Let's Make Healthy Change Happen.

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

Rideau Community Health Services

3/31/2020

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 as well as regional community programming. 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. RCHS offers a significant amount of community programming including a regional diabetes education program, telemedicine services, social work, pharmacy, client support, smoking cessation and lung health and an oral health program to name a few. These programs are offered through the RCHS 4 sites (Smiths Falls, Merrickville, Perth and Brockville) as well as 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 andimproved based on experience.

In 2017/18 the RCHS Board of Directors approved three new Strategic Directions, which were reconfirmed in 2019/20:

- 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 2020/21 Operational Plan includes objectives that focus on :

- Information technology (IT) modernization and optimization
- Strengthen our Approach to People- and Community-Centred Care
- Increase access to primary care
- To meaningfully engage the population we provide services to by community and stakeholder engagement
- Improve Collaboration with Health System and Community Partners
- Work effectively within the LLG OHT to enhance and improve care and services to the community

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

Cross Sectoral Community Rounds:
With the elimination of the Health Link funding, RCHS has transitioned that program into our day to day operations.

The dissolution of the Health Link Program has propelled all partners in the system to continue to evolve in how we work together. Each participating organization is sharing the responsibility of caring for our shared complex clients.

RCHS hosts and facilitates a bi-weekly Cross Sectoral Community Rounds table where local service providers come together to triage referrals. The partners determine who is already involved with the client and identify a lead. Our process includes brainstorming ideas to help one another support the client, refer to each other as needed and share resources. Agencies with representation at this table include: Perth and Smiths Falls District Hospital, Lanark County Mental Health, Home and Community Care, Nurse Practitioner Led Clinic, Community Paramedicine, RCHS and Country Roads CHC as well as other ad hoc members as needed. This is a true model of integration, collaboration and 'right provider at the right time'.

Community Connects:
Aligned with the RCHS Operational Plan Objective of Building Community Resiliency we have implemented Intergenerational Programming in the Village of Merrickville-Wolford. In an aim to decrease social isolation and increase a sense of community belonging, while also building in mentorship and mutual learning for the children and the older adults involved. RCHS has partnered with the Merrickville Public School for this Intergenerational Mentorship initiative and has included the Merrickville Public Library in the conversation for future partnered programming as well.

The group has named itself 'Community Connects'. The participants are providing weekly or monthly support in the following ways:

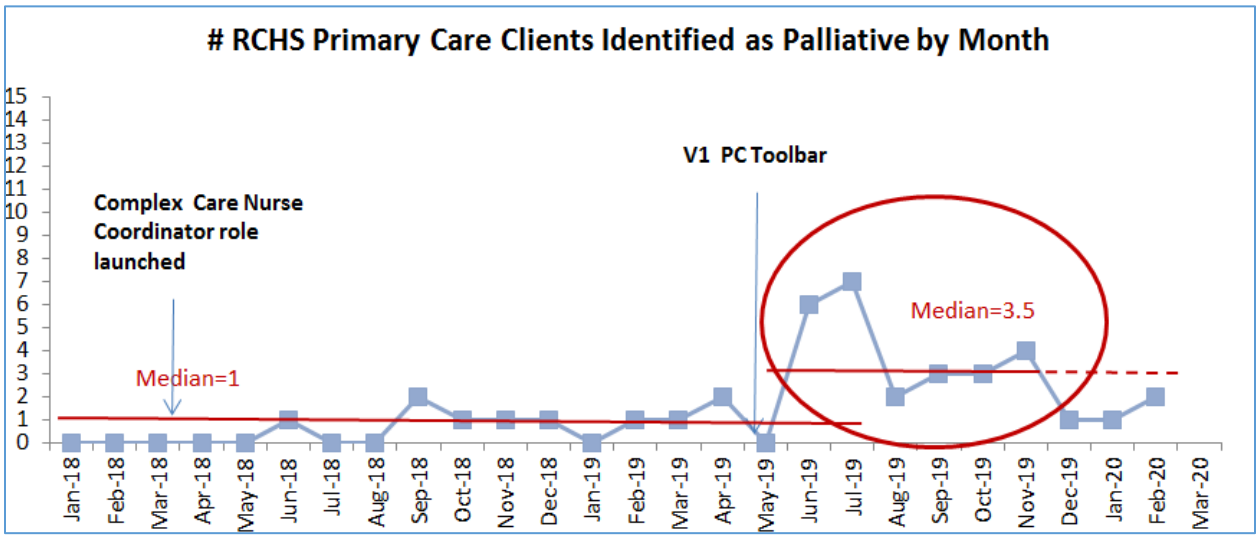
- School Breakfast/Snack Program
- Reading Buddies Program
- Knitting Club
- Kindergarten Class
- Tech Support Group
- Chess Club
- Monthly Community Pot Luck

