Let's Make Healthy Change Happen.

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

Port Hope Northumberland Community Health Centre

"Building a healthier community together"

3/30/2017

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.

Overview

The Port Hope Northumberland Community Health Centre (CHC) finalized its new strategic plan at the end of the 2015/16 fiscal year. This year, 2017/18, marks the CHC's movement into its 10th year as an entity. Adherence to the principles of Patient's First, our growing partnerships with Northumberland Hills Hospital, the Northumberland FHT and others will set the stage for the next phase in our development. The strategic plan outlines the organization's goals for thoroughly evaluating our performance to date and for consolidating our partnerships, collaboration, and presence in the community of Northumberland. The organization will be working to promote awareness of the programs and services that are offered by CHC and working to enhance the services we offer in other parts of the County. The Quality Improvement Plan is one tool that can be used to educate the community about the value of the work being done at the CHC and to demonstrate how this model of care is a valuable contributor to its health and well-being. The CHC's client-centred philosophy and emphasis on illness prevention, population health, and the social determinants of health are evidenced in the QIP 2017/18 as well as in our strategic goals for the coming year(s). This Centre is dedicated to improving timely access, and supporting those in greatest need, to obtain the recommended cancer screening, influenza vaccines, and follow-ups needed to deliver equitable health care to everyone. Delivering high-quality health care and providing a positive client experience for those that receive services at the Centre as well as for those who access services at various outreach sites in the Northumberland Community, is of utmost importance to the organization.

The Association for Ontario Community Health Centres (AOHC) has developed a computer program for extracting statistical data from the client electronic medical records (EMRs) for all CHC's that belong to the AOHC. This is a significant project and provides opportunities for creating automated statistical reports and comparison data across this health care sector. However, in the start-up phase of this significant project there have been many 'bugs' to work out and the reliability of the data has been questionable at times. This was a challenge over the last year as we relied on this reporting tool to pull lists of clients that were overdue for cancer screening, etc. and discovered along the way that these lists were not always accurate. We have been working hard along with the data managers at AOHC to improve date entry and extraction methods and to validate accuracy.

QI Achievements From the Past Year

The PHNCHC greatest achievements are in the area of positive client experience. Clients regularly report on their high degree of satisfaction with the level of care received at the Centre. They report their appreciation of: a) being included as an equal partner in their health care plan, b) having enough time to discuss their conditions, concerns and treatment options, c) being viewed as a whole person with social and living conditions that contribute to how they are doing, d) having access to programs and services that support wellbeing and illness prevention, and e) being part of a community and a place where they feel treated with respect and belonging. The PHNCHC has worked hard to bring in new patients and reduce its waitlist over the past year. Despite increasing the panel size of each primary care provider, the positive experience of clients and their confidence in their level of care has remained consistent.

Population Health

The PHNCHC has identified unique populations that are in particular need of access to primary health care. The Centre targets the frail elderly, youth at risk, those

with mental health and addiction problems, and those who live at or below the poverty line. The Centre provides outreach at several locations throughout the county to help reduce barriers to access. This is made possible by working with partners such as Cornerstone Centre for the Prevention of Family Violence, Transition House, The New Canadian Immigration Centre, Alderville First Nations, the Greenwood Coalition, Northumberland for Youth, Northumberland County Social Services, the Northumberland Health Link to name a few. The CHC belongs to the Northumberland Health Link which coordinates care for those at risk. This year staff members of the CHC have had several meeting with the Northumberland Hills Hospital (NHH) and the Northumberland Family Health Team (NFHT) to develop a plan for providing primary health care to individuals that frequent the Emergency Department and do not currently have a primary health care provider. The PHNCHC has developed an MOU and a process for prioritizing these clients to access a provider.

Equity

Health equity is an integral part of the CHC model of care. One of the three pillars of the model is 'Community Engagement' which dictates that each CHC reaches out to the community it serves to conduct regular ‘needs assessments’ to find the vulnerable populations within the community who have been ‘under’ served and who need improved access to care. As a result, the PHNCHC has identified and provides care in many focused areas that work to improve equitable access to health care. These include services for the homeless, frail elderly, and Indigenous populations in Northumberland. Our nurse practitioners provide primary health care to individuals living in poverty by doing outreach at shelters for the homeless, by doing street health services at community dinners, by doing weekly clinics at the Alderville First Nations Reserve and the New Canadian Immigration Centre. The CHC Diabetes Team provides services at various outreach sites. Home visits are available to frail elderly and other individuals unable to come to the clinic. Home visits are provided by many disciplines including Nurse Practitioners, Doctors, Diabetes Nurses and Dietitians, and the Geriatric Assessment and Intervention Network (GAIN) Team. The CHC regularly provides space and invites other service providers into the Centre (e.g. legal clinic, osteoarthritis, Hep C clinic) to make services more accessible for those facing barriers. The Centre also offers dental services at a much reduced cost to those living on fixed incomes and in poverty. In its new QIP for 17/18, the PHNCHC will put a greater emphasis on trying to increase specialized services for Indigenous people ‘at risk for’ and ‘living with’ diabetes. Seventeen staff members, including managers, will be completing training in Indigenous Cultural Safety.

