Ontario Health
Quality

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 17, 2020

Grand Bend Area
Community Health Centre
Every One Matters.

OVERVIEW

The Grand Bend Area Community Health Centre (GBACHC) is committed to delivering high quality and accessible primary health care and community services that are integrated, evidence based and build on the strengths of each patient. This commitment supports the patient's/client's ability to build resiliency and self-management skills.

In accordance with the mandate of Community Health Centres (CHCs) in Ontario, the GBACHC offers a broad range of programs and services addressing several of the social determinants of health including education and housing.

The GBACHC's mission and vision are central to all of the work at the Centre.
Mission: Empower the health and well-being of the people in our communities – together.
Vision: Health and Well-being for all are central to everything that we do.

The focus of the GBACHC's quality improvement plan is on the services provided by physicians, nurse practitioners, nurses and allied health professionals at the Grand Bend and Hensall locations.

The key primary care objectives are aimed at improving and sustaining the patient experience in the following key areas:

- Timely access to primary care when needed.
- Sustained screening rates for cervical, breast and colorectal cancers for eligible patients.
- Identification and focus on equity factors contributing to lower screening rates in the attributed population.
- Patients demonstrating a feeling of being involved in the decision making around their health care.
- Palliative care patients are being referred to appropriate resources.
- Care coordination and support for patients with low screening rates.
- Managed transition of care for patients who have been discharged from hospital in the past seven days with a mental health diagnosis.
- Commitment to collecting data on non-palliative opioid prescribing and recognition of the rate of prescribing and alternatives, when appropriate.

The above areas continue to align with the GBACHC's strategic priorities of patient/client-centered care, equity, and improvement and innovation. The decision to keep cancer screening rates in the QIP work plan is influenced by the GBACHC's Multi-Sectoral Accountability Agreement (MSAA) with the Erie St. Clair LHIN and the population's health improvements achieved through preventative screening.

DESCRIBE YOUR ORGANIZATION'S GREATEST QI ACHIEVEMENT FROM THE PAST YEAR

This year's work has continued to build on the success of previous years' as it relates to quality improvements. The GBACHC continues to focus on the identified areas of access and transitions i.e. helping people receive the right care in the right place at the right time.

plus, equity, mental health and addictions, and opioid use.

The first greatest accomplishment at the GBACHC this year is the empowerment of clients and caregivers through the formation of a partnership with patients, clients and caregivers through the Community Advisory Council (CAC). The CAC meets monthly with staff representatives to review, support and enhance the work of the GBACHC. Patient/client engagement was previously identified as a strategic objective of the GBACHC. Enhanced patient/client, caregiver and community involvement will assist the GBACHC through input into policies, protocols, services, programs, QIP indicators and strategic plan objectives.

In particular, the GBACHC has increased patient/client awareness on how to make suggestions or complaints to the Centre, incorporated patient/client feedback into program design, included patients/clients in community hub planning and the Connected Rural Communities Collaborative initiative, patient/client handouts, health literacy checks and overall facility access.

In an effort to continue to address patient/client feedback, the GBACHC conducts annual patient/client experience surveys. Survey data is reviewed quarterly by the Quality, Utilization and Risk Committee, board of directors and the CAC.

The second greatest achievement was the engagement of community residents and stakeholders (municipality, service clubs, churches), through the Connected Rural Communities Collaborative (CRCC). The CRCC and the GBACHC conducted more than 60 lived-experience interviews and collected data through 250 surveys to understand the strengths and the gaps in connectedness across the GBACHC catchment area. The CRCC report was completed using community input obtained regarding the collected data. The CRCC report contained the community's recommendations for strengthening connectedness across areas including income/money, transportation, access to health and mental health services and the natural environment. The report entitled "Strengthening Social Inclusion and Connections in the West Coast Shores Region" will guide the GBACHC Health Equity Plan and will be used for the planning of the West Shores Culture Recreation and Wellness Hub. Further, the report will be the foundation for the 2020/21 GBACHC program planning and to develop the West Shores Community Action Plan.

The third greatest accomplishment has been the effort to work with 60+ partners to become the newly approved Huron Perth Area Ontario Health Team (OHT). The GBACHC patient/client and caregiver care will be strengthened in the Huron Perth Area through a collaborative effort to create a "sustained people-driven system that strives to provide a positive experience for all!" The GBACHC also collaborates with the Sarnia-Lambton and Bluewater Alliance OHTs to support patient/client and caregiver care in these areas.

