Let's Make Healthy Change Happen.

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

Rideau Community Health Services

3/22/2019

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

Rideau Community Health Services (RCHS) is a medium-sized primary health care organization with approximately 80 staff. It operates two Community Health Centres, the Regional Diabetes Education Program, and Telemedicine Services for Lanark, Leeds and Grenville (LLG), as well as regional Oral Health and High Risk Chiropody programs. The CHCs, located in the towns of Smiths Falls and Merrickville, serve a predominantly rural area with a greater catchment area of up to 40,000 residents. The CHCs are about 20km apart and are situated about one hour between Kingston and Ottawa which are both home to major health science centres. Community programming, primarily delivered through the diabetes education program and telemedicine services is offered through approximately 25 partner locations throughout LLG.

RCHS has been fully accredited since 2003 through the Canadian Centre for Accreditation, a third-party review based on accepted organizational practices that promote ongoing quality improvement and responsive, effective community services. In April 2018 RCHS received full accreditation for another 4 year term. The accreditation process and framework has formed the basis of our quality journey. The tools and processes we use to continually assess and maintain compliance with accreditation standards have been tested and improved based on experience.

In 2017/18 the RCHS Board of Directors approved three new Strategic Directions:

- Strengthen our Approach to People- and Community-Centred Care
- Improve Collaboration with Health System and Community Partners
- Expand Organizational Capacity for Innovation and Renewal

The 2019/20 Operational Plan includes objectives which focus on:

- Develop a digital health strategy for the organization
- Continue to improve our ability to use data to inform decision making
- Influence and actively participate in Regional planning and integration
- Use a health equity lens and approach to expand team based care to those in our sub region who currently have no access to same

These priorities are aligned with the quality dimensions chosen for this year's QI plan.

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

EMR Roll Out

RCHS invested a significant amount of time and resources on preparations for the implementation of a new Electronic Medical Record. We are highlighting the transition we made from Nightingale on Demand to Practice Solutions (we went live on February 11th, 2019) as a successful Quality Improvement initiative.

We were purposeful in our engagement of our team members and our partners throughout the process. We did this through consultations, steering committee meetings, team meetings, huddles, and frequent conversations. We collaborated with our partners who went 'live' before us and adapted our plan based on their lessons learned.

We did as much preparatory work as possible. Multiple opportunities for learning and sharing quick tips were made available to the staff. We designed the roll out so that as soon as we were live with the new EMR team members would have the right tools in place to support interdisciplinary collaboration and to ensure that clients are receiving the right care at the right time by the right person.

Since the roll out we are responding to questions and lessons learned in real time, and applying a rapid test of change approach, with continued opportunities for Q&A at huddles and lunch and learns. We will continue to assess and make improvements as we learn more and become more comfortable with the EMR.

RCHS identified some safety issues and communication barriers when rolling out our previous EMR. This experience helped inform decisions made as to how we roll out this product. This EMR has the capacity to improve communications between RCHS staff, particularly allied health staff and other primary care organizations outside of RCHS through the use of data sharing agreements.

RCHS has successfully negotiated and completed 2 data sharing agreements and has another 5 in progress. This will ensure that allied health and primary care providers have timely access to important information regarding client encounters in a secure and rapid manner.

Oral Health

RCHS has been working with several CHCs within the SELHIN regional dental program in order to deliver an emergency dental program while completing evaluations and assessments to identify the need for a sustainable dental program. RCHS participated in a regional evaluation process and has secured base funding for a dental program for low income adults. This was the result of the work we did in collecting client experience data, data on ER visits related to dental issues, and working with the Ontario Oral Health Association (OOHA). RCHS held 2 meetings with stakeholders to discuss the need and evidence that is available for a low income dental strategy and how we can contribute to a seniors' dental strategy.

The RCHS Board of Directors and staff advocated strongly for the need for this program through written briefings, meetings with MPs, etc. The program will be implemented using a health equity framework in fiscal year 2019-20 and we have plans to continue using QI initiatives such as engaging stakeholders, communications strategies, use of PDSA to promote adaptability and frequent assessment, and development of a comprehensive evaluation framework.

Health Equity Planning

A Health Equity Planning Tool was tested with the RCHS foot care program and is currently being tested with a 'client needs fund' process. Client input was encouraged during the implementation of the change. Staff was engaged prior to the change to both share information about the proposed changes as well as to ensure there was an understanding from them on client needs, and challenges with the current process.

The expanding team based care initiative is testing an intake role whereby responsibilities include screening questions that ask about the various social determinants of health in order to early in the point of contact, identify the full needs of those referred from our FHO partners and ensure that there is early connection to the other Community Health Centre programs and services that may be of benefit.

Patient/client/resident partnering and relations

Patient / Client Engagement

RCHS is committed to continually engage clients through a variety of means throughout the year. Examples of how we have advanced our client engagement include:

- An annual client survey of 650 clients including Primary Care Clinic clients, Diabetes Education Program clients, Telemedicine Clients and High Risk Chiropody Program clients; results were analyzed and used for program planning and delivery.

