

Let's Make Healthy
Change Happen.



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

3/20/2017

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

Seaway Valley Community Health Centre (SVCHC) is committed to providing the highest quality care possible for the clients and the community we serve.

SVCHC is a charitable, not-for-profit, community-led and community-governed organization. We provide primary health care, health promotion and community development services to residents of Cornwall (a small urban centre) and the rural area Stormont, Dundas and Glengarry Counties (SDG). The population of our catchment area is just over 111,000.

SVCHC's mission is to support the health and wellbeing of local people and our community, working in an interdisciplinary team and partnership approach. The target populations SVCHC serves include seniors, low income individuals and families, newcomers to Canada and those with long-standing issues accessing a primary care provider. An interdisciplinary team of health and wellness professionals, committed to promoting healthy lifestyles and healthy communities offer a range of community-based services to respond to our community needs and concerns. Our vision is "Working with you for a healthier community" and our values are as follows:

- Anti -oppressive and culturally safe
- Based on the social determinants of health
- Accessible
- Population needs-based
- Community-governed and Grounded in a community development approach
- Inter-professional, integrated and coordinated
- Accountable and efficient.

This year's QIP remains aligned with our 2016-2021 Strategic Plan which articulates our commitment to creating a positive client experience by providing quality services to our clients and our community. We strive to deliver primary health care services to full panel size, meet our Multi-Sector Service Agreement (MSAA) targets established with the Champlain Local Health Integration Network (LHIN) and maintain a zero-based balanced budget as per Ministry of Health Financial Policy directive. Annually, SVCHC administers a Client Satisfaction Survey to ensure we engage our clients to learn of their concerns, issue or needs and implement mitigation strategies for quality improvement. Additionally, we survey our Staff every 18 months to ensure high job satisfaction and to provide opportunities for staff to make recommendations for improvements.

An internal Occupational Health and Safety Committee meet minimally 4 times a year to discuss health and safety and all recommended improvement measures are discussed with senior management and implemented as needed. Additionally, monthly site inspections are completed by the Occupational Health and Safety Committee members to ensure the building, equipment, property and grounds are safe and in good repair.

We are committed to providing quality health care and promoting healthy communities ~~by delivering effective primary care. We are accountable to our clients, to the~~

community-led, twelve (12) member Board of Directors and to the Champlain LHIN. In 2016-17, SVCHC Staff worked diligently on policies and procedures to meet accreditation planned for December of 2017, under the Canadian Centre for Accreditation.

SVCHC uses Nightingale on Demand (NOD), as the electronic medical record however in the 2017-2018 fiscal year SVCHC is expected to transition from NOD to Telus PS Suites (as part of the provincial project). The EMR is a required operating IT system which provides Health Maintenance Reports, indicates drug interactions and allergy alerts, is linked OLIS for results of our clients' lab work from other labs and has the capacity to produce data to recall clients for health prevention tests (i.e., mammograms, FOBT, vaccines, Paps). Meeting our targets in 2017-2018 may be difficult in this fiscal year with the roll out of the new EMR as Staff will need time to learn PS Suites and become adept with its functionality. The transition will be project managed over 3 months with a projected start in the third quarter of 2017.

Our providers are currently charting in NOD and the NOD data is rolled up to the Association of Ontario Health Centre's (AOHC) provincial data warehouse using Business Intelligence and Reporting Tool (BIRT). The BIRT reporting tool has been developed in accordance with the Information Management Strategy (IMS) that supports the overall strategic directions of Ontario CHCs. The purpose of using the BIRT tool and sharing/including our data is to provide reporting and analysis capabilities to the sector for comparative analysis, supporting performance management and quality improvement for SVCHC and across the CHC sector in Ontario.

SVCHC continues to focus QIP on the three key priorities identified by the Ministry of Health including accessibility (improving client access to care and services), integration (providing timely follow-up after hospital discharge), and client-centered care (improving the client experience).

Integration & Continuity of Care

As noted above, our EMR report allows SVCHC to clearly articulate the impact of the full model of health and wellbeing on our clients and the community by providing us with data to monitor and deliver health promotion services and report on client health outcomes. The use of a common EMR will support local, regional and provincial collection and standardization of data and processes. This data is now being used for decision support in quality improvement. Additionally a feature of NOD is the connectivity to OLIS, which has enabled the sharing of lab results from community laboratories to our CHC which supports our goal of improving the client's experience and healthier client outcomes.

