

Let's Make Healthy
Change Happen.



2015/16 Quality Improvement Plan for Primary Care organizations in Ontario



Belleville and Quinte West
Community
Health Centre

**Belleville and Quinte West
Community Health Centre**

March 31, 2015

Overview of Our Organization's Quality Improvement Plan

Overview

Belleville and Quinte West Community Health Centre (BQWCHC) has worked to create a culture of quality through the formation of a quality committee (inclusive of Board, Staff and clients) that has focused on building our capacity to provide high quality care that is responsive to our clients and community needs. The Strategic Plan was recently revised (November 2014). The four strategic directions are:

- **ENGAGE** : BQWCHC will ensure provision of client centered care supported by continuous client and community engagement
- **INFLUENCE**: BQWCHC will lead and influence our communities: proactively engaging in system transformation utilizing a social determinates of health approach
- **INNOVATE**: BQWCHC will create a culture of innovation, safety, prudent risk taking and quality performance
- **INTEGRATE**: BQWCHC will engage in strategic partnerships to enhance health and wellness through system integration

The Board has aligned the Quality and Risk Management frameworks to be consistent with these new directions. The strategic plan has driven the development of the operational plan to guide the work of staff and the dashboard for the Board to monitor results.

This Quality Improvement Plan (QIP) clearly links our strategic plan, operational plan, MSAA indicators and Quality Framework. The QIP also supports the identification of skill development and training needs. Our intent is to use our QIP as a springboard to build capacity, skills, knowledge and expertise in quality improvement within our organization. Our goal is to have all managers participate in IDEAS in 2015/16 to form a solid basis for QI activity.

Integration and Continuity of Care

BQWCHC has been focused internally on building the capacity of our Interprofessional team and improved access for clients. The CHC model has always employed a "wrap around" approach that links clients with other health and community services to ensure coordinated/integrated care. We have been intentional this past year in the provision of co-led community programs to promote integration with our community partners. Through our involvement in Health Links we have utilized the standard provincial Coordinated Care Plan (CCP) tool to develop fully integrated care plans for the most complex of our clients. We will be working to spread the use of CCP's to more clients this fiscal year.

Furthermore BQWCHC is the administrative lead of Quinte Health Link (QHL). We have created our QIP to be consistent with the provincial quality measures related to avoidable ER visits and % of PHC visits 7 days post discharge. In addition the QHL primary and acute care partners have agreed to work collaboratively to improve the care pathway for COPD and to collect baseline data that will support establishing an improvement target for fiscal 2016/17. A variety of data sources will be required to effectively monitor our plan and to ensure we are linked to the broader quality initiatives that are emerging across the region and health system. We are committed to working with the LHIN and other health care partners to integrate access to data across systems to monitor cross - sectoral indicators and measure the effectiveness of integration activities in improving quality of care.

Challenges, Risks and Mitigation Strategies

Given we are experiencing significant system transformation; it is challenging to balance internal and external demands. In our plan last year we had identified barriers in accessing data from our acute care partner related to ER utilization and notification of discharge to facilitate the 7 day post discharge visit. We had anticipated the launch of web based portal (SHIIP) to allow real time access to hospital utilization data. Unfortunately the

implementation of SHIP has been delayed. We now believe it will occur in the 1st quarter of 2015/16 but we face further risk if this is not the case. To mitigate this risk we have worked with QHC to set up access for our providers into their database so we can mine their data system. While this solution will not provide the alerts of SHIP, it will provide access to the information required to monitor our progress towards identified indicators.

IMS

Currently we use our EMR to identify our practice profile and monitor the indicators in our operational plan and quality framework. We have initiated the practice of regular monthly reporting to providers on progress towards achievement of established targets /metrics. Regular monitoring has allowed us to test change through PDSA methodology. Results will be posted to visually track our progress.

BQWCHC has been working to develop meaningful reports to help us to confirm we are indeed serving our priority populations. As our involvement in Health Links unfolds, we will be focusing on the identification of our high risk/complex populations.

In addition to service data we believe it is critical to listen to the voices of the people we serve. We have developed a strategy to capture real time feedback from clients (using a tablet) on an ongoing basis to replace our annual client survey. This will allow us to react more quickly when the need for improvement is identified. All programs include an evaluation component to ensure the design and delivery of services meets the needs of our populations.

Engagement of Clinical and Broader Leadership

The full management team has been involved in the identification of our QI aims, measures, targets and change ideas. The primary care and community health teams have participated in discussions regarding the indicators and planned improvement initiatives. The Quality and Risk Management (QARM) Committee of the Board reviewed the document and subsequently forwarded the document to the full Board for review and approval.