COLLABORATION AND INTEGRATION

The GBACHC is a signatory partner of the Huron Perth & Area Ontario Health Team (HPA-OHT). The HPA-OHT is comprised of 60+organizations that have made a commitment to continue long-standing formal and informal partnerships to advance an integrated health care system, improve community health outcomes and patient experience. Year 1 priorities of the HPA-OHT are improved care coordination, navigation and communication with three identified target populations – complex health, palliative care, and mental health and addictions. The Ministry of Health's data demonstrates that there are opportunities to improve the following system performance indicators in the HPA-OHT:

- Avoidable emergency department (ED) visits
- Alternate level of care (ALC)
- 30-day readmission rate for selected conditions
- Repeat ED visits within 30 days for mental health and substance abuse
- Hospitalizations for ambulatory care sensitive conditions

The performance indicators all have the potential for improved performance with successful care coordination.

The 2020/21 QIP priorities, sector-specific indicators and the two mandatory hospital sector indicators resonate with the HPA-OHT's commitment for quality improvement across all sectors of the health system. In their respective QIP submissions, the HPA-OHT partners will address collaboration and integration, alternate levels of care and virtual care. The HPA-OHT will advance a historically strong performance in these areas as demonstrated through such initiatives as Health Links (since 2014), the purchase of non-funded, long-term care beds for ALC-LTC patients, and a 13 member Community Support Services Network through which clients and caregivers benefit from a centralized intake, shared record and shared coordination of care.

In 2019/2020, seven organizations of the HPA-OHT partnered for Ontario's first Sub-Region Accreditation. Through this initiative the partners created a Collaborative QIP Change Plan and implemented a harmonized multi-sector Workplace Violence policy, one of several harmonized policies that have the opportunity to spread to the partners of the HPA-OHT. These same seven organizations have partnered in a 2020/21 Collaborative QIP Change Plan advancing workplace violence prevention through shared education regarding

responsive behaviours to front line staff and physicians.
The GBACHC is an active member of the Health Quality Partners of Sarnia-Lambton, a regional quality improvement initiative, which has developed a systems approach to improving care delivery. The partners are a working group of health care providers, service organizations and a patient experience partner. The partners have been developing pathways over the past few years to improve communications, standardize action plans and create effective transitions for patients. This has enabled a robust dialogue and collaboration with community partners on a cross sectorial Quality Improvement Plan. As community partners we continue to align and share accountability for quality initiatives, facilitate more integrated care, and leverage best practices while contributing towards a healthier community and optimal delivery of health care.
The partners have worked collaboratively on a common QIP indicator to establish best practice and standards of care for patients with chronic disease, in particular, Chronic Obstructive Pulmonary Disease (COPD). The partners committed to a work plan over the last two years and established key drivers on their action plan to improve the quality of life and health outcomes of patients with COPD. The group works through action plans that have been developed by the partners who identified areas for improvements in effective transitions of care. A key initiative from this team is a standardized pulmonary rehab referral including a standardized process and form. This enables patients to have the best evidence-based care for improved quality of life, as well as, connections for a social network. This integrated care plan for COPD is the first step in collaborating as cross sectoral partners for patients with chronic disease to ensure coordinated, consistent, equitable and appropriate access.
The Health Quality Partners have chosen to continue having a collaborative QIP with the primary focus for 2020-2021 being the earlier identification and documented assessment of palliative care needs among patients with progressive, life-limiting illness who would benefit from palliative care.

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

As indicated above under our greatest achievement, the formation and on-going development of the Community Advisory Council (CAC) continues to be a priority for the GBACHC.

Patient engagement is a fundamental strategy for achieving patient-centered care. By engaging patients and caregivers as partners in practice improvement at the primary care and practice level, we have empowered patient involvement at the clinical level. It is recognized that an organization in which patients and their families are key drivers of the design and operation of care, the experience of care and economic outcomes can be substantially improved.

WORKPLACE VIOLENCE PREVENTION

As a means to bring departments, concerns and skill sets together, the GBACHC has formed a Workplace Codes and Violence

Prevention Working Group. The group meets bimonthly.

Each month the working group looks at the different aspects of the Workplace Violence Assessment Checklist. The assessment completed by management, the Joint Health and Safety Committee (JHSC) members and those who work in the GBACHC's locations and departments is a valuable tool to identify risks and determine if existing controls are adequate. A matrix of risk probability and the impact of the exposure, should it happen determines if the risk is high, medium or low. Suggested mitigations recommended to the JHSC can be acted upon quickly, or if there is a budgetary impact, taken to the GBACHC Management Team. The assessment is on-going at committee meetings and is documented with accountability and timelines.