The nine (9) Executive Directors from the Champlain region continue to meet on a monthly basis in a forum known as the Champlain Community Health Centre Executive Director's Network. We are committed to open communication, collaboration, sharing resources, standardizing policies, procedures and processes, and building regional program models. This regionalized effort is reflected in our QIPs with common themes related for quality initiatives that ensure continuity of care and smooth transitions (hand-offs) from one health service to another.

SVCHC staff is actively involved in two local Health Links from Steering Committee members to training four (4) SVCHC Staff as Health Link Care Coordinators. We have developed an internal weekly client triage meeting (called "Bridges") as a mechanism to case conference SVCHC complex clients internally prior to identifying and referring these individuals to "Health Links". This "Bridges Committee" has allowed all SVCHC to participate in case conference discussions related to clients

~~in all program and service areas, and the "Bridges" table has expanded our staff's~~

knowledge of internal and external programs available. In this way, "Bridges" has built, and continues to build, internal capacity amongst our own Staff. We currently have an in-house System Navigator working on Care Coordination for our SVCHC primary care clients exclusively. This model has proved to be most effective in supporting our clients' complex needs and enhanced the client's experience in the health care system. However, the funding for this position expires March 31st, 2017, and although the internal System Navigator has proven to be highly effective for improved client outcomes, the program will end on March 31st, 2017. SVCHC is unable to sustain this level of service in 2017-2018 without Health Links funding to do so.

SVCHC participates at several local Community tables work groups and we are integrated and engaged in our community through several Networks and Committees, (i.e., Situation Table, the Community Action Network Against Abuse, the Food Security Network, Active Living Programs, Social Development Council, Poverty Reduction Network, Local Immigrant Program Partners, etc.). Additionally, SVCHC participates at Provincial and Champlain Regional tables including, the Champlain Regional Falls Prevention Network, Champlain Inter-CHC Lung Health Network and Working group, Champlain CHC Primary Health Care Directors Network, the Ontario Telemedicine Network and the Regional Primary Care Network. Collaborative efforts at these tables support the development of standardized practices and tools for efficiencies and more effective client outcomes.

SVCHC has several partnership agreements in the form of Memorandums of Understanding (MOU) and Purchase of Service Agreements (POS), with other health care organizations to ensure our clients and community receive high quality, locally accessible, coordinated and non-duplicative and practical services in our area. The following are examples of SVCHC's QIP client-centered, integrated partnerships:

- 1) SVCHC has been working with Cornwall Community Hospital, since December 2012, accepting referral of their admitted patients (who are unattached, have complex conditions and are considered to be high users of the health system) to SVCHC as our fast-tracked primary care clients.
- 2) SVCHC is actively involved on two (2) Health Links at the Governance/Steering Committee levels with the goal of improving outcomes for high risk/high needs clients in the health system.
- 3) SVCHC operates a Healthy Smiles Ontario, oral health program 3 days a week in collaboration with the Eastern Ontario Health Unit (EOHU) for low income children and youth 17 years of age and younger. This partnership has been in existence since the opening of SVCHC in 2012. The EOHU provides the staff and supplies for the program and SVCHC provides the space, equipment, reception and facility infrastructure.
- 4) Additionally, SVCHC works in partnership with the EOHU on the Smoke Cessation Program. Staff shares protocols and supplies to deliver an efficient and concerted program to our community. This program also includes the Cornwall Community hospital's Centre for Addiction and Mental Health and the Mohawk Council of Akwesasne Aboriginal Health Care Centre as key partners. In 2016-2017 SVCHC expanded our internal Lung Health Program with the addition of a full-time Nurse Practitioner and expanded hours for the Respiratory Therapist to become full-time (from the previous 3 days a week). This enhanced program will support more clients to quit smoking.

5) SVCHC partners with the Champlain Community Care Access Centre (CCAC) for client referrals and care planning for client needs in their homes. Additionally, the Champlain CCAC delivers the Regional Memory Disorder Clinic at SVCHC several times a month, where clients with Alzheimer Disease or related dementias and their caregivers are seen by geriatricians and geriatric nurse assessors for assessment, diagnosis and health care planning.