Integration and Continuity of Care

As mentioned earlier, the PHNCHC is an active participant in the local Health Link and is working to develop coordinated care plans for clients with complex care needs. Collaboration between the NHH, NFHT, and the PHNCHC has begun to look at the collective impact of working together to identify and provide services for the residents of Northumberland who are in need of primary health care in order to prevent visits to the Emergency Department that could be better managed elsewhere. The PHNCHC also actively participated at the Northumberland Situation Table along with many community agencies. This table provides a forum for identifying individuals at high risk for crisis and intervenes to wrap services around them. The nurse practitioner sitting at the situation table assesses health care needs and intervenes early to prevent and further health crisis and address current needs. The PHNCHC’s work at Alderville First Nation’s Wellness Centre will be a focus of the next QIP and how to better integrate diabetes care for that unique population.

It is anticipated that the new 'In-patient Discharge Alert' (IPDA) system that has been implemented at NHH will provide data that will enable more timely communication regarding PHNCHC clients who have been admitted to hospital and have been, or are soon to be, discharged. Once the CHC receives this information appointments can be booked within the seven day corridor. The PHNCHC has met with NHH to create open communication regarding the admission of its patients. Several departments at NHH are now calling to personally book appointments for clients approaching discharge. This has provided much needed continuity of care.

Access to the Right Level of Care - Addressing ALC Issues

The PHNCHC belongs to the Northumberland Health Link and has participated in the development of a process whereby our CHC clients who are admitted to hospital and at risk for ALC can be flagged while in Acute Care programs and a request for the implementation of a Coordinated Care Plan and Health Link can be sent directly to the our Centre to engage their primary health care provider. Similarly, the PHNCHC GAIN team is available to actively participate in discharge planning for all of its clients who are in acute care beds at the hospital. These initiatives are meant to prevent clients transfer into ALC beds and to generate timely coordinated care plans that facilitate the right level of care.

Engagement of Clinicians, Leadership & Staff

The PHNCHC is a small organization and so communication about the QIP flows easily across all areas of the CHC. Board Members, staff, clinicians, and leadership are all very aware of the QIP and its areas of focus. The Staff Quality Committee (made up of representatives from all departments) meets monthly. A large part of the work being done by the committee involves the QIP action plan. The Committee makes a presentation annually at an ‘All staff” meeting and is part of the new staff orientation schedule. The Quality Committee reports on its activities and progress regularly to the Board of Director’s Quality and Risk Committee. A member of the senior leadership team facilitates the Staff Quality Committee and communicates between leaders and staff on the actions and status of the QIP. This senior leader is also a member of the Board Committee which facilitates communication between the two groups.

Resident, Patient, Client Engagement

The PHNCHC has a Client and Family Advisory Roundtable (CFAR) which meets approximately 6 times throughout the year with the Executive Director and Board President. This group identifies, reviews, and provides feedback on key areas from the client and family perspective. The QIP is one of several activities reviewed by CFAR. The PHNCHC Quality Committee also has two clients that sit on the committee and provide input into the QIP process and associated action activities. A key area of contribution this past year was the input into the literacy of the client experience survey and feedback on methodology for distribution and completion of the survey. Clients also provided much needed input into key enablers for client motivation to access cancer screening.

The Centre also provides information about its QIP activities via the client bulletin boards, its website, and social media.

Staff Safety & Workplace Violence

The PHNCHC has a policy for Workplace Violence Prevention. Staff, clients and volunteers were all provided with opportunities for input into this policy and have received education on their roles, rights and responsibilities for reporting events related to workplace violence and its prevention. Last year the CHC conducted a

thorough workplace assessment to determine the risk for workplace violence. This assessment included, a staff survey, a review of related incidents, a review of complaints, and an environmental scan of the physical plant. There are processes in place for confidentially reporting incidents of violence as well as for investigating and responding to reports. The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and improve the workplace violence prevention policy. Last year (2016) all staff received mandatory training on the prevention of workplace violence including information on Bill 168 and Bill 132. Volunteers are also provided with training on the prevention of workplace violence and how to report incidents. New staff, students, and volunteers receive information and education on this topic at their orientation.

Contact Information

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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

Board Chair Mark Peacock
Quality Committee Chair or delegate Mark Peacock
Executive Director / Administrative Lead Duff Sprague
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)