In discussion around GBACHC's current policies and procedures, it emerged that staff were happy with the ways they could identify and "show up" to support other staff if needed, especially for medical emergencies. There was still uncertainty, however, about what to do in the event of a violent situation. De-escalation and self-defense training by a third party was provided to a quarter of the staff. Budget will allow the GBACHC to rotate staff through the course each year to help provide the peace of mind and knowledge for which staff is looking.

The GBACHC is further progressing by looking at the Ontario Health Association Code System and Code Procedures, which have been put in place at other Community Health Centres.
Code Silver (person with a weapon) is currently under consideration with a very impactful video being viewed by the committee. The video explicitly shows what to do if there is an active shooter at the GBACHC. Learning from the video will be used to educate the Centre's staff.

Other learning and education regarding workplace violence underway include the following:
- Physical Environment
- Workplace Practices - working alone, working offsite, etc.
- Direct Care of Patients – aggression and mental health challenges

ALTERNATE LEVEL OF CARE

A full-time system navigator has been in place for two years (unfunded) to address the needs of complex patients.
The Southwest and Erie St. Clair LHIN Home and Community Care agencies work with the system navigator to address complex patients' high needs. Medication reconciliation is done for each high-needs patient discharged from hospital.

The system navigator/clinical care coordinator position is now being funded by Home and Community Care and recruitment is underway for a permanent staff member.

The system navigator role at the GBACHC has become important in helping patients navigate their way to timely and quality care while also providing assistance in overcoming barriers to care including obtaining and/or maintaining the appropriate level of care.

The GBACHC offers clients a variety of supports to prevent hospitalization whenever possible. In addition to system navigation, these supports include extended evening hours, after hours on-call services, home visits and weekend walk-in clinic services.

VIRTUAL CARE

Virtual care will be an important aspect to GBACHC as we work with our Huron Perth area OHT (HPA-OHT). The perfect storm for digital improvement has come our way as we are in final preparation phases of our Transition from our current Nightingale EMR to Telus Practice Solutions. This is the most common EMR across HPA-OHT. This solution integrates well with emerging products to support virtual care.

Aspects of Virtual Care are Ontario Telemedicine Network eVisits (email, telephone, virtual visits etc), eBooking, eReferral and eConsult. It will be important that these solutions are procured centrally by Ontario Health and supported with licences, etc. However, the Ontario government functional structure is not yet up and running. The timing of the above decision making and ability to appropriately engage is therefore unknown at this time

For 2020/21 we will continue working with the HPA-OHT on the Digital Advisory Committee. Possible activities may be determining the number of doctors, nurse practitioners, midwives, physician assistants and specialists signed on to the HPA-OHT to establish our denominator for primary care MDs/NPs, midwives, and specialists. Identifying current workflows, new solutions to improve our work and patient experience will follow, such as the Ocean Platform which may improve referral capability across Primary Care and Hospitals to specialists. Once our new EMR is established in our practice we will present, educate, deliberate and initiate virtual care in alignment with the work of our HPA-OHT.

CONTACT INFORMATION

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OTHER

The GBACHC has been actively involved in and is part of the approved Ontario Health Team (OHT) application for the Huron Perth Area. The Centre is also involved with two other OHT applications (Western and Sarnia Lambton) as the GBACHC's patients/clients and organization interact with all three OHT's.

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 on _____

_____
Board Chair

_____
Quality Committee Chair or delegate

_____
Executive Director/Administrative Lead

_____
Other leadership as appropriate

_____

Equity | Equitable | Custom Indicator

Indicator #1

Identify equity factors that influence access to cancer screening based on an analysis of socio-demographic data, postal code regions (Grand Bend Area CHC)

Last Year		This Year	
CB	CB	CB	--
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

collect data via EMR related to socioeconomic factors specific to : income, ethnicity associated with our screening for Colo rectal screening, Mammogram, Cervical Cancer

Target for process measure

- Assess the data and investigate if there is a disparity in income, ethnicity in schedule cancer screening initiatives. If there is a noted disparity, formulate a plan to ensure equitable access. This could include extended evening hours, language barrier challenges, more education for the public on the benefits of screening.