- Completed in person interviews with clients who were accessing our Emergency Food Cupboard and Smoking Cessation program in Merrickville. As a result of the input we received, RCHS offered a Cooking with Cents personal development group to this population. In addition, this input resulted in ongoing programming to promote physical activity being offered at the Merrickville CHC site.

- Other means of client input include: suggestion/feedback boxes located at each RCHS location, direct contact by phone, input solicited for new programs/services, etc.

- RCHS continues to have client representation on committees and engagement sessions, such as the Expanding Team based Care Steering Committee and Community Hospice Residence awareness sessions. We also engage with client advisors for feedback in specific situations such as asking clients for their input, perspectives and experiences about the changes to the Foot Care Program so that we could continue to improve the program. Another example, in anticipation of a physician shortage, RCHS hosted an open house for community members to share their views and ideas related to physician recruitment. RCHS also hosted a small focus group of community members in order to obtain preliminary information/ input on the feasibility and needs for a hospice residence.

Partner Integration

RCHS participates in numerous partner Integration initiatives and is using a quality improvement approach to planning and implementation for each. Examples include:

Participation in the Lanark, Leeds and Grenville Sub Region Integration Table (SRIT)
All sub regions in the south east agree to attend to the prevalence of COPD and improve access to Lung Health programming as our collective plan to minimize 30 day hospital readmission rates. The SRIT efforts related to Lung Health are in the discovery phase, collecting existing data and resources, mapping assets and reconciling with existing gaps. The committee agrees to apply an upstream and proactive approach while applying a quality lens to the co-design of any new systems. The planning will aim to address gaps across the continuum from disease prevention to end of life care.

Expanding Team Based Care
More than 20,000 people in the Smith's Falls-Perth Region currently don't have access to team-based care. The evidence shows that access to inter-disciplinary team members who collaborate closely with primary care providers is better for patients, better for primary care providers and better for the health care system. The Expanding Team Based Care initiative is well underway, and will be a made-in-Rideau Tay model of team-based health care. Our goal is to ensure that every patient connects with the right health care professional(s) at the right time. From design to service delivery, our local team-based care model is being developed collaboratively with leadership from RCHS and input from all major stakeholders, including patients, physicians, hospitals and others who offer programs and services in the area. The focus will be on preventative care by employing health-use data to proactively make connections between the patients and health care professionals and services. A Quality Facilitator has been hired who will use a LEAN and Six Sigma approach to design and delivery. Value stream mapping specific processes continues. A steering committee comprised of three FHO physicians, patients, program leads and the local hospital result in collaboration and invigoration.

Integrating Home and Community Care
RCHS is testing ‘Total Integration’ with local LHIN Care Coordinators (CCs) to better integrate with primary care. A LHIN care coordinator maintains a physical presence at both RCHS primary care sites enabling greater opportunities for communication, sharing of information and learning. The LHIN CC’s attend meetings and/or huddles and connect regularly with providers about client care. LHIN Care Coordinators who support palliative clients have attended team meetings at both sites and provided a presentation about supports and services specific to home palliative care and home death. Communication between primary care providers including nurses and Home and Community Care has improved through this integration.

Integration of Psychogeriatric Specialty and Community Supports with Primary Care
The integration of Specialty Care (Lanark County Mental Health Geriatric Psychiatrist) and Community Care (LLG Alzheimer Society) into RCHS Primary Care is proving to be a great success. The intent of this collaborative is threefold: to build capacity and exchange knowledge re: best practice, to promote a fully integrated team approach while caring for the whole person and to promote wellness through chronic disease self-management. The aim is that the efforts of this collaborative will result in increased capacity among the primary care team to screen, assess and treat older adults who may be struggling with issues related to addiction, mental health and cognition as well as build patient and family self-efficacy. A geriatric psychiatrist, Psych-Nurse and the Alzheimer Society Counsellor work directly within RCHS primary care team in an effort to provide more timely access to specialty and community care.

The use of health utilization data and EMR data enable the minimization of duplication and an increase in levels of safety and clear communication. Consults on site in real time as well as by phone and email are utilized regularly. There have been two education sessions jointly facilitated by Dr. Ken LeClair and the Alzheimer Society promoting awareness of current best practices re: screening and assessment of cognition as well as Driving Cessation. The cross sectorial collaborative leading this initiative is in the midst of developing a Brain Health Protocol for Primary Care teams. Senior Leaders from this committee are engaged in conversations with the SELHIN advocating that the LLG Sub region benefit from funds to resource staffing comparable to other regions in the SE LHIN.

