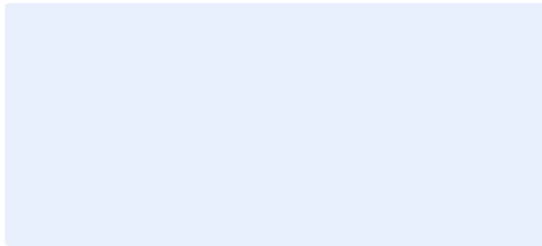
Let's Make Healthy Change Happen.

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



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This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

The South Georgian Bay Community Health Centre (SGBCHC) is a non-profit community health organization providing primary health care, health promotion/community development and related services to the residents of the South Georgian Bay region which is located within the North Simcoe Muskoka LHIN region. Since 2010, SGBCHC has been implementing a range of programs and services focusing on the health needs of the residents of the community. SGBCHC endorses the CHC Model of Health and Wellbeing. The focus is guided by the principles, values and tenets underlying the social determinants of health. The organization works collaboratively with other health and social service providers in an integrated and cost efficient manner to achieve quality of service.

Our Vision
To be the leader in providing collaborative health and wellness

Our Mission
We will inspire the health of our community by empowering self-determined care. We will strive to eliminate barriers to those with complex health conditions by providing system navigation so that everyONE has access to the care and services they need.

Our Strategic Opportunities
1.Strengthen Community Engagement
2.Maximize the Value and Function of New Building
3.Focus on Mental Health Services
4.Build Fund Development
5.Collaborate in Community Leadership

Our values of inclusiveness, compassion, accountability, respect and equity guide the development and delivery of programs and services and inspire the 2018/19 Quality Improvement Plan.

The 2018/19 QIP includes indicators that stem from our recently updated strategic plan as well as our Multi-Sector Accountability Agreement. The centre focused on implementing organizational changes in which interdisciplinary committees have been formed with the guidance of the new data coordinator and new clinical manager. Each of the indicators included in the QIP are embedded in the work of these committees.

Having achieved a four year accreditation status the through the Canadian Centre for Accreditation SGBCHC has been working on implementing the requirements expected operationally and organizationally as a result of this process.

Focus on the centre’s strategic priority of engaging with the centre’s community has been a priority this year.

Describe your organization's greatest QI achievement from the past year

Having achieved accreditation in late 2018, the SGBCHC board bylaws and policies as well as operating policies continue to be reviewed for best practice, in addition to focusing on the ongoing changes implemented continues to ensure the programs and services being delivered met or exceeded the standards identified.

Community engagement as a strategic priority was accomplished with a focus on raising community awareness of the centre’s programs, services and staff involved. This is further discussed below under staff engagement due to the overwhelming support provided by staff to develop new resources and planning processes.

As one of 10 pilot sites, the SGBCHC has engaged in social prescribing under the Alliance funded through the MOHLTC for 18 months to achieve 2 priorities: 1) develop staff to engage in system navigations similar to the Health Links model in partnership with 211; 2) engage SGBCHC clients to either lead as a Health Champion or become involved in activities to address social isolation and overall well-being. Based on the UK's Altogether Better Model, this initiative addresses both client and staff engagement and collaboration, a paradigm shift from prioritizing medical needs typically found in a primary care setting to also prioritize psycho-social needs and will be described more fully here.

The overall goal is to redirect clients to engage more with staff and volunteers, connecting to social activities allowing the opportunity to create new friendships, receiving support from other staff (e.g. nurses who are system navigators) and freeing up the health care providers to see more clients as a long term goal once completely established. While still in its infancy phase, it has shown some promising results with some of the centre's clients, in particular addressing social isolation and raising staff's awareness of the impact of social isolation on people's health. For example, a group of women chose and began to offer friendly visiting to the centre's clients through the guidance of the clinic nurse. As a result of their volunteer work which also included informing this pilot have developed into their own friendship group. Some clients have led new social groups such as cards and coffee and colour and coffee, that has allowed them access to social opportunities that otherwise did not exist, including linking them to programs at the centre as a result of the sense of trust and belonging that developed with other staff they had access to at the centre. Needing volunteer support for the centre's clients of which many are vulnerable to outside situations, has allowed the development of a new volunteer coordinator to fill this gap in order to support further development of these social programs and engaging the centre's new volunteers more directly to start in the next fiscal year. Referral of a client by a clinician to social prescribing has been built into the EMR, which also supports tracking and potential evaluation based on the Alliance developmental evaluation framework being used for the 10 pilot sites. Referral to 211 for further supports is also built in to support better system navigation.