Lessons Learned

Took several attempts to obtain the data and have it broken down by socioeconomical factors. Not all patients feel comfortable in disclosing their financial information

Theme I: Timely and Efficient Transitions | Timely | Custom Indicator

Indicator #2

Participate in the cross-sector collaborative quality committee working towards effective transitions for patients with Chronic Obstructive Pulmonary Disease (COPD) (Grand Bend Area CHC)

Last Year		This Year	
CB	CB	22	--
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Work with other Pulmonary Rehabilitation programs (PR) in the sub region to streamline the transition from hospital to PR. Work with Key stakeholders to refine the collaborative referral from and disseminate to hospital and other partners.

Target for process measure

- Collecting Baseline.

Lessons Learned

This was implemented but requires constant follow up to ensure that the program remains front and center in the regional partners programs programming/referral options

Theme I: Timely and Efficient Transitions | Timely | Priority Indicator

Indicator #5

Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed. (Grand Bend Area CHC)

Last Year		This Year	
57.14	**70**	**48.42**	**60**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

More patients are struggling with access to medical appointments due to work, transportation and after school hours for children. The GBACHC is going to increase their evening hour access at the Hensall site to help ensure equitable access to appointment. Currently the Grand Bend site has evening access 4 days a week. This would increase accessibility in Hensall to 2 evening/ week. Exploring additional evening access with our NP.

Target for process measure

- Currently only 55 % of patients are reporting they see a Dr or Np same day or next .The GBACHC hopes that by increasing accessibility we will notice a 5% increase in satisfaction over last year in our Client experience survey

Lessons Learned

Due to unavailability of staff (long term illness) combined with a MD vacancy unable to stabilize this metric.

Theme I: Timely and Efficient Transitions | Efficient | Priority Indicator

Indicator #6

Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge. (Grand Bend Area CHC)

Last Year		This Year	
CB	**CB**	**100**	**--**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

All patients discharged by any hospital with a mental health diagnosis will be seen within 7 days discharge by a social worker, PA, NP or Physician .

Target for process measure

- 75% of patients discharged with a mental health diagnosis are scheduled with an appropriate provider within 7 days

Lessons Learned

All identified patients were seen within the seven day as defined in the metric

Theme II: Service Excellence | Patient-centred | Priority Indicator

Indicator #3

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 (Grand Bend Area CHC)

Last Year		This Year	
91.86	**95**	**94.17**	**97**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Education with the focus on caregiver support will be offered to clients so that they can better identify when they are in need of help and what they can do to better look after their individual health and the health of those they care for

Target for process measure

- 95 % of patients respond that they always and or often are including in decisions regarding their care

Lessons Learned

Continue to promote the focus on caregiver support offered to clients such as Powerful Tools for Caregivers which is coaled by a patient adviser.

Theme III: Safe and Effective Care | Effective | Priority Indicator

Indicator #7

Proportion of patients with a progressive, life-limiting illness who were identified to benefit from palliative care who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment. (Grand Bend Area CHC)

Last Year		This Year	
CB	**CB**	**CB**	**CB**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Engage the Primary Care Providers to develop processes to identify individuals with early palliative care needs (step 1), initiate discussions, and develop an internal referral pathway to the system navigator Step 2 engage patients/ families in discussions round Advance Care Planning and palliative care supports

Target for process measure

- Baseline data collection this year with a focus on patient involvement in end of life planning.

Lessons Learned

Minimal data collection due to improper identification of patients as a result of inconsistent use of identifying ICD codes

Will reintroduce process with correct identifying ICD codes to be used

Theme III: Safe and Effective Care | Safe | Priority Indicator

Indicator #4

Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system within a 6-month reporting period. (Grand Bend Area CHC)

Last Year		This Year	
CB	**CB**	**6**	**5**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

The GBACHC will utilize the available data from the "My Practice" reports to support providers in understanding prescribing practices and better understanding the patients that we serve and the community needs.

Target for process measure

- Specific attention for new clients starting on opioids and benzodiazpines will be compared to assess/ identify practice standards in place or a reflection of other health related concerns within our geographic region that may be resulting in an increase utilization ie:work place injuries, aging population etc. As a baseline data collection year no formal targets for improvement will be set up at this time.

