QI work-plan *(time period April 2024-March 2025)*

Theme I: Access and Flow

Dimension: Timely

Indicator #1: Number of new patients/clients/enrollments (most recent consecutive 12-month period)

Planned Improvement #1: *Redevelopment of existing intake procedure for primary care department.*

Method: *meetings with providers, client focus groups, creation of working group*

Process measures: *creation of a project plan to bring people referred to primary care into other GRCHC programs and services that would support them, build a relationship with GRCHC and improve their health, while waiting for primary care services*

Target: Create and sustain a working group by June 30, 2024; complete 3 staff/provider focus groups/meetings by September 30, 2024; complete 3 client/community member focus groups by October 31, 2024; develop a project plan by December 31, 2024

Target Justification: *As we are redeveloping our existing intake procedure, target dates are appropriate*

Indicator #2: Patient/client perception of timely access to care: % of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the day they wanted (Client experience survey, most recent consecutive 12-month period)

Planned Improvement #1: *PDSA cycles to tweak and maintain the level of access achieved through AA30 implementation.*

Method: *Client Experience Survey; discussions with individuals re: provider- level alignment of bookings into schedules; decision-tree formations for front desk*

Process measures: *alignment of provider bookings in schedules between provider and Director of PC; % of unbooked AA30 appointments; % of client responses on experience survey when asked if they were satisfied with the date of the appointment*

Target: *alignment of provider bookings in schedules by September 30, 2024; 80% of one-to-one provider-Director meetings included discussion about AA30 appointments; 5% improvement from 2023/24 Client Experience survey (70%) of client responses on experience survey when asked if they were satisfied with date of appointment*

Target Justification: *keeping target % within realistic expectation of improvement*

Theme II: Equity

Dimension: Equitable

Indicator #1: Completion of socio-demographic data

Planned Improvement #1: *Start development of new health equity questionnaire implementation*

Method: *engage and collaborate with other CHCs to learn about data collection processes; attend meetings with Alliance regarding implementation and training related to health equity questionnaire (RALI)*

Process measures: *utilize students to engage with other CHCs learning about data collection processes related to new Health Equity questionnaire; # of CHCs engaged with; # of project leads engaged with Alliance implementation and training sessions (RALI)*

Target: *Baseline data collection; development of a project plan by March 31, 2025*

Target Justification: *With implementation of the new Health Equity questionnaire in the future, we are starting from scratch and therefore collecting baseline data is a logical approach*

Indicator #2: Develop a comprehensive, coordinated and intentional approach to build knowledge and capacity, enhance programs and services, and foster an inclusive environment at GRCHC via an equity, diversity, inclusion and anti-black lens.

Planned Improvement #1: *Improved coordination of equity, diversity, inclusion and anti-racism related efforts at GRCHC*

Method: *Review and revision of 2024-2025 work plan by EDI Committee members, as needed; engagement of GRCHC staff, clients and/or volunteers to develop EDI related questions for staff and client satisfaction surveys and strategic planning tools; inclusion of EDI as a standing*

agenda item on all GRCHC internal committees; development of organizational EDI strategic chart (i.e., who is supporting what work); development of an EDI and AODA policy, procedure and form assessment tool; attend OHT EDI monthly meetings

Process measures: *# of GRCHC staff, clients and/or volunteers engaged to develop questions for surveys and tools; # of questions drafted/included for staff and client satisfaction surveys and strategic planning tools; # of agendas EDI is a standing item on; # of organizational planning and/or assessment tools developed to support EDI work; # of OHT EDI meetings attended*

Target:

- *A minimum of three GRCHC staff are engaged by July 2024 to identify amendments needed in staff and client satisfaction surveys, and additions to strategic planning tools in relation to equity, diversity, inclusion and anti-black racism*
- *A minimum of two equity-related questions are included on annual staff and client satisfaction surveys, and on strategic planning data collection tools in 2024*
- *80% completion rate of equity, diversity, inclusion and anti-black racism related questions on annual staff and client satisfaction surveys, and on strategic planning data collection tools for 2024-2025*
- *100% of internal GRCHC agendas contain EDI as a standing item by July 2024*
- *A minimum of two organizational planning and/or assessment tools developed at GRCHC to support internal EDI work*
- *Attend a minimum of eight OHT EDI committee meetings in 2024-2025*