Another initiative that socially prescribes is Food Fit that began in spring of 2018 with funding through Canada Food Centres in which a coordinator hired runs a 6 week program that engages clients of the centre and community residents to learn to cook simply, access food and engage in a socially encouraging and welcoming environment. Gentle physical activity is provided as well. With the success in 2018, further funding was provided to continue for another year. Referrals to this is built into the EMR system. Client feedback focuses more on the appreciation of the social interaction, and social connections being made in addition to food preparation. One client having finished the program is now a volunteer of the program.

Patient/client/resident partnering and relations

South Georgian Bay CHC values client engagement and feedback on all aspects of programs and services. The organization continues to receive client feedback on their experience with primary care services, allied health services and groups/programs being offered throughout the year.

The Client's Bill of Rights and Responsibilities was updated this year to ensure clients were more involved in their interactions with their providers in particular regarding their responsibilities with a greater emphasis on creating a more emotionally safe environment for all.

Another change to better understand clients and engage further in their care, is the revamping of intake forms and how the information is collected. Through the leadership of the data coordinator, collaboration with staff, input from community partners including those representing priority populations such as francophone, LGBTQ, Metis and indigenous, and newcomer/refugee- the intake forms will provide much needed socio-economic data including more information about social needs the clients would like to engage in at the centre in addition to the usual medical needs collected. Staff will be oriented to other forms of intaking beyond that traditionally collected in the first intake meeting via clinicians to ensure collection is done is a more welcoming, inclusive manner honouring cultural sensitivity for better client interaction and participation. Methods may include using other staff versus the clinicians directly, the use of OCEANS tablets, and intaking over longer periods of time versus within the first 90 minute meeting which has been found to be exhausting, unwelcoming and even intrusive as reported by many clients and staff.

Client engagement continues to be evident from within the SGBCHC Board of Directors, having 3 new members. The 12 Board membership is comprised of local residents and clients that receive services. The Board members represent community engagement at the governance level.

SGBCHC continues to put out great effort on working towards improving partnerships with local community partners with the aim of improving access and services, and preventing duplication. This year new partnerships and expanded partnerships have occurred to ensure community partners serve local residents preventing them from travelling further. Some of the partnerships to provide services on-site include the local regional Lung Program and Diabetes program, Simcoe Community Services Housing case managers, local CMHA counsellors and their family programming, SCDSB learning centre and alternative school, RVH Eating Disorder team, Simcoe Trans Health Team, and 211. Additionally, the centre has become a site for community partners to meet to address local housing and homelessness issues and planning new initiatives such as the Green Prescribing Initiative with the Town of Wasaga Beach, Simcoe Muskoka District Health Unit and local Provincial Park.

Another big achievement was the centre working with the Town of Wasaga Beach to make the centre a site for an After Hours Clinic (AHC). The AHC has been well utilized by local residents preventing them from travelling to Barrie, Midland or Collingwood, many of whom are the centre's own clients. The AHC will continue to more evenings as more local GPs and NPs come onboard.

The SGBCHC has been working closely in their new partnership with the local hospital (Collingwood General and Marine Hospital) to provide back door services of IT, HR and finance transitioning from 7 years of service with the CCAC. This integration model has allowed the SGBCHC to have expertise supporting the back office support to the operations of the CHC at a reasonable cost, and has benefited in learning newer ways of managing IT issues in collaboration with the local GBFHT. Additionally, the centre's management team have had to engage more directly in HR issues, attending education opportunities to understand more about payroll, creating a new system for conducting payroll, managing maternity leaves and other leaves of absences, with the creation of new policies with hospital HR support. The SGBCHC continues to collaborate with other organizations from within the region to improve the integration of care across organizations, in particular as the funding for the Healthlink model winds down.