6) The Cardiac Rehabilitation Exercise Program operates four days a week and works collaboratively with the University of Ottawa Heart Institute (UOHI) to deliver the Cardiac Exercise Rehab Program on site (via Telemedicine technology). SVCHC's trained physiotherapist and registered nurse customize rehab exercise programs for clients from our community who have experienced a recent cardiac event. Referrals to the cardiac rehab program come directly from the Heart Institute and our own community hospitals and primary care providers. Via OTN and OASIS, SVCHC and UOHI share client information and SVCHC's cardiac team assess, monitor and deliver the program for improved client heart-health outcomes. An MOU with a local internist/cardiologist provide regular consultant services for our RN, PT and clients.

7) SVCHC operates a Lung Health/COPD Program in collaboration with Cornwall Community Hospital (CCH). SVCHC employs a full time Nurse Practitioner (NP) and Respiratory Therapist five days a week to serve our clients. The NP visits and assesses CCH's patients in the hospital's clinic setting, then follows up in a community outreach capacity seeing clients in their homes and/or at SVCHC for best outcomes. This initiative is part of a greater Champlain Regional Lung Health initiative funded by the Champlain LHIN.

8) SVCHC is the host Ontario Telemedicine Network (OTN) Coordination site for the catchment area. Telemedicine is a growing and highly utilized program and SVCHC with two (2) full time Registered Practical Nurses coordinating a variety of virtual service connections including: Tele-nephrology, psychiatry and mental health services, cardiac rehab, diabetes education and counselling, weight management, pre and post op follow-up, children's mental health, health education, infectious diseases, eating disorders, coordination of administrative meetings and conferences, etc. This program is made possible through a collaborative purchase of service agreement with Hawkesbury General Hospital. This initiative fits well with the QIP Accessible initiative as it ensures our local, rural residents have access to tertiary and regional health services close to home, at no cost to the client.

9) Falls Prevention and Exercise classes are delivered throughout the City of Cornwall and Stormont, Dundas and Glengarry Counties. This initiative is part of the Champlain Regional Falls Prevention and Exercise initiative supported through a purchase of service agreement with Pinecrest Queensway Community Health Centre as the regional lead agency.

10) SVCHC delivers a Primary Care Outreach (PCO) service with a Registered Nurse and Community Health Worker working as a team. They provide PCO community outreach services by visiting vulnerable, at-risk seniors in their homes. The PCO program began in July 2014 and is a program operating in partnership with South-East Ottawa Community Health Center as the regional lead agency.

11) St Elizabeth's Health Care Services offers free foot care at SVCHC to low income adults and seniors living in our catchment area. St Elizabeth's provides the service and SVCHC provides the use of the Centre, administrative support and the use of its amenities at no cost.

12) Through an MOU, the Regional Arthritis Society delivers support and counselling to individuals with Arthritis and linked conditions by sending an Occupational Therapist to SVCHC twice a month. SVCHC provides the use of the Centre, administrative support and its amenities at no cost.

13) Walk-In Counseling Clinics are free, single-session counselling services to individuals, couples and families on a first-come, first-served basis held every Thursday from 1:00 to 8:00 p.m. This professional service is delivered through a MOU partnership agreement with several community health and social service agencies with a mandate to provide mental health counseling services. SVCHC is one of several partner organizations involved in this service delivery model who rotate through a schedule to provide services to the community.

The extensive list of innovative and integrated programs and services offered by SVCHC visit are listed on our website at www.seawayvalleychc.ca. Programs include: GLBTQ Support Program, Living with Chronic Conditions, Chronic Disease Pain Management, Exercise and Walking Programs, Smoke Cessation, Nutrition counseling, Seniors Wellness Programs, Men in the Kitchen Program, Green Food Box, Baby Food Making courses, Social Drop-In, etc. All programs and services are free and available to families and individuals currently living or working in our catchment area. Particular focus is on vulnerable or disenfranchised individuals and families, seniors, newcomers to Canada and those without a health provider.

As noted above, SVCHC is actively involved in two Health Links in our catchment area. Improved alignment of a common EMR would greatly enhance Health Link client outcomes.

Challenges, Risks & Mitigation Strategies

1) EMR Data Collection: Automated data transfer between organizations remains a challenge and impedes efficiency, data reliability and timely service to clients. With three local community (rural) hospitals submitting referrals and discharge summaries using different Electronic Medical Record (EMR) systems, processes and formats, (or by fax if manual charting), SVCHC's challenge is one of receiving timely and legible client discharge summaries. SVCHC is expected to provide timely access to primary care appointments post-discharge through coordination with hospitals as an "Integrated" quality dimension however with all organizations using different EMR software this is difficult to impossible at this time. The risk related to this challenge is one where SVCHC cannot meet the goal identified until the Ministry of Health and/or the LHIN streamline and standardize processes amongst the health organizations in relation to electronic data sharing. Additionally the collection of comparative data for decision support purposes is impossible until we are using a common electronic health record and standardized processes for information sharing.

