Seaway Valley Community Health Centre

Working with you for a Healthier Community

2018/19 Quality Improvement Plan for Ontario Primary Care
Improvement Targets and Initiatives

Seaway Valley CHC Inc. 353 Pitt Street, Cornwall, ON K6J 3R1

AIM		Measure								Change				
Quality Dimension	Issue	Measure/Indicator	Type	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	A	% / Patients meeting Health Link criteria	In house data collection / most recent 3 month period	92242*	CB	70.00	Primary Care Outreach Regional and the LHIN devised a formula whereby 90% of clients referred to PCO would be recognized as requiring a Health Link approach. SVCHC took 90% of clients referred to PCO in 2016/2017 which results in 98 clients who will be offered Health Links. However, we will be submitting a corridor of 70-100 Coordinated Care Plans as this is a baseline year.	1)Primary Care Outreach Team (PCO)will be pivotal as a team complement of Community Health Worker and Registered Nurse to provide coordinated care and complete Coordinated Care Plans (CCPs). The LHIN has recognized for 2018-2019 that PCO is the ideal team to coordinate care of those 65+ with complex needs. Coordinated care plans will be completed with the person, caregivers and care team in validation of of a person-centred care approach, using the language of the client. CCPs will be completed in the CHRIS EMR. PCO Regional and the LHIN devised a formula whereby it is understood for this developmental year that 90% of clients referred to PCO will be offered a Health Links approach.	CCPs will be tracked. As CCPs are already understood as a quality initiative that promotes a client-centred approach, empowering people to take central role in their health, completion of CCPs will reinforce this quality standard.	# of CCPs	70-100 (corridor) Coordinated Care Plans (CCPs) Based on corridor of 90% (98)of # referred clients in fiscal 2016/2017	This is a stretch goal within a change management system, hence a corridor of CCPs. There are identified system level issues to be managed, including multiple consent forms, two different EMRs being used. As well, with current access issues to primary care providers, this may pose a significant barrier to fulsome care.
	Effective Transitions	Percentage of patients who have had a 7-day post hospital discharge follow up. (CHCs, AHACs,NPLCs)	P	% / Discharged patients	See Tech Specs / Last consecutive 12 month period	92242*	CB	20.00	Hospital reporting data EMR data CIHI DAD	1)Improve regular communication with local hospitals. Currently we do not have reliable data to work with as we do not receive consistent timely admission notification and/or discharge summary reports from local hospitals.	1) Ensure SVCHC receives the faxed list of clients who visited the ER and who were admitted, weekly basis. This requires ongoing partnerships with our local hospitals. 2) Continue to retrieve client information through others measure such as OASIS, OLIS. Become a participating member of Connecting Ontario. 3) Train staff on how to use hospital portal and/or discharge reports shared by hospitals.	Receive weekly list of cl frequenting the local hospital. 20% of clients discharged from hospital who access their provider within 7 days of hospital charge will be offered an appointment when applicable.	20% of SV clients will have been contacted and provided an appointment when applicable within 7 days post discharge.	Note that the LHIN has endorsed that Coordinated Care Plans (CCPs) will be available via the CHRIS EMR (Home and C
										2)Continue to monitor client admission 2)Continue to education clients of the importance of timely follow-up with the primary care providers and/or health care team.	1) Nursing staff will review the local hospital's list of ER and admission weekly. 2)Staff will contact clients who where admitted or who are still admitted to organize a follow-up appointment with the most appropriate provider. 3)During orientation, client are instructed to call to book appointments within 48 hours of discharged from the hospital. 4)Reminder message to call post discharge will be posted in client areas.	Nursing will document in the ER/hospital EMR template on all clients who where contacted from the hospital list. Clients and/or their families will contact staff within 48 hours of discharge from hospital to book an appointment for follow up with a appropriate provider.	20% of clients discharged from hospital will be contacted and provided an appointment with the appropriate health care provider.	
		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.	P	% / Discharged patients	EMR/Chart Review / Last consecutive 12 month period	92242*	CB	90.00	Hospital admission data CIHI DAD	1)Track # of hospital discharge notifications received 2)NP with local hospital, courtesy privileges will see client when admitted.	All notifications received will be forwarded to nursing staff and NP doing hospital rounds. The # of notification will be tracked. Nursing staff will call client and/or family to either book an appointment or ask that they call the day the client is discharged. 2) The NP with courtesy privileges will visit client at the beside. A reminder note is handed to clients to call the day of discharge and review of plan of care.	# of hospital notification # client of contacts and appointments booked	90% of client that a notification of admission was received will be contacted for follow-up and review of discharge plan of care.	Discharges on Fridays remain a concern and will be a challenge for contact within 48 hour follow-up.
Efficient	Accreditation	SVCHC will receive full accreditation through Canadian Centre for Accreditation this coming fiscal year.	C	Accreditation received / Clients	Canadian Centre for Accreditation / Fiscal year	92242*	CB	CB	Canadian Centre for Accreditation is the body that allows community-based primary health care organizations to keep pace with accountability expectations and lead when it comes to service quality. CCA's standards for community-based primary health care are accredited by ISQua, the International Society for Quality in Healthcare.	1)SVCHC has been preparing for first Accreditation through Canadian Centre for Accreditation (CCA) July 2018.	Ongoing efforts by SVCHC Board of Directors, Management team and staff in preparation for meeting standards of CCA.	The ability to receive CCA Accreditation through thorough review of accreditation standards and site visit as well as community surveys with partners and volunteers.	SVCHC will receive accreditation through CCA in 2018/2019.	