Services provided in the highschools system by the youth outreach worker and a RN have expanded as a result of the growing partnerships with other community partners providing mental health supports to the highschool population in a collaborative

manner. A new initiative that has just completed planning with the local health unit, the schoolboard and the GBFHT and the SGBCHC is for the 2 staff members in the school to meet with all grade 7 and 8's to discuss services available using the local resources from the Be Well Collaborative. The success of the staff from SGBCHC engaging so well with the student population may be attributed to being the only community partners who use the EMR system and can collaborate with are physicians and NPs including those of the centre. The BE Well Collaborative came out of funding from the Healthy Kids Funding initiative several years ago in Collingwood and has grown to developing resources imbedded into the EMR to guide health care professionals in this region under both the GBFHT and the SGBCHC.

SGBCHC continues to work on the capital submission that would support SGBCHC and CMHA to be co-located in a future building within the next 2 years.

Workplace violence prevention

Population Health and Equity Considerations
SGBCHC recognizes the need to identify ways to reduce inequity by considering the unique needs of our priority populations. Capacity due to a number of competing priorities prevented SGBCHC implementing the MOHLTC the Health Equity Impact Assessment (HEIA) tool, however equity focused questions on planning any new services and programs have been implemented.

Screening for poverty has been a strong focus this past year, to better identify as well as provide immediate support to the financial barriers that are identified by clients by including the tool into the EMR and within the intake forms, and any program screening of new clients. Referral systems and processes developed in partnership with 211 has continued this year, with access to 211's new RN to provide in person support for more in-depth system navigation for those clients who struggle with complex psycho social needs as well as providing consultative support to the centre's staff to determine best community resources required for shelter, housing, income and transportation supports in addition to food and clothing. In addition designated RNS supporting the clinicians have been put in place to complete income related forms related to ODSP and social assistance. This has freed up more time for clinicians to see more clients.

SGBCHC continues to have supports in place to assist clients with clothing (community closet), food (good food boxes being available), transportation (bus passes), Dental Care (partnership with Georgian College) and funding for medications (client care funds). With a new donation site posted this year on the website, the centre hopes to be able to attract local donations to support the client care funds to help clients with basic needs until a sustainable plan is put in place with community supports particularly for those struggling with being homeless or precariously housed; and/or experiencing poverty with minimal to no resources creating barriers to managing their health care needs. With neighbourhoods poverty rates varying from 12%- 56% (SMDHU Health STATS,low income interactive maps, 2019) significantly higher than the Ontario rates, basic needs not being met is continuously being identified by the centre's clients particularly those who have been newly intake in the past year with prescriptions, clothing, food, housing and transportation as key barriers needing support from the client care fund which is often depleted in this past year.

SGBCHC is working at the local community level in supporting equitable access to services through the work of many committees. Staff continue to attend the

following committees: Age Friendly Committee of Wasaga Beach, NSM CHC French Language Services Planning Committee, Green Prescriptions Committee of Wasaga Beach and the local Poverty Reduction Task Group. SGBCHC is also a member of the SGB Alliance which is a collaborative governance committee that are working together to improve system level population health and wellness needs of the community. New this year as a result of the growing issues of homelessness among clients at the centre and lack of service integration and supports is attending the local Simcoe County Alliance to End Homelessness Chapter chaired by our local 211.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder
SGBCHC supports a very vulnerable population struggling with, mental health and/or chronic pain such that opioid prescribing is monitored regularly by the team to meet the needs of our clients. The shared use of our local EMR system optimizes on the safety of e-prescribing across the local primary care providers, pharmacies, after hours clinic and hospital emergency department.