2) SVCHC has grown in the past 7 years from 16 to 36 staff plus contractors, with 21 programs and services in addition to provision of primary care. Despite all the growth, the funding for administrative and support staff has remained the same. SVCHC staff wear several hats, (i.e., service provider and manager) with several roles and added responsibilities which increases the risk for error and burnout. The mitigation strategies include streamlining processes internally and working with our external partners to share roles and responsibilities for service delivery (as noted above in the Integration and Continuity of Care section) and requesting additional funding from the LHIN for added staff to support the horizontal infrastructure growth experienced.

3) The requirements of the Broader Sector Accountability Act, specifically the lack of new funding for cost of living allowance (COLA) over several years has demoralized staff and decreased the CHC Sector's appeal as an employer of choice. With the CCAC and hospitals paying higher wages it will be increasingly difficult for CHCs to recruit highly qualified individuals, particularly in our rural area. SVCHC received a base funding increase in 2016-2017 dedicated to recruitment and retention. This funding allowed SVCHC to increase all Staff wages by at least 2.5%. As a mitigation strategy to ensure continued operating funds for COLA, the AOHC, on behalf of the provincial membership, continues an advocacy campaign with the Ministry requesting additional base funding for COLA and compensation to the community sector. The CHC Sector also continues to advocate to the Ministry and LHIN for COLA funding. If the base funding envelope does not increase soon, services may have to be cut and staff may be laid off to balance the budget.

4) Multiple reporting requirements are another challenge. Streamlining reporting requirements to HQO, to AOHC (the provincial association), the Canadian Centre for Accreditation (CCA), the Champlain LHIN as funder and the Ministry would result in greater efficiencies and quality and consistency in reporting. SVCHC is working towards accreditation process through the Canadian Centre for Accreditation and this has added a great deal of work to all Staff, including additional reporting requirements.

5) Lack of health care physician specialists (particularly psychiatry, rheumatologist and pain specialist) available to support the primary care providers with advice for their clients health needs. The risk may result in our providers refusing to accept new referrals of clients with mental health and addiction issues as they have little support from specialists and feel they are working outside their scope of practice and expertise.

6) A great challenge SVCHC faces is ensuring the necessary threshold number of administrative staff as resources to achieve the various components of the QIP Plan. Critical to the success of our plan is our ability to accept the responsibility for the roll-out of the initiatives, (and their component tasks) given the day-to-day work of all employees. We are very lean in terms of administrative support in the entire the infrastructure.

7) Transition to a new Electronic Health Record: In 2017-2018 SVCHC will, once again, transition to a new Electronic Health Record. In February, 2014, SVCHC transitioned from Purkinje to Nightingale on Demand (NOD) as the new Information Management System. In 2017-2018 SVCHC will once again be required to transition to another electronic health record as NOD was sold to Telus PS Suites. The transition to the new EMR is part of a much larger provincial project managed by the Association of Ontario Health Centres and accepted by most Community Health Centres in Ontario. The roll-out and transition to the new EMR will require some change management and allow time for staff to learn and become proficient with the new software. SVCHC projects this transition to occur in the fall of 2017, and further projects our deliverables (targets) will be reduced as we reduce service to manage/learn the new charting requirements in PS Suites.

The use of a common EMR supports regional and provincial data collection and standardization of processes. This data assists and will continue to be used to inform our decisions for quality improvement. Additionally a feature of NOD is the connectivity to OLIS, enabling the sharing of lab results which will support our goal of improving the client's experience. SVCHC transitioned to OLIS in December 2014. Automated data transfer between organizations remains a challenge and impedes efficiency and data reliability.

SVCHC uses the NOD data to inform on the health care needs and trends of our clients and our community prior to making formal requests for funding. We will also use the data for client recalls - when we need to contact out clients to inform them that specific health prevention tests (such as mammograms, paps, vaccines, or their health exam) are due. This will ensure clients receive quality preventative health care and that SVCHC achieves the approved MSAA targets. We query information from the NOD to support funding requests to the Ministry, LHIN or others and share this information with our partners to ensure we coordinate to deliver quality services in our community.

