Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	"How would you describe your sense of belonging to your community?" (Very strong/Somewhat strong/Somewhat weak/Very weak). (%; Clients; 2018/2019; EMR data)	92242	30.43	35.00	77.00	77% of individuals described their sense of belonging as "very strong" or "somewhat strong". This means that 23% indicated their sense as "somewhat weak" or "very weak".

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Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
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.	Yes	We have postponed #2 Client forum in light of other time commitment to large scale change management processes underway (e.g. Health Links). However, we have included this question in evaluations of our Personal Development Groups (PDGs).

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2	# of Community Initiatives (CI)s (Number; Community; 2018/2019; CIRT)	92242	CB	10.00	14.00	Note that this pilot project is a joint initiative under Western University, Renison University College (Dr Jennifer Rayner 647-683-8437).

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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	Yes	SVCHC has included 14 Community Initiatives entered into the Community Initiatives Resource Tool (CIRT). (increase of 4 from 10 last year). SVCHC is part of a pilot project "An evaluation of community development activities in Ontario Community Health Centres" which will document and attempt to measure the activities and impacts of CIs.

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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? (%; PC organization population (surveyed sample); April 2017 - March 2018; In-house survey)	92242	91.15	92.00	CB	Our Client Satisfaction survey indicated that 92% of our clients either "Strongly Agree" (56%) or "Agree" (36%) with the statement that they feel involved in their treatment decisions. (NOTE: the automatic tabulation for this indicator is not functioning; note it is not 100 as indicated above).

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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.		

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4	Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for colorectal screening in each calendar year (%; PC organization population eligible for screening; Annually; See Tech Specs)	92242	81.00	65.00	80.00	Primary health care team continues to monitor this performance on a regular basis. Data is as of December 31 2018.

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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.	Yes	Primary Care Providers continue to monitor their performance rates on a regular basis.

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5	Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period. (%; PC organization population eligible for screening; Annually; CCO-SAR, EMR)	92242	78.20	67.00	71.00	Primary health care team continues to monitor performance on a regular basis. Data as of December 31 2018.

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6	Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach (%; Patients meeting Health Link criteria; most recent 3 month period; In house data collection)	92242	CB	70.00	67.00	SVCHC CCPs: Primary Care Outreach team (age 65+) - 50 CCPs. SVCHC CCPs (under 65+): 17 CCPs. Data is as of March 1, 2019.

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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.	No	There were challenges in the way the targets were determined. Targets were based on "Referrals" versus "Accepted Referrals". We found that there were declined referrals for valid reasons (e.g. deaths, transferred to Long-term care, client refusals) so basing the data on "Referrals" only is not a good measure. As well, that component is out side of our ability to control versus the more appropriate target of Accepted Referrals. With all new referrals accepted, we are satisfied that all new clients have had Coordinated Care Plans completed this year.

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7	Percentage of patients who have had a 7-day post hospital discharge follow up for selected conditions. (CHCs, AHACs,NPLCs) (%; Discharged patients ; Last consecutive 12 month period; See Tech Specs)	92242	CB	20.00	CB	Challenges remain ensuring that we receive reports from hospitals in timely way. We strive to collaborate with the largest local hospital to continue to reinforce ongoing electronic communication to facilitate effective transition from hospital to community. Challenge also remains that some clients do not prefer to meet within the 7 days as they may have specialist appointments, as example.

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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.	Yes	SVCHC receives list of clients discharged from a local hospital and offers follow up to clients as appropriate.
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.	Yes	Staff continue to remind clients of follow up with their care team post-discharge as appropriate which is also part of the self-management strategy.

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8	Percentage of patients with medication reconciliation in the past year (%; All patients; Most recent 12 month period; EMR/Chart Review)	92242	CB	20.00	CB	SVCHC received funding for part-time pharmacist fall 2018 and so is able to offer medication reconciliation as needed for primary care clients.

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Medication reconciliation appointments with clients. 2)Pharmacist support	Yes	

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9	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. (%; Discharged patients ; Last consecutive 12 month period; EMR/Chart Review)	92242	CB	90.00	25.20	Data is from the 2017 Practice profile as the 2018 Practice Profile is not yet available.

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Track # of hospital discharge notifications received 2)NP with local hospital, courtesy privileges will see client when admitted.		SVCHC continues to track hospital discharge as best as possible provided the local hospital has shared the information. We have a Nurse Practitioner who visits the hospital weekly to review concerns regarding admitted SVCHC clients. We continue to monitor the hospital discharge notifications we receive and follow up with clients in timely way. We have noted that some clients do not wish follow ups with their primary care provider immediately after discharge as they have follow ups booked with specialists, as example.

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10	SVCHC will receive full accreditation through Canadian Centre for Accreditation this coming fiscal year. (Accreditation received; Organization; Fiscal year; Canadian Centre for Accreditation)	92242	CB	CB	1.00	We received confirmation of Canadian Centre for Accreditation approval August 2018.

Accredited by Canadian Centre for Accreditation

Agréé par Centre canadien de l'agrément

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SVCHC has been preparing for first Accreditation through Canadian Centre for Accreditation (CCA) July 2018.	Yes	We received confirmation of Canadian Centre for Accreditation approval August 2018.