A Palliative Approach QI project:
Rideau Community Health Services (RCHS) became the sponsor of the South East Regional Palliative Care Network's Coordination of Care Priority Project in late 2017. A cross-sectoral improvement team came together to assess and understand the current state, using a quality improvement approach, including interviews with caregivers/family and health care providers. Analysis of root causes identified a need to identify patients earlier for the palliative approach to care and to engage in important conversations with patients and families. The improvement project was scoped with an aim, measures and change ideas. A search began for tools to support early identification in primary care with a hope to leverage the EMR. Meanwhile RCHS providers were offered LEAP training and a workshop in Advanced Care Planning, Health Care Consent and Goals of Care.

The team became aware of the Palliative Care Toolkit for PS Suite (PSS- Electronic Medical Record) developed by the eHealth Centre of Excellence. A plan was established for training on the tool, customization of the contents for Lanark Leeds and Grenville (LLG) and to begin testing on a small scale following the implementation of PSS in spring 2019. The project was re-scoped slightly to align with the Palliative Care Quality Improvement Plan Indicator for 2019-2020. The main change idea was customization and testing of the Palliative Care Toolkit for PSS at RCHS and to scale up to include other practices and primary care models in testing. Based on early feedback, the number of resources in the toolkit was reduced and the resource section was reformatted for improved user experience. The Palliative Toolbar which flags patients for palliative review is triggered by search criteria aligned with the Gold Standards Framework. After review of reports generated by the search criteria, editing was required to reduce false positives. In addition, coding used by CHC's (Encode-FMs) was added. The team reviewed assessment tools available within the toolkit against CHPCA (Canadian Hospice Palliative Care Association) Domains of Care to assess for comprehensiveness and a holistic approach. There are ongoing discussions related to the addition of more assessment tools. RCHS is also considering better integration of the Toolkit into the existing CHC encounter workflow, to improve uptake.

RCHS data demonstrated a positive signal of change in the identification data with the introduction of the Toolkit (see run chart), despite lower than expected uptake across primary care providers. Twenty- nine clients were identified, most by the Complex Care Nurse Coordinator (RN). Further training and engagement of primary care providers in the processes supporting identification is being planned. The team also tracked initial Palliative Performance Scale (PPS) at identification to determine 'early' identification as well as the primary diagnosis of clients identified to determine whether more clients with a non-cancer diagnosis were being identified.

A number of outreach sessions have been done throughout LLG. Two CHCs, one Family Health Team, a Nurse Practitioner-Led Clinic, and a Family Health Organization practice requested the toolkit and 4 are in the early stages of using the Toolkit. There are also a number of inquiries from the south east region and beyond to hear about the RCHS experience and next steps.



Collaboration and integration

Cross Sectoral Community Rounds: see description above

Ontario Health Teams (OHT): Rideau Community Health Services is part of the Lanark, Leeds and Grenville Ontario Health Team. This OHT covers a large geography and the partners have a history of collaboration. This team submitted an update by the required date and is awaiting an update on their status. We have committed to continuing the work of the OHT. We will be continuing our work on clients with COPD and improve access to Primary Care for those unattached clients that are discharged from hospital. This should result in an improvement in the health of the community over time.

Palliative Approach Early Identification Project: The Early Identification Project Team included the Project Lead (QI Advisor) a local Caregiver, a Palliative Care Coordinator from Home and Community Care, the Palliative Care Nurse Coordinator from Perth Smiths Falls District Hospital, the Health Links Manager, the Manager and a Registered Nurse from the BGH Palliative Care Program, a Nurse Practitioner from Long Term Care Program, and the Quality Coordinator from the SE LHIN. Team members from RCHS included the Primary Care Manager, the Complex Care Nurse Coordinator (RN) and the RCHS Executive Sponsor of the project.

The team often discussed the challenges of communication as the client moves through the Health System. Specifically how information is shared amongst the Care Team when a client is identified for the palliative care approach, given that several organizations may be working on earlier identification. We identified opportunities through community rounds, embedded Care Coordinators and consideration of a standard tool to share. The Toolkit may have a future role in informing rounds and huddles as well as standardizing referrals to the Care Team.