Client Engagement

Last year the Board undertook an extensive community engagement process. Our target for engagement was:

- Interviews with other community organizations (target 16- actual 15)
- Focus groups with clients and non-clients in our target populations (target 4- actual 4)
- Survey to clients and non-clients in our target populations (target 100- actual 259)

Based on the outcome of this process the Board has struck an ongoing communication and community engagement committee to build on our learnings to further enhance our client and community engagement strategy.

Accountability & Management

The QIP will provide a framework to support the organizational focus on quality. Our intention is to drive the commitment to quality across the organization utilizing our Interprofessional team approach. As we collectively identify our aims, measures and change ideas we can build commitment to and capacity for process improvements. Specific improvement initiatives and change plans will be tracked by the Director of Primary and Community Health and the Director of Decision Support Services. This shared leadership approach will ensure clinical practice changes are driven by data decision support tools/methodology. Several tools and resources available through Health Quality Ontario will be utilized to support our efforts with planning, implementing, monitoring and reporting on quality improvements. Results will be shared across team / staff meetings. The Board and the Board's quality and risk management committee will monitor the progress on the achievement of QIP goals at least twice per year.

Our Improvement Targets and Initiatives

Insert "QIP template" (Excel file).

submission to HQO (QIP@HQOntario.ca).

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan


Lori Cooper
Board Chair


Maggie Flynn
Director of Primary and Community
Health


Marsha Stephen
Executive Director

2015/16 Quality Improvement Plan for Ontario Primary Care "Improvement Targets and Initiatives"



Belleville and Quinte West Community Health Centre 161 Bridge Street West, Belleville, ON K8P 1K2

AIM		Measure					
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification
Access	Access to primary care when needed	Percent of patients/clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	X	75	We experienced turnover in our primary care provider staff and had 2 vacancies at times through the year, At full complement of staff we will be better able to meet access needs.
	Reduce ED use by increasing access to primary care	Percent of patients/clients who visited the ED for conditions best managed elsewhere (BME).	% / PC org population visiting ED (for conditions BME)	Ministry of Health Portal / April 1 2013 - March 31 2014	12.8	20	We will have access to data for ER visits in real time so will be able to develop strategies to address the issues identified
Integrated	Timely access to primary care appointments post-discharge through coordination with hospital(s).	Percent of patients/clients who saw their primary care provider within 7 days after discharge from hospital for selected conditions (based on CMGs).	% / PC org population discharged from hospital	Ministry of Health Portal / April 1 2013 - March 31 2014	5	30	We have established access to QHC database for our clients so we will be able to track client discharges and reach out to make an appointment . We have implemented same day/urgent care appointments to facilitate timely access to care.
Patient-centred	Receiving and utilizing feedback regarding patient/client experience with the primary health care organization.	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) give them an opportunity to ask questions about recommended treatment?	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	95.51	96	Based on a practice change to elicit feedback on an ognig basis we anticipate a slight increase in this target as we will be able to monitor results and intervene more quickly .
		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)	In-house survey / April 1 2014 - March 31 2015	96.59	87	Based on a practice change to elicit feedback on an ongoing basis, we anticipate a slight increase in this target as we will be able to monitor results and intervene as more quickly
		Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) spend enough time with them?	% / PC organization population (surveyed sample)	In-house survey / April 1 2014 - March 31 2015	95.65	88	Based on a practice change to elicit feedback on an ongoing basis we anticipate a slight increase in this target as we will be able to monitor results and intervene more quickly

AIM		Measure					
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification
Population health	Reduce influenza rates in older adults by increasing access to the influenza vaccine.	Percent of patient/client population over age 65 that received influenza immunizations.	% / PC organization population aged 65 and older	EMR/Chart Review / na	35	52	We will be more aggressive with calling clients and following up on immunizations received elsewhere.
	Reduce Cancer mortality through regular screening.	Percent of eligible patients/clients who are up-to-date in screening for breast cancer.	% / PC organization population eligible for screening	EMR/Chart Review / n/a	57	68	We plan to be more intentional about informing eligible women to contact breast screening clinic for appointment
		Percent of eligible patients/clients who are up-to-date in screening for colorectal cancer.	% / PC organization population eligible for screening	EMR/Chart Review / n/a	55	70	Target set based on experience to date
		Percent of eligible patients/clients who are up-to-date in screening for cervical cancer.	% / PC organization population eligible for screening	EMR/Chart Review / n/a	66	72	Based on experience to date