Target Justification: *Collecting Baseline Data on all targets declared within planned improvements declared. This is ongoing work at GRCHC, and we do not have any existing data at this point to improve upon*

Planned Improvement #2: *Enhanced staff and volunteer knowledge (executive-level, management, or all) in equity, diversity, inclusion and anti-racism education*

Method: *Develop staff survey to identify GRCHC staff and volunteer knowledge gaps in relation to equity, diversity, inclusion and anti-black racism; provide staff and volunteer training opportunities based on identified needs; develop resource bank with equity, diversity, inclusion and anti-black racism related materials*

Process measures: *% of GRCHC staff and volunteers who complete knowledge survey related to equity, diversity, inclusion and anti-black racism; # of trainings, knowledge exchange sessions and other learning opportunities offered for staff and volunteers at GRCHC related to equity, diversity, inclusion and anti-black racism; # of resources included in the equity, diversity, inclusion and anti-black racism digital library*

Target:

- *A minimum of 80% of GRCHC staff and volunteers complete the equity, diversity, inclusion and anti-black racism knowledge assessment survey by July 2024*

- *A minimum of two equity, diversity, inclusion and anti-black racism related trainings, knowledge exchange sessions and/or other learning opportunities are offered for GRCHC staff and volunteers in 2024-2025*
- *A minimum of 30 resources are added to the equity, diversity, inclusion and anti-black racism digital library in 2024-2025*

Target Justification: *Collecting Baseline Data on all targets declared within planned improvements declared. This is ongoing work at GRCHC, and we do not have any existing data at this point to improve upon*

Planned Improvement #3: *Application of equity, diversity, inclusion and anti-racism best practices to enhance GRCHC organizational culture; community connectedness; and client, staff and volunteer physical and psychological safety*

Method: *Engage community partners as well as individuals with lived/living experience to inform equity, diversity, inclusion and anti-black racism related work and initiatives at GRCHC – focus – inclusive signage for single- and multi-stalled washrooms, and value walks; gather best practices and existing resources related to identified projects*

Process measures: *# of community partners and individuals with lived/living experience engaged; # of times community partners and individuals with lived/living experience were engaged; # of products/materials produced*

Target:

- *A minimum of two community partners are engaged in value walks at GRCHC in 2024-2025*
- *A minimum of two individuals with lived/living experience are engaged in value walks at GRCHC in 2024-2025*
- *A minimum of two value walks take place at GRCHC by October 2024*
- *Creation of one report outlining findings and recommendations from value walk at GRCHC by December 2024*
- *A minimum of three individuals with lived/living experience are engaged in the design/development of inclusive washroom signage at GRCHC by June 2024*
- *Three types of inclusive washroom signage are produced at GRCHC by July 2024*

Target Justification: *Collecting Baseline Data on all targets declared within planned improvements declared. This is ongoing work at GRCHC, and we do not have any existing data at this point to improve upon*

Theme III: Experience

Dimension: Patient-centred

Indicator #1: Do patients/clients feel comfortable and welcome at their primary care office? (Client survey, most recent consecutive 12-month period)

Planned Improvement #1: *Improving waiting room and primary care office experience based on feedback from Client Experience Survey 2023/24 using technology, additional signs for improving flow and centre resource sheet for volunteer training and clients*

Method:

- *Using TV screens in reception with timely program information, centre updates and trivia or fun facts about GRCHC for client entertainment in waiting room. Including information on the TV about the outreach station and that refreshments are for all clients to avoid misinformation*
- *Researching best practices and format for signage within primary care hallway to improve patient flow in and out of clinic space*
- *Creating a centre wide program and service eligibility/registration/information sheet for volunteers to share with clients and to feel prepared to answer program and service questions*
- *Add signage and volunteer buttons at the outreach station with prompt "Ask me about programs and services at GRCHC!" to reduce lines at reception for questions that can be directed to volunteers.*
- *Updating community board near ramp entrance monthly with centre initiatives for special days or holidays to improve waiting room experience by reducing boredom*