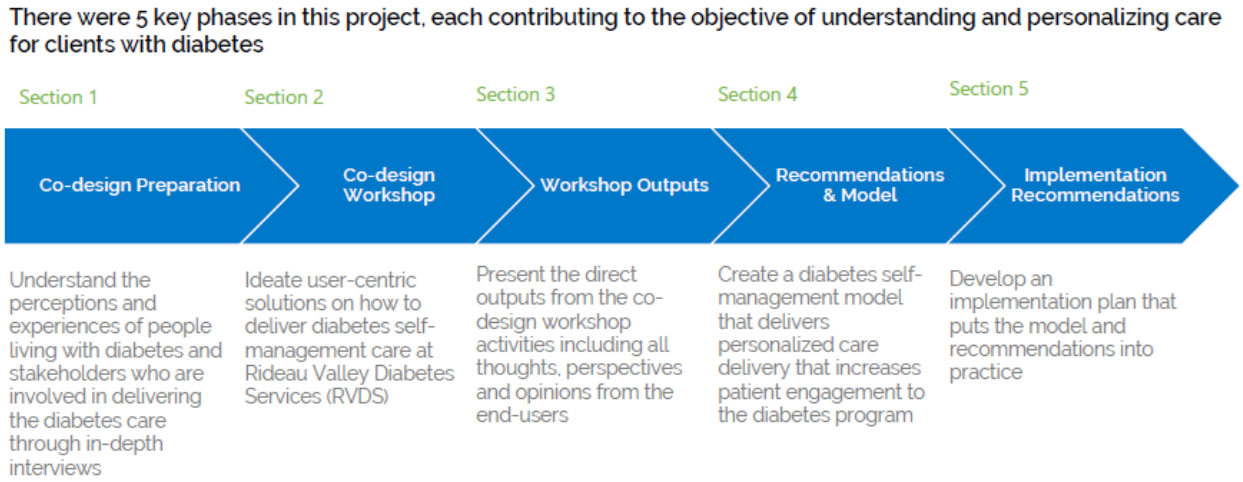
The Project Lead consulted with other providers at RCHS as well as partners in the system, including Family Physicians and the Palliative Care Nurse Practitioner, who were unable to attend meetings but were asked to provide input and were interested in regular updates. Regular update meetings were held with the LLG Sub-Regional Director and Home and Community Care Leadership. Project work was shared at the local Palliative Care Education Day session and a number of outreach sessions were scheduled with primary care organizations and Palliative Care Programs. Many of the project team were also members of the Health Links Palliative Care Committee and will continue with the Perth Smiths Falls Hospital & Community Palliative Care Committee to address system issues.

Lanark, Leeds and Grenville Oral Health Initiative:
With leadership from the Leeds Grenville, and Lanark Public Health Unit, RCHS has been participating in a regional working group in order to implement an Oral Health Program that is inclusive of funding received to support low income adults who have dental emergencies as well as implementation of the recently announced Ontario Seniors Dental Care Program. These two programs are being operationalized by RCHS with input from the steering committee. The collaboration will allow the RCHS oral health program to be able to offer eligible seniors and low income adults dental care based on the criteria provided by the funders. This collaboration and the leadership of the health unit has supported an additional 4 dental suites, for a total of 7 in 4 communities across the geography. The steering committee is responsible for developing messaging, collaborating to raise awareness and assist clients who are eligible to apply for the programming and ensure that a social prescribing practise is implemented within this program delivery model.

Patient/client/resident partnering and relations

RCHS has implemented a real time client feedback process in addition to our usual means of obtaining client input which includes suggestion boxes, interactions with staff and members of the leadership team reaching out to clients and family members for input, through the use of a client experience survey on tablets. We will continue to grow this tool over the next fiscal year.

The Diabetes Education Team engaged clients in the development of our Diabetes 2.0 project. This project engaged diabetes education program staff, and stakeholders which included both primary care team members as well as clients to co-create a diabetes service model that enhances individualized care for the diabetes education program clients. Clients and stakeholders participated in phone interviews as well as focus groups. We are currently in the process of sharing the results of the collaborative work back with staff, partners and clients.



Community Engagement Council

The Community Engagement Framework will support Rideau Community Health Services' strategic goals through, transparent, accountable, consistent and accessible community engagement. We will build engagement opportunities that inspire community stakeholders to develop and partner with RCHS in program development.