8) SVCHC implemented a new Management Team on April 1st, 2016. Each Team member was assigned new roles and respective staff/programs aligned with the organizational chart/structure created. As a result, 2016-2017 was a year of Team and skills building, change management, and transitions ('storming and norming').

9) Quadrant Human Resource and Payroll Software: In March 2015, SVCHC purchased Quadrant as the Human Resource and Payroll software to manage our own in-house payroll, benefits and attendance management. In 2016-2017 SVCHC upgraded the Microsoft Dynamics GP Payroll System to have full in-house service capacity. This new software resulted in annual operating savings and efficiencies. This software interfaces with Great Plains (installed and implemented in 2013-2014) which further improves our ability to collect, share and analyze data with, and from, many health care providers using Quadrant and Great Plains software.

Engagement of Clinical Staff & Broader Leadership:

SVCHC engages with the Board of Directors and Staff in establishing shared quality improvement goals and commitments for the organization in the following ways:

- a) SVCHC's Strategic Plan for 2016-2021 and the 2016-2017 Operating Plan include the QIP goals of integration, improving access and improving the client experience.
- b) Quality Improvement has been standing items on each monthly Staff and Board Meeting agenda for input, information sharing and decision making.
- c) The Executive Committee of the full Board of Directors has the oversight responsibility for regular input, monitoring and decision-making for the QIP.
- d) The QIP is reviewed and approved by the Board of Directors on a quarterly basis through the review of the quarterly "Management Summary Report."
- e) The SVCHC Management Team monitors the QIP through the various initiatives at their weekly meetings.
- f) The Executive Director prepares and disseminates a monthly Executive Director Report to the Board which is shared with all staff following the Board meeting. This report includes updates on QIP initiatives, MSAA results, information bulletins, SVCHC successes, upcoming training opportunities, etc.
- g) SVCHC's primary care team works has work with the Champlain Primary Care Quality Practice Facilitation Program to create efficiencies, improve practice systems and improve the client's experience and outcomes.
- h) Documentation and reporting of all incidents to the Board and to the Occupational Health and Safety Committee helps to inform on trending of incidents, training required and areas for improvement.
- i) SVCHC is working towards accreditation with the Canadian Centre for Accreditation by December 2017.
- j) SVCHC is actively involved in Health Links and Sub-Region planning initiatives in our area.

Patient/Resident/Client Engagement:

SVCHC administers an annual Client Satisfaction Survey. Once again, in the fall of 2016, SVCHC's clients reported a very high satisfaction rate with services received

~~at SVCHC. The 2016 Client Satisfaction Survey reported 92.4% of clients felt that~~

their health provider spent enough time with them at SVCHC. Additionally 96.7% of SVCHC clients agree or strongly agree that their health care provider treats them with dignity and respect. In terms of access, 63.8% of SVCHC clients reported they obtained an appointment in 3 days or less when they were sick.

Our clients are surveyed minimally on an annual basis each fall to monitor the client's experience, receive the client's input and suggestions, and to monitor the quality of our services offered. A client "Comment, Suggestions and Complaints" box is available in the reception area and on line on our website. Providers routinely ask their clients if they have questions, concerns, understand the information provided, etc., to improve the client experience. The 2016 Client Satisfaction Survey reported 97.8% of clients reported their health care provider gives them an opportunity to ask questions about recommended treatment.

Accountability Management

SVCHC's Board of Directors and Leadership Team is accountable for achieving the targets set out in QIP through the following mechanisms:

- 1) SVCHC is compliant with the LHIN's MSAA and CAPS requirements. All monthly and quarterly reports are reviewed at the Management Team level, approved at the Board level then submitted to the LHIN.
- 2) An Annual Report is completed at fiscal year-end which is approved by the Board at the Annual General Meeting, then submitted to the LHIN and all entities requiring copies.
- 3) "QIP" has been added into the quarterly Management Summary Report to the Board to ensure a focus on quality is maintained.
- 4) The Client Satisfaction Survey is issued each fall to monitor the client experience. A client "Comment, Suggestions and Complaints" box is available in the reception area. Providers regularly and routinely ask their clients if they have questions, concerns, understand the information provided, etc., to improve the client experience.
- 5) SVCHC reports on MSAA targets to the LHIN quarterly and annually. The expanded, stretch MSAA targets ensure quality improvement targets are specific to improving access, the client experience and integration.
- 6) All incidents are reported in writing on an "Incident, accident or complaint Form" to the Executive Director, which are then reported to the Board as needed but minimally on an annual basis in a summarized report called the "Risk Management and Client Safety Summary Report". This report is presented to the Board and to the Centre's Occupational Health and Safety Committee (on a quarterly basis) for their information, and to implement mitigation strategies and/or improvements as needed. The summary report is a reflective report broken down into themes. This Summary Report identifies risks and mitigation strategies for improvement.
- 7) Training: SVCHC has developed an elaborate in-house staff development and training tracking tool to ensure all legislated training and other training funded and supported by SVCHC is tracked for all employees, contractors, volunteers and students. Certificates of successful completion are printed and filed in personnel files.

8) Program Evaluations and Program Charters:


In fiscal year 2016-2017 SVCHC Health Promotion staff have been actively involved in developing evaluations to measure Community Initiatives (C.I. Tool) & Personal

Development Groups. Program Charters are used to ensure the goals of our initiatives meet the original strategic objectives of the programs. This work will continue in 2017-2018 and the evaluation results used to inform future service planning and/or delivery.


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



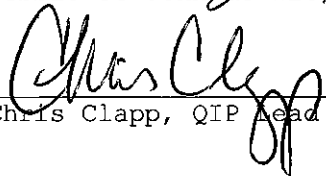
Peter Chisholm, Board Chair (signature)



Leanne Clouthier, Clinician Lead (signature)



Debbie St John de Wit, Executive Director/Administrative Lead (signature)



Chris Clapp, QIP Lead (signature)

QI Achievements From the Past Year

Seaway Valley Community Health Centre (SVCHC) was successful in receiving new annualized, operating funding to expand the Lung Health/COPD Program for our community. The new funding allowed SVCHC to hire a full time Nurse Practitioner (NP) and extend the hours of the Respiratory Therapist (RT) from 3 days a week to full-time at 5 days a week.

This was a great achievement as the residents of Cornwall and the surrounding Counties of Stormont, Dundas and Glengarry, are identified as having the highest poor lung health issues in the Champlain Region and 19 % of admissions to our local hospital is related to lung health issues. As a result, SVCHC is working in collaboration with the Cornwall Community Hospital and sharing the NP who works in their hospital COPD clinic and follows these patients when discharged by visiting them at home in an outreach capacity.

The NP and RT see community clients in our Centre or in an outreach capacity in their homes to ensure best health outcomes. As a result of this expanded Lung Health/COPD Program, SVCHC has been able to expand the Smoke Cessation Program and is reducing hospital ER visits and readmissions.

Population Health

Seaway Valley Community Health Centre's (SVCHC) mandate is to serve low income clients and families, seniors, newcomers to Canada and those individual who have been unable to access a primary care provider.

Cornwall and surrounding Stormont, Dundas and Glengarry Counties is known as an economically deprived area with high rates of low income, low literacy, lack of employment, high health complexity, lung health issues, and high mental health and addictions rates, etc.

As our area is identified as having the highest poor lung health issues in the Champlain Region and 19 % of admissions to our local hospital is related to lung health issues. As a result, SVCHC is working in collaboration with the Cornwall Community Hospital and sharing the NP who works in their hospital COPD clinic and follows these patients when discharged by visiting them at home in an outreach capacity.

The NP and RT see community clients in our Centre or in an outreach capacity in their homes to ensure best health outcomes. As a result of this expanded Lung Health/COPD Program, SVCHC has been able to expand the Smoke Cessation Program and is reducing hospital ER visits and readmissions.

The Eastern Ontario Health Unit is also a key partner in the Smoke Cessation program and we work closely amongst the partners to ensure our financial and human resources are not working in isolation of each other's role and mandate, non-duplication, sharing resources and service delivery efficiencies.

Equity

Seaway Valley Community Health Centre (SVCHC) set a goal to provide Indigenous Cultural Sensitivity training to all Board members and Staff over three years, (commencing in 2016). SVCHC met this goal in less than one year. The following training has been completed:

- The Executive Director and the three Management staff participated and completed the Ontario Core Sanyo's Indigenous Cultural Awareness Training (\$250/participant) over the summer of 2016

- All SVCHC staff were offered the opportunity to participate in the free Cancer Care Ontario, 9 module training. The Executive Director completed 8 / 9 Cancer Care Ontario training modules (with the exception of the clinical module).