Process measures: *Client Experience Survey open ended questions; % of client written responses related to themes of comfort and welcome on client experience survey re: '2 things to improve' question and % responses of 'yes' on 'do you always feel comfortable and welcome at GRCHC' question, # of resources compiled to learn about best practices for patient flow in primary care hallway (floor signage, wall signage etc.)*

Target*: 70% reduction in written responses related to themes of comfort and welcome on client experience survey re: '2 things to improve' question. Maintain result from 2023/24 Client Experience survey result (94.70%) by declaring 95% target performance in 2024/25 Client Experience survey; completed evidence based resource document on implementing patient flow signage in primary care hallway to inform next steps*

Target Justification: *We believe that focus to maintain our already stellar performance in this indicator a logical approach*

Indicator #2: % 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

Planned Improvement #2: *To develop chronic disease self-management programs such as Living Well with a Chronic Disease and How to Get the most from your health care appointment in Brantford/Brant. These programs further client skills in developing goals, identifying questions and how to discuss issues with their health care providers. Our change idea is to develop a service delivery partnership with Hamilton Self-Management Program to train staff and to develop a process for offering both in-person and virtual sessions for both PC clients and community clients. We also want to further develop opportunities to offer self-management programs that are disease specific with Waterloo Wellington Self-Management Program*

Method: *Utilizing new partnerships, develop 1-2 groups to deliver self-management programs in Brantford/Brant*

Process measures: *The development of program plans to implement self-management programming*

Target*: Have training completed for 1-2 staff in leading self-management groups by June 30, 2024; implement 1-2 self-management group programs by March 31, 2025. Improve result from 2023/24 Client Experience survey result (92.49% Always/Often) by 2% based on 2024/25 Client Experience Result.*

Target Justification: *We recognize that once already within the 90th percentile of satisfaction, moving the needle even a couple of % points can prove difficult, and we believe maintenance of this high satisfaction result would also be an accomplishment.*

Theme IV: Safety

Dimension: Effective

Indicator #1: % of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system.

Planned Improvement #3: *Building from the baseline data gathered during our last year's QIP, and using CNO and CPSO best practice guidelines around opioid prescribing for non-palliative patients, developing a standard operating procedure to standardize these practices across our primary care clinic. Guidelines, lessons learned, and resources from GRCHC's Brantford-Brant Safer Opioid Supply (BBSOS) Program will be used to guide capacity-building efforts around safer opioid prescribing with the Primary Care team.*

Method: *identify gaps in service provider knowledge via a survey completed with GRCHC primary care staff. Create resources to address the identified gaps and facilitate a presentation for the Primary Care team. BBSOS will continue its work as a content expert related to opioid prescribing, safety and diversion. Any information/research/knowledge gained will be actively shared with the Primary Care team as it becomes available.*

Process measures: *% of primary care staff completion of service provider knowledge survey; development of a report and recommendations based on gaps in knowledge; % of GRCHC primary care staff attendance at presentation by BBSOS Program team; # of resources and materials shared around safe prescribing protocols; establishment of a BBSOS Program quality improvement work plan; # of new BBSOS Program clients*

Target:

- *80% of Primary Care team members will complete service provider knowledge survey by June 30, 2024*
- *Report and recommendations based on gap in knowledge created by July 31, 2024*
- *80% of GRCHC primary care staff attend presentation from BBSOS Program team by September 30, 2024*
- *A minimum of best practice resources related to opioid prescribing are shared with the GRCHC primary care team by October 31, 2024*
- *Establishment of a 2024-2025 BBSOS Program quality improvement plan by June 30, 2024*
- *A minimum of 10 additional in-takes (i.e., total 40 clients) into the BBSOS Program by October 31, 2024*

Target Justification: *Knowledge sharing and education to develop standard operating procedure for opioid prescribing with the Primary Care team is a logical approach to this planned improvement*