehomecare program for CHF self management	The RPN navigator will be sending referrals to the BBT team who will then ensure that one patient per quarter is enrolled into the program.	Number of Patients enrolled in each quarter into CCAC program over four quarters	100 % 4 per year for start.	
		Percentage of acute hospital inpatients discharged with selected HIGs that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission, by primary care practice model.	% / Discharged patients with selected HIG conditions	CIHI DAD / April 2015 - March 2016	92233*	CB	60.00	Navigator and support from CCAC is essential in meeting this goal. Lens will be an effective tool	1)When Patients with selected HIGs see Primary Care provider post discharge medication reconciliation is done	When appointment is given post discharge it will be noted in the Patient contact information to do medication reconciliation	# of med reconciliations / discharges for selected HIGS	60% of med reconciliations done on post discharge patients with selected HIGs	Keeping track of this process is new for us.
	Population health - cervical cancer screening	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	92233*	57.52	75.00	Same as MSAA	1)Extract data Quarterly for women aged 21-69 who have not had a Pap in the past 3 years. Book appointments utilizing the newly hired Physician Assistant, MDs and NPs	Continue to Extract data from EMR and contact eligible clients on a more consistent basis utilizing newly hired Physician Assistant, MDs and NPs	# of tests done/eligible clients for past three years	65% of eligible women have a pap smear	Improve access to women for pap testing using Physician Assistant

	Population health - colorectal cancer screening	Percentage of screen eligible patients aged 50 to 74 years who had a FOBT within the past two years, other investigations (i.e., flexible sigmoidoscopy) within the past 10 years or a colonoscopy within the past 10 years.	% / PC organization population eligible for screening	See Tech Specs / Annually	92233*	48.91	55.00	Same as MSAA	1)Work to ensure that clients aged 50-74 have had a FOBT within the past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within 10 years	Obtain EMR list quarterly of patients who are due for colorectal cancer screening test. Book appointments with PA, NP MDs RPN (if appropriate) for colorectal screening	Number of people aged 50-74 who have been offered or completed appropriate testing for colorectal cancer divided by number of patients aged 50-74	55% of patients 50-74 will have appropriate colorectal screening. 45% or less overdue	
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	92233*	95	95.00	We have achieved our goal of 95% and will continue to maintain and improve it	1)The Centre will be utilizing the Teach Back Tool. A presentation will be scheduled with Southwest CCAC Self Management Program	All Staff will be trained on the benefits of the Teach Back method to improve patient experience. This will be scheduled with the Southwest CCAC during Grand Rounds at our staff meeting	number of patients who reported they were involved in decisions about their care and treatment.	95%	
Safe	**Medication safety**	Percentage of patients with medication reconciliation in the past year	% / All patients	In house data collection / Most recent 12 month period	92233*	CB	55.00	This is a new indicator. Plans are underway to include a method of	1)When patient comes to see family Dr. or NP a medication reconciliation is completed	Provider seeing patient performs medication reconciliation and indicates that it's complete using radial button in EMR	Number of medication reconciliations over the number patients seen.	55%	
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	92233*	65.14	70.00	We will be hiring a new NP to replace the gap in our staffing levels for both Hepsall & Grand	1)PA and RPNs working to full scope of practice so that appointments are available with MDs/NPs	Provide training for PA and RPNS on procedures such as ECGs, wound care etc.	Percentage of patients that respond positively to the question that they were able to be seen same day or next.	70%	