- SVCHC purchases the Thunder Bay/Thunderstone Pictures produced video entitled "Walk-A-Mile Film Project". The video is broken down into 10-15 minute subjects and addresses treaties, racism, violence against women, and the way forward. All staff has joined in the training during staff meetings. To date, 3/5 videos have been viewed by all staff. The SVCHC Board of Directors also watched 2/5 of the videos in this series to date.

- On October 13, 2016, The LHIN offered CHCs the opportunity for a specific number of free Ontario Core Indigenous Cultural Awareness seats. SVCHC was initially offered 10 free seats but due to increased demand, the LHIN decreased spaces to a total of five (5) free seats. Board members and staff were invited to participate in the training. We received a high demand of requests to participate in this training: In total 4 board members and nine (9) completed this training.

The training was considered to be invaluable and has created a greater sensitivity, awareness and appreciation of indigenous issues. This learning is incorporated into day-to-day work/approach with indigenous clients using an equity lens.

SVCHC is actively involved in supporting LGBTQ and Trans populations and as such we are participating in a regional program to help bridge the gap in health care services for the Trans* population. Specifically we are a partner in a regional program to work with Trans population in hormone assessments and hormone starts for Trans* who are gender transitioning, but also in their access to culturally safe primary health care and social services.

Key areas of activity for this Trans population proposal are:

1. To increase regional capacity to address social service support for trans* clients and their families (Hormone Replacement Therapy (HRT) assessments, social transitioning support, mental health counselling and family supports). This requires increased counselling hours and locations of access, and includes a purchase of service to increase counselling and community supports to trans* clients and families.
2. To increase access to hormone starts in the region, through increased capacity in the community.
3. To pursue a regional approach to planning for health and social service delivery for the trans* population, including integrated care delivery from childhood through to adulthood.
4. To continue to build capacity for ongoing hormone maintenance and culturally safe primary care
5. To continue engagement with the trans* community, and advocacy.

Integration and Continuity of Care

SVCHC staff is actively involved in two local Health Links from Management participating as Steering Committee members to training four (4) SVCHC Staff as Health Link Care Coordinators.

SVCHC developed an internal weekly client triage process, called "Bridges". "Bridges" is the internal mechanism to case conference SVCHC's complex clients (who are falling through the cracks) internally prior to identifying and referring these individuals to "Health Links". This "Bridges" table has allowed all SVCHC to participate in 'case conference' discussions related to clients in all program and service areas, and the "Bridges" table has expanded our Staff's knowledge of both our own internal programs and external programs available. In this way, "Bridges" has built, and continues to build, internal capacity amongst our own Staff and strongly alliances with external service providers.

Over the past fiscal year SVCHC has seconded 3 staff to Health Links to become immersed in the Health Links model to fully appreciate the model, and return to SVCHC to embed the model into our primary health care organization. The difficulty is the said staff return to their original positions, with full caseload/workload and little time to practice the Health Links philosophy/practice (which is time consuming). The value of the Health Link model is clear and not in question, but the reality of its application in practice without dedicated resource(s) is unlikely.

Until March 31st, 2017, SVCHC has an in-house System Navigator working on Care Coordination for our SVCHC primary care clients exclusively. This model has proved to be most effective in supporting our clients' complex needs and enhanced the client's experience in the health care system. However, the funding for this position expires March 31st, 2017, and although the internal System Navigator has proven to be highly effective for improved client outcomes, the program will end without dedicated funds. SVCHC is unable to sustain this level of service in 2017-2018 without Health Links funding to do so.

Access to the Right Level of Care - Addressing ALC Issues

SVCHC works with the two local Health Links lead organizations as active Steering Committee members and in intensive and direct System Navigation working on Coordinated Care Plans for clients with highly complex needs. This intensive case care coordination ensures the client is linked to the right service as quickly as possible and the aim is to improve the client experience in the health system and reduce ER visits and admissions.

Additionally, SVCHC works directly with the local community hospital on several initiatives and programs including accepting referrals for new clients for admitted patients without a primary care provider, on outreach referrals for the Lung Health/COPD program, the Cardiac Rehab Program and the Primary Care Outreach.