Lessons Learned

Data from "my practice" is over a year old and not updated quarterly - unsure if initiative made a difference without real time data - will require lengthy baseline data

Theme III: Safe and Effective Care | Effective | Custom Indicator

Indicator #8

Using the HQO "My Practice" profile for GBACHC, review data and determine if there are areas of improvement in opioid and benzodiazpine prescribing practice. This collection of data will help the GBACHC better understand trends in prescribing,and work to ensure alternative medications can be considered in their practice. (Grand Bend Area CHC)

Last Year		This Year	
CB	CB	CB	--
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

The GBACHC " My Practice " Report will be provided to all providers who prescribe.This report will provide the foundation for education initiatives that may be required within the practice to identify options in pain management .This report will help develop a sense of awareness of prescribing practices and open up dialogue on other potential alternatives to Opioid and Benzodiapine prescribing when appropriate.

Target for process measure

- The "My Practice" report for this year will act as a data base for the patients we service. Another report will be run at year end to assess improvements or changes to practice. Specific attention for new clients starting on opioids and benzodiazpines will be compared to assess/ identify practice standards in place or a reflection of other health related concerns within our geographic region that may be resulting in an increase utilization ie:work place injuries, aging population etc.

Lessons Learned

The practice report received is over a year old - require a lengthy baseline period to obtain data from the "my practice" report

Theme I: Timely and Efficient Transitions

Dimension: Efficient

Measure

Indicator #1	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients who have had a 7-day post hospital discharge follow up, by a community care provider for selected conditions- CHCs.	P	%	See Tech Specs / April 1 - Dec 31, 2018	CB	CB	Actual data being collected	South Huron Hospital

Change Ideas

Change Idea #1 Verification/navigation of adequate discharge follow up with patients with complex needs from SHHA

Methods	Process measures	Target for process measure	Comments
This information will be manually collected by our system navigator who will confirm that patient will be followed up with.	Number of clients from GBACHC discharged from SHHA defined as "complex" as compared to total number of GBACHC patient discharged from SHHA	Unsure of the total number of patients that may be discharged from SHHA therefore will be collecting baseline	SHHA is the only centre that we can obtain this data from

Measure

Indicator #2	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	P	%	In-house survey / April 2019 - March 2020	48.42	60.00	Decreasing the metric to a more realistic and obtainable target	

Change Ideas

Change Idea #1 Identified staffing shortages are being addressed which will provide for greater access. Long term illnesses have been resolved. Continue to support same day access for all practitioners with open time available for less routine booked patients

Methods	Process measures	Target for process measure	Comments
Previous Vacant positions will be filled. Public education will be developed and presented in various forms (rolling screen, print etc.)	In house satisfaction survey sent to clients on a monthly basis along with surveys available in waiting room. Complements and complaints process in place for client feedback	70% of all roster'd clients of the CHC will report same day next.	Total Surveys Initiated: 100 Public education on the different providers available (NP's) so that people who are offered same day/next with someone other than their roster'd family doctor are provided timely access.

Theme II: Service Excellence

Dimension: Patient-centred

Measure

Indicator #3	Type	Unit	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	P	%	In-house survey / April 2019 - March 2020	94.17	97.00	Just shy of meeting target, slight increase for next reporting period	

Change Ideas

Change Idea #1 This remains slightly below the identified target. We continue to empower and educate our primary care providers to include the patient in their care decisions and treatment

Methods	Process measures	Target for process measure	Comments
OHT - Partnership with external providers to promote more patient interaction with care decisions and treatment. Educate our primary care providers to ask questions to actively engage their clients. Connect the Dots: ensuring practitioners ask key questions of each patients caregiver they see.	Client satisfaction survey which will be sent out on a monthly basis along with survey's in the waiting area. Team base care will be enacted in the new PS Suite environment to account for patients served throughout the OHT. Measure each time caregiver asked key question"how a caregiver is doing"	97% Target will be minimally increased to reflect the OHT changes.	Total Surveys Initiated: 103 We are very proud of our staff as we continue to achieve a high standard in this area. We want to ensure clients and their caregiver are involved in the decision about their care and treatment.

Measure

Indicator #4	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of Huron-Perth and area Family Health Teams/Community Health Centres who have adopted standard policies, as identified by the Huron Perth Executive Directors	C	%	In house data collection / by March 31, 202	11.00	100.00	As the Huron Perth and Area Ontario Health Team matures, we as primary care organizations within Huron and Perth (10 in total) believe it to be an important step for us to align key safety and operational policies across our team based primary care organizations (Family Health Teams and Community Health Centre). This will strengthen our already existing partnerships and also ease future alignment not only within primary care but also across sectors within our OHT.	