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)

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Quality Dimension	**Issue**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization ID**	**Current Performance**	**Target**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Target for Process Measure**	**Comments**
Equitable	**Population Health - Cervical Cancer Screening**	Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period.	A	% / PC organization population eligible for screening	CCO-SAR, EMR / Annually	92242*	78.2	67.00	67% is the target we have identified with the LHIN	1)Continue to monitor the EMR data. If the data indicates the percentages are slipping downward, the management team will inform the providers and re-educate as required.	EMR data is collected and reviewed quarterly by Team Lead, nurses and providers. Clients that are due for procedure are booked an appointment. All MSAA data is reviewed and shared with the all staff and the Board	Quarterly MSAA review of % of eligible pap tests completed.	67% of eligible clients will have had a pap test within 3 years.	
	Population Health - Colorectal Cancer Screening	Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for colorectal screening in each calendar year	A	% / PC organization population eligible for screening	See Tech Specs / Annually	92242*	81	65.00	65% is the target we have identified with the LHIN.	1)Continue monitoring EMR data. If the data indicates the percentages are slipping downward, the management team will inform the providers and re-educate as required.	EMR data is collected and reviewed quarterly by Team Lead, nurses and providers. Clients that are due for procedure are booked an appointment. All MSAA data is reviewed and shared with the all staff and the Board	Quarterly MSAA review of % of colorectal screens done/offered.	65% of clients will have had a FOBT test within 2 years	
	Community Initiatives Resource Tool (CIRT)	# of Community Initiatives (CI)s	C	Number / Community	CIRT / 2018/2019	92242*	CB	10.00	In past fiscal year of beginning entries of Community Initiatives into CIRT, SVCHC entered x	1)SVCHC looks forward to: 1.Continued entry all Community Initiatives into the Tool; 2. Review of reporting capabilities and ability to integrate information for funders 3. Ongoing review of CIRT for best practices indicated by other CHCs	SVCHC team will continue to add new Community Initiatives, update progress and measurable data. Management team will continue to work at strategic levels around reporting mechanisms and use of data.	# of CIs;	Baseline year	Examples of our current Community Initiatives reported in the tool include Cornwall Green Food Box, Cornwall Social Housing Community Gardens, SFIC Volunteer Fitness leader development, Situation Table, Drug Awareness Group, Champlain Lung Health Network, Smoking Cessation Community Network, Trans Regional Planning Table, to name some.
	Sense of Belonging	"How would you describe your sense of belonging to your community?" (Very strong/Somewhat strong/Somewhat weak/Very weak).	C	% / Clients	In-house survey / 2018/2019	92242*	30.43	35.00	SVCHC will examine survey data and do further analysis according to income brackets. Be Well Survey indicated that those with strongest sense of belonging (88.41%) were at 40000-59999 income bracket. Those reporting weakest sense of belonging (30.43%) were at 15000-19999 income bracket. We will pilot various Community Initiatives and Personal development groups with pre and post testing to see if engagement results in improved sense of belonging for lower income groups.	1)This question has been added to our Client Satisfaction Survey to be completed fall 2018. 2. We will hold a Client forum Fall 2018 in conjunction with our Client Satisfaction Survey where we will ask this question and further probing questions to better understand clients sense of belonging. 3. BIRT data can be extrapolated as this has also been added to our EMR.	Data from the methods described will be extrapolated, reviewed and analyzed against other data (income, gender orientation, as examples).	1. # of client surveys 2. Client forum	This will be a developmental year to ensure this question has been systematically included within our PDG (personal development groups).	
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?	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	92242*	91.15	92.00	Note that Champlain LHIN data for this indicator in 2016 was 89.1%. SVCHC remains above this performance. (Health Care Experience Survey, MOHLTC).	1)SVCHC will continue to build on our success with client forums to gather information about client experience. Different methods, besides surveys, may create an opportunity to understand how we can improve our communication to clients and their overall experience. 2. Integrate the client experience feedback into the design, development, implementation and evaluation of service delivery and programming. 3. Completion of Care Coordination Plans (CCPs) enable the client voice and goals into their overall care planning.	In-house survey data Client forum	1. Questions asked on in-house survey (fall) and analysis 2. Questions asked at client forum (fall) and analysis	92% will respond "always" or "often" to this question.	
Safe	**Medication Safety**	Percentage of patients with medication reconciliation in the past year	A	% / All patients	EMR/Chart Review / Most recent 12 month period	92242*	CB	20.00	EMR chart audits We will be implementing a new EMR (from Nightingale on Demand to Telus PS Suites) in Fall of 2019. With PS Suites we expect to have a mechanism to track medication reconciliations for our clients.	1)Medication reconciliation appointments with clients. 2)Pharmacist support	1)Providers will have client with multiple long term medications book an appointment with nurse to review medication. 2) the Cumulative Patient Profile (CPP) will be update in our current EMR. (New EMR is expected to have this option also) 3) Client with very complex medication list will be booked with a local pharmacist to complete a Med Check.	# of medication reconciliations appointments completed # of med Check received from pharmacists	20% of clients will have had a medication review/reconciliation done by nurse or pharmacist.	