While SGBCHC is a Naloxone distribution site, there has been little uptake by clients or community residents in general. The newly formed RAAM clinic through RVH is a new partnership and support to this region's clients with the hope the centre becomes a touchdown site as their capacity builds for more outreach. Much needed expertise for e-consultation has been expressed by the centre's clinicians with the hope to see this made available through the regional opioid strategy and its partners.

The development of a new situational table in 2018 under the direction of the local OPP in Wasaga Beach with the centre as one of its partners may be a promising intervention to managing the local opioid crisis over the next couple of years.

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Other

Engagement of Clinicians, Leadership & Staff
The SGBCHC has continued to focus on improving the level of engagement within the organization. All staff, team building day occurred that focused on understanding more of one's personal strengths to enhance relationship building and building trust facilitated through the McQuaig's Institute's resources.

The voluntary community members that comprise the Board of Directors at the SGBCHC continue to offer many hours of voluntary service over the past year to complete meeting the strategic plan priorities, ensuring bylaws and governance policies are followed to support the leadership of the organization. This year their focus has been on raising awareness of the centre in the community supporting the strategic priority for community engagement; in addition to supporting several new board members.

A revised internal committee structure was implemented to support guidance and direction within operations, ensuring performance targets are being met. The new committee structures (3 new committees) reports monthly at all staff meetings. The focus this year for these new committees was on developing staff engagement on

those committees, understanding of the TOR, engaging in understanding targets, indicators and individual performance through the support of the data coordinator and manager. These targets for individual performance are also built into performance appraisals. Learnings have been staff's improved documentation and tracking of work achieved, better understanding of centre's capacity to support individual clients and run programs, planning programs and services based on need, capacity and our local partnerships (preventing duplication). A big focus was on health promotion and community engagement with the goal of raising the community's awareness about the centre by developing a new website with the support of a communications provider contracted. The communications provider worked alongside clinicians and staff engaged in weekly planning over the winter of 2018/2019. Additionally, planning programs and services have been streamlined developing templates and planning processes for all to use, including a streamlined communication planning process to better promote programs and services, including using social media and the new website. New quarterly program guides about the centre and some promotional items was developed and purchased for staff to use when attending several spring community events in this region. Feedback from community partners and clients has been overwhelmingly positive including the uptake of promoting the centre in local newspaper and radio, a first for this centre.

Mandatory staff education continues to be well received with the focus on health and safety, privacy and non-violent crisis intervention training. Health and safety has begun to have a stronger focus in its training on creating emotionally safer working environments and will continue by developing staff champions in the next fiscal year. With the support of the CGMH's health and safety resources, online training will be made available at no cost to centre's staff in next fiscal year. On line training modules were chosen by staff.

Engaging staff and clinicians to meet targets for this year's QIP through the new internal committees, improving methods of tracking, direct one on one support by data coordinator with clinicians which have all proved helpful to understanding and working towards meeting targets with improved tracking and documentation efforts in the EMR. The following provide some example of meeting targets

- 80% of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months are being seen regularly by our diabetes educators at the centre
- 89% of screen eligible patients aged 50 to 74 years who had a FOBT within the past two years, other investigations (i.e., flexible sigmoidoscopy) within the past 10 years or a colonoscopy within the past 10 years were offered a screen
- 88% of women aged 21 to 69 had a Papanicolaou(Pap)smear within the past three years
- Increase of 12% to 62% clients able to see a doctor or nurse practitioner on the same day or next day, when needed as a result of increased same day appointments initiated late summer 2018

The leadership and engagement of the clinicians with support from nursing staff using a system navigation model; reception encouraging same day appointments will free up more time on the clinicians part to see more clients. However, until a new system occurs from local hospitals that allows the centre to receive discharge reports immediately upon discharge (vs several weeks later or never) challenges to have clients see their provider within 7 days of discharge will continue. CGMH is addressing making changes to improve access to discharge reports that will support this centre and other providers needing same access.

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

Board Chair _______________ (signature)
Quality Committee Chair or delegate _______________ (signature)
Executive Director/Administrative Lead _______________ (signature)
Other leadership as appropriate _______________ (signature)