Other examples include:

- Brockville General Hospital, Perth and Smiths Fall District Hospital collaborations have resulted in increased access for clients who require specialist service including oncology, ENT, and mental health to name a few.
- Integration of diabetes education services within Upper Canada FHT, as well as various primary care providers throughout LLG and the development of data sharing agreements which will improve client care.
- Expansion of diabetes education services in Perth area in collaboration/ consultation with primary care, hospital and community partners.
- Collaboration with Lanark Community Home Support and CPHC Home Support to ensure timely, effective and efficient foot care services for high risk clients.
- Increased collaboration with community partners in order to provide additional services and supports to new moms and their children, school based healthy nutrition programs, etc.
- Collaboration with a group of local community members and church groups has resulted in a monthly food security initiative that provides a healthy meal, socialization and skill development in the area of cooking.
- RCHS has been collaborating with local food banks in order to improve access to a variety of food choices for the Merrickville Food Cupboard. In addition this group submitted a joint proposal requesting funds to assist with the transportation of excess food from one community food bank to another.

Workplace violence prevention

The Occupational Health and Safety Committee provides leadership, training, and monitoring in relation to employer and employee obligations.

Examples of activities include:

- ‘All Staff’ Training regarding policies and procedures and employee/employer obligations
- Prevention of workplace violence by shared identification of areas of increased risk and developing strategies to mitigate same.
- RCHS provides debriefing sessions for staff involved in situations where they have felt at risk. RCHS has applied lessons learned from those sessions to ensure our physical space promotes safe working environments.

- Engagement of staff in policy development aimed at identifying and reducing risks (e.g. home visiting policy)
- An RCHS staff member is certified in non-violent crisis intervention. Courses are offered to staff two to three times per year. This year the course has been made mandatory and will be offered in a combination of in person training as well as on-line.
- RCHS maintains and exceeds compliance with accreditation standards related to staff safety and workplace violence

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 : Jacques Pelletier _____(signature)

Director, Primary Care : Kelly Robinson _____(signature)

Director, Community Services: Onalee Randell _____(signature)

Chief Executive Officer: Michele Bellows _____ (signature)

Date: Tuesday March 26, 2019

2019/20 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

Rideau Community Health Services 354 Read Street, P.O. Box 550, Merrickville, ON K0G 1N0

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	Percentage of patients who have had a 7-day post hospital discharge follow up for selected conditions. (CHCs, AHACs,NPLCs)	P	% / Discharged patients	See Tech Specs / Last consecutive 12-month period.	91418*	95%	95%	This allows for approx 5% of clients who may refuse follow up.	Perth and Smith Falls District Hospital, SHIIP	1) Spread the use of SHIIP to more team members throughout RCHS and one external Perth FHO provider 2) Assess the impact of data sharing with other primary care clinics to identify clients who would benefit from Allied health follow up post discharge.	1) Enable access and train 2 assigned staff to SHIIP. 2) Perth FHO physician joining SHIIP and supported by RCHS Pharmacist as part of an expanding team based care initiative. 3) Secure data sharing agreements with Upper Canada FHT, Prescott FHT and develop consistent communication processes regarding hospitalization and discharges in order to identify clients who would benefit from DEP follow up.	Staff trained and given access, # of hospitalized FHO patients who access physician/ allied health care within 7 days of discharge, # of clients referred to RVDS following diabetes hospital admission for targeted clinics.	2 staff trained, Collecting baseline data	This target is dependent on RCHS accessing accurate and complete hospital data. To be noted, a subset of those clients identified as fitting criteria for follow up refuse the follow up visit.
Theme II: Service Excellence	**Patient-centred**	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 2018 - March 2019	91418*	94.12	98	In previous years we have achieved a target of 98 and we continue to strive to improve this indicator.		Continue to broaden efforts to obtain and respond to client feedback through regular contact, patient orientation and patient representation on committees.	RCHS team members continue to foster and invite client involvement.	survey response rate	40%	
Theme III: Safe and Effective Care	**Effective**	Proportion of primary care patients who have been identified for the palliative approach to care and have had their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	91418*	Unknown	To gather baseline data	This year will be a data gathering year to inform setting targets next year.	SE RPCN Palliative Care Coordination working group (Early Identification Project)	1) Test the implementation of the locally customized E-Health Centre of Excellence Palliative Care Toolkit for PSS that supports: Earlier identification of patients for palliative approach to care Assessment of the patients' palliative care needs Planning according to patient preferences and values Processes to support assessment and planning.	We will pilot the tool with one primary care provider with a plan to provide training and increase uptake of tool. We expect this will grow as primary care providers see the benefits of the tool and processes. 2) Network with other providers to make aware of opportunity to provide input on tool and future testing. 3) Spread of the Toolkit tool with change package information and the tool with other health care organizations who are accessing same EMR. Look at processes that support the PC EMR Toolkit (e.g. assessment and development of plan) including patient caregiver engagement.	Primary Care Provider Uptake # of clients who have been identified, # clients identified in stable palliative phase, % clients identified who have a non- cancer diagnosis % of clients identified who have a documented care plan developed with the patient. Patient Experience measure TBD	Baseline year	We are participating collaboratively with a variety of FHT/ FHO partners. This will likely be a multiyear QIP and the plan this year is to establish a common understanding across partners of the tools used for the identification of patients.