Change Ideas

Change Idea #1 1)The Huron Perth FHT and CHC Executive Directors will identify key safety and operational policies to be adopted across all team based primary care organizations (Huron Perth FHT's and CHC) in the 2020/21 fiscal year.

Methods	Process measures	Target for process measure	Comments
A proposed list of policies will be presented to the group for feedback by the NPFHT Quality Manager. The Executive Directors will collectively agree on policies for adoption in 2020/21. The NPFHT Quality Manager will provide each FHT with the standard policies. Each Executive Director will take the necessary steps within their organization with the aim to approve each one by March 31st, 2020/21. Each team based primary care organization will report on their progress in approving the policies within their organization	Percent of identified policies approved.	100% of all identified policies to be completed	This indicator is team based primary care specific

Theme III: Safe and Effective Care

Dimension: Effective

Measure

Indicator #5	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Proportion of patients with a progressive, life-limiting illness who were identified to benefit from palliative care who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment.	P	Proportion	Local data collection / Most recent 6 month period	CB	CB	Data not previously obtained therefore need to collect baseline for accuracy	

Change Ideas

Change Idea #1 Holistic assessment of identified palliative care patients

Methods	Process measures	Target for process measure	Comments
Doctor education of ICD code Using palliative care toolkit	number of palliative patients given a holistic assessment over the number of patients identified as palliative	It is expected that we would be able to achieve a 50% target if not greater	Since last year we collected baseline and found challenges recording palliative patient numbers - this year we will be using ICD code 9 and educating physicians/NP - this is part of our switch over to a new EMR

Measure

Indicator #6	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system within a 6-month reporting period.	P	%	CAPE, CIHI, OHIP, RPDB, NMS / 6 month period ending Mar 31, 2019	6.00	5.00	With more timely "my practice reports - this target could be better influenced	

Change Ideas

Change Idea #1 The GBCHC will continue to collect baseline data with the goal of reducing new opioid prescriptions.

Methods	Process measures	Target for process measure	Comments
Research current options other than the My Practice report (2 years old data) such as our new EMR to monitor our current status. GBACHC IT to pull data from EMR which is then reviewed quarterly (when its available) with the Director of Primary Care. Educate the public on alternative to opioid's (Persistent Pain classes, Mindfulness, and Cannabis for Pain presentation. Explore options for automated referral to primary care provider.	We will utilize the My Practices report , our EMR and patient feedback.	Our target for this measure will be 5.1 % this year in keeping with the CHC provincial average.	Challenges to this metric relate to long wait times and lack of access to acute care centres for surgery. (hip, knees, shoulders etc.)

Equity

Dimension: Equitable

Measure

Indicator #7	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Strengthen social inclusion/health equity initiatives in response to the CRCC report	C	Count	Other / April 1 - Mar 31	CB	4.00	This report (CRCC) was just finalized in 2019 - the resulting information will be used to develop/create events targeted at addressing health inequities and social isolation	Grand Bend Community Foundation, Gateway Centre of Excellence in Rural Health, Alzheimers Huron County, Huron Shores United Church, Huron Perth Public Health, South Huron Hospital Association, West Huron Care Centre , Lambton County Public Health

Change Ideas

Change Idea #1 To increase awareness and participation in CHC activities and programs that address social inclusion and isolation

Methods	Process measures	Target for process measure	Comments
Providing a series of educational events and training opportunities for community and staff participation. Collaborate with partners to optimize participation in events and confirm community action items on CCRC report recommendation	Number of events held	Number of events held in the community/CHC in collaboration with partners with identified action items that three communities/significant groups agree on.	

Measure

Indicator #8	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
To improve the rate of screening of breast, colo-rectal and PAP in populations that are in the lower income groups	C	Number	In-house survey / April 1 - March 31	CB	CB	Data not previously obtained therefore need to collect baseline for accuracy	

Change Ideas

Change Idea #1 Increase cancer screening/testing for individuals who have self identified their income levels below the 25,000 mark.

Methods	Process measures	Target for process measure	Comments
Once identified , the MOA's will prioritize those lower income clients to the top of the recall list. Theses clients will be encouraged to attend the clinic. MOA's will identify and barriers that may exist and document in the charts as appropriate. Clients with identified challenges will be referred to social work with their consent.	number of patients that complete the testing compared to the number that are eligible in this defined group.	We will be planning on collecting baseline for this identified group	Challenges are that not all patients will list their income levels.