RCHS has developed a council to work with RCHS and the Leadership to work with us to further develop programs and identify community needs. This work also aligns with the requirements of OHT for community engagement. Our desire is to expand this group to include persons who are accessing other services (e.g., Community Support Services, Alzheimers Society) The Engagement Council would work with the partners to assist in developing better ways to provide services and improve access and enhance transitions.

The Community Engagement Council when fully developed should align with the IHI Quadruple Aim component of Improving the Patient Experience. By advising organizations in how to better to support their clients we will achieve a better experience for the users of the system- some of whom are the most vulnerable persons in our communities.

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 has updated our policies related to Panic buttons and use of Codes in Emergency situations with input from staff, the leadership team and relevant stakeholders (e.g., OPP, hospitals, etc).
- Training was provided at all staff day as well as on site specific training has been offered.
- RCHS provides debriefing sessions for staff involved in situations where they have felt at risk or there was a potential for risk.
- RCHS has applied lessons learned from those sessions to ensure our physical space promotes safe working environments.
- RCHS has a staff member trained in CPI and has offered three courses this fiscal year. In order to facilitate staff participation we have changed our model to a flex model of delivery which combines face to face and an on line learning component. RCHS provides staff time for their participation in this initiative.

Virtual care

We have implemented the Virtual Care Clinic to support those unattached persons in the Smiths Falls region. We have started slow but we will be ramping up to capacity in the next weeks. The team has risen to the challenge and the LHIN has supported the administrative needs for this project until the end of the fiscal year. We have let our partners know that we cannot sustain this project without the administrative supports of our partners past March 31st, 2020. This project is to support unattached patients in the Smiths Falls area. This initiative is as a result of the Health Human Resource Collaborative and the Perth and Smiths Falls District Hospital.

This project aligns with the new directives from the Ministry to support Virtual health. We will be moving forward with a business plan to the regional recruitment team and CEO of Perth and Smiths Falls District Hospital (PSFDH) to support this project in the next fiscal year if the RCHS team determines the feasibility of supporting this project.

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 : Janet Cosier DocuSigned by: Janet Cosier CFDE408BE083A1... (signature)

Director, Primary Care : Kelly Robinson DocuSigned by: Kelly Robinson B4767E22F780445... (signature)

Director, Community Services: Onalee Randell DocuSigned by: Onalee Randell BDA7D8E3630E45F... (signature)

Chief Executive Officer: Michele Bellows DocuSigned by: Michele Bellows 828F3FAB15D14F3... (signature)

Date: Tuesday March 31, 2020

2020/21 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

Rideau Community Health Services 354 Read Street, P.O. Box 550, , P.O. Box 550, Merrickville , ON, K0G1N0

AIM		Measure									Change				
Issue	**Quality dimension**	**Measure/ Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Org. 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 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.	P	% / Discharged patients	See Tech Specs / April 1 - Dec 31, 2018	91418*	Kelly R fill in	95%	This allows for approximately 5% patients who refuse follow up, get placed into LTC, etc.	Perth Smiths Falls District Hospital, SHIIP, The Ottawa Hospital	1. Maintain current practices and gains, continue to invest in the RN Care Coordinator resource for this activity as it is a new RN filling in a mat leave role. 2. Assess the feasibility of utilizing Connecting Ontario to support Allied Health in working with external Primary Care Providers	1. Implement existing processes and ongoing evaluation of same 2. Information gathering, orientation to RNs and RDs on use of Connecting Ontario platform	1. New RN Care Coordinator trained and given access to SHIIP and achieving target of reaching and scheduling visits with those discharged (for whom we are aware) 2. - # of staff trained and provided access to Connecting Ontario.	1. RN Care Coordinator will attempt connection to 100% of those discharged (those who we are aware) 2. 15 staff	
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 2019 - March 2020	91418*	to be completed	98%	In previous years we have achieved a target or 98% and we continue to strive to improve this indicator	Internal	In previous years we've mailed out 500 client satisfaction surveys with a response rate of 40% however this year we are implementing a point of care on site electronic survey system	Implementation of electronic point of care survey tool to ensure timely and accuracy of information from our patients	Survey Response Rate	Collecting Baseline	
		Percent of clients who state that the diabetes education program provides him/her with information and tools needed to manage diabetes	C	Count / %/ patients with diabetes, aged 18 and older (in Athens FHT client population)	In house data collection	91418*	collecting baseline	collecting baseline	this is a collaborative QIP developed in partnership with Athens FHT	Athens FHT	Implement a survey for clients with diabetes to assess efficacy of collaborative between RHCS / Athens FHT diabetes	Survey data	Survey Response Rate	Collecting Baseline	