Engagement of Clinicians, Leadership & Staff

In March 2017, the entire SVCHC interdisciplinary Team was engaged in a 2016-2017 "Year in Review" facilitated session to celebrate last year's successes and provide input and advice on how we can improve to best meet our client's needs. The QIP goals are designed into the Centre's strategic objectives and subsequent initiatives delivered in Staff's work plan.

The Board of Directors approves the QIP each March. Subsequently, each month the Board of Directors receives for review and approval an "Executive Director's Report to the Board" which highlights achievements to date and provides information on how the organization is moving forward with the established Strategic Directions and QIP goals. Additionally, a Management Summary Report is presented to the Board on a quarterly basis summarizing the following: financial and contractual reporting requirements, evaluations of programs and QIP goals, and deliverables to the LHIN and Ministry.

All Staff, including Clinicians receive these same reports for their information and use and discussion in their respective discipline meetings.

The Clinicians individual data is synthesised and analysed each month and provided to them in summary format review. This data is used to identify data reporting (charting) errors, to understand where education and training is required, to plan workloads and to evaluate performance.

Resident, Patient, Client Engagement

Client engagement occurs in many ways at SVCHC.

Initially, clients are engaged during the development of the organization's Strategic Planning process. Clients are invited to attend the many meetings, focus groups, planning events, etc., hosted to ensure adequate client input into the Strategic Plan.

Clients are surveyed on an annual basis to inform the organization of potential areas for improvement and celebrate the successes identified.

Upon each Primary Care appointment, clients are asked for their input and if they have any questions in an attempt to involve the client in decisions about their care and/or treatment plan. The Inter-professional team also uses the "Teach Back" approach asking clients to repeat back their care plan goals to confirm they understand the instructions and for best outcomes.

Self-management is incorporated into all Community Initiatives and Personal Development Group activities we deliver on a routine basis.

We also host a monthly Social Drop In Program so clients can return after their program ends (i.e. Stress Management Program or Cooking Program, etc.), to visit with friends made and feel comfortable in SVCHC as "their" centre. Many of our clients become volunteers with the Centre.

Staff Safety & Workplace Violence

SVCHC has completed a "Prevention of Violence in the Workplace Risk Tool Assessment" and followed up on all recommendations made, including renovating the reception area to ensure front-line reception staff are safe.

All SVCHC Staff have received Crisis Prevention Intervention (CPI) Training and all staff received CPI training and/or refresher training each year. Two SVCHC are trained as CPI Certified Instructors.

The SVCHC building has undergone many physical renovations for enhanced staff safety including, installation of video cameras on all exterior corners of the building and throughout the parking lot, improved lighting in the parking lot,

renovations to the reception area, installation of automatic doors with phobes for opening, new eye-wash station installed, etc.

The MDS Manual is reviewed and updated regularly.

SVCHC's Occupational Health and Safety (OH&S) Committee tours and inspects the Centre and communicates with staff on a monthly basis to identify any safety concerns, potential risks, or repairs needed. The OH&S Committee conduct routine fire drills and training for staff on all new safety policies and procedures.

Safety and Workplace Violence Prevention policies are up-to-date meeting the latest legislative requirements from 2016 and area reviewed annually by the OH&S Committee.

There is a process for all Staff, Volunteers, Students, Clients, Partners and/or general public to identify and report safety risks or incidents. The Executive Director receives all incidents and compiles these into an Incident Report reviewed quarterly by the OH&S Committee, and annually by the Board: From this review, trends are identified, and mitigation strategies and required training are implemented.

Contact Information

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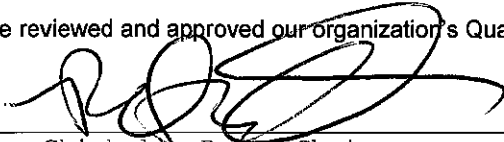
Other

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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



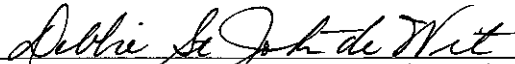
Peter Chisholm, Board Chair

(signature)



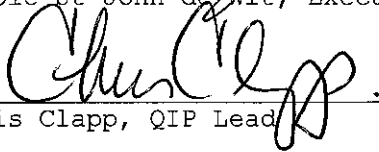
Leanne Clouthier, Clinician Lead

(signature)



Debbie St John-de Wit, Executive Director/Administrative Lead

(signature)



Chris Clapp, QIP Lead

(signature)