

OVERVIEW

We had big things planned for 2024/25, and we delivered. Our organization underwent unprecedented growth, adding an Interdisciplinary Primary Care expansion at our Tillsonburg site, our county-wide Pediatric Outreach Program “First Five”, and a new Transitional Housing facility in Ingersoll. As a team, we have collectively felt ourselves transitioning from being a “small” to a “medium” sized team and have adapted various workflows to reflect this increase in organizational complexity. Despite these changes we continue to deliver high-quality services and a positive care experience to more clients than ever before. Please see below for feedback directly from our client experience surveys....

“I think they do well in about everything. Answer calls when I call and help with everything needed and more”.

“The receptionists are always caring and helpful and they try their best to accommodate based on needs.”

“I just want to say that I appreciate all the years I've been coming to the clinic and all the help they have given to me. You are always on the ball!!!”

“I am REALLY happy with the care I get in Tillsonburg, my NP saved me and I wouldn't be alive without her.”

ACCESS AND FLOW

In 2024/25 we took several important steps & engaged in impactful projects to improve access and flow for individuals in Oxford County:

- Internally, we have established formalized absence coverage

models for primary care providers that improve our responsiveness to client needs, including increased availability for same day appointments.

- In collaboration with the Tillsonburg District Memorial Hospital (TDMH), we have identified, and begun rostering, unattached high-volume Emergency Department users to our expanded primary care team in Tillsonburg.
- In collaboration with several partners and the Oxford OHT, we co-authored a successful HART Hub proposal and are engaged in the planning process.
- In collaboration with the Oxford County Paramedicine Team, we have expanded our Community Paramedicine chronic disease partnership by increasing the roster size and adding new medical delegations to expand their scope and impact.

This year we will:

- Scale, stabilize, and sustain the above projects and initiatives.
- Conclude planning and initiate collaborative implementation of the HART Hub, including new OCCHC staff - Housing Stability Workers, a Registered Nurse, a Nurse Practitioner, and a System Navigator to improve flow and fill gaps in the continuum of care for people experiencing addictions and/or homelessness.
- Integrate our local Ontario HealthatHome Complex Care Coordinator into our team care conferences and provide her periodically with on-site office space to facilitate collaboration.
- Review and revise our Primary Care telephone triage system to ensure individuals can expediently access care from the right provider, in the right place, at the right time.

EQUITY AND INDIGENOUS HEALTH

In 2024/25 we created our first ever FMIMUI and Health Equity workplans. We have completed all elements of these plans, which included All Staff training and relationship building with local agencies such as the Southwestern Aboriginal Health Access Center, and the Oxford County Community Employment Services (CES) Newcomers program.

Additionally, in partnership with the CES Newcomers Program, we have rostered many equity-deserving families to our primary care and Pediatric Outreach teams.

Moving into 2025/26 and beyond, the OCCHC will continue to expand on our efforts to build our capacity to improve health equity in Oxford County. We await specific direction (i.e. standardized indicators) from Ontario Health, which will enable us to further refine our efforts.

PATIENT/CLIENT/RESIDENT EXPERIENCE

In 2024/25 we:

- Collaborated with our partners at Western University to complete a research project that involved completing semi-structured interviews with 20 of our Community Dental Clinic users. During these interviews, service users outlined their experiences with their oral health and our community dental clinic. The results will directly inform our forthcoming expansion of the Community Dental Clinic in 2025/26.

o Jessani, A., Borges, G., Torti, J., Ugwu, A., Watling, C., Hollingham, Z., Vos, P., Roden, T., & Mclean, S. Impact of community service learning on oral health equity in Ontario: patient and provider perspectives. Submitted for publication to the Journal of Dental Education. 2025.

- Collected 100 client experience surveys, the results of which will inform our progress report (completed separately) and our forthcoming goals and actions within our 2025/26 work plan (completed separately)

This year, in collaboration our research partners at Western University's Schulich School of Dentistry, we will survey 350 of our clients to better understand their oral health needs and their experiences at our Community Dental Clinic. This will further the body of research related to the oral health experiences of marginalized populations in Ontario and will position us to adapt our community dental program to better meet the community's needs.

PROVIDER EXPERIENCE

We continue to experience low annual staff turnover rates among our permanent staff despite the considerable pay inequities affecting our sector. We attribute this to a cohesive and trusting team environment, an approachable and supportive management team, and several other factors.

SAFETY

Our Primary Care team have established formalized absence coverage models for providers to improve our responsiveness to client needs, reduce the risk of time-sensitive needs being met, and increase our availability for same day appointments. We will monitor their effectiveness and impact and iteratively adapt the plan according to provider and patient feedback.

PALLIATIVE CARE

We have taken the following steps to ensure delivery of high-quality palliative care:

1. Staff Training - Our primary care team of MDs, NPs and RN/RPNs are signed up for training for serious illness conversations to increase their comfort and capacity to have effective conversations about end of life with their clients.
2. Adoption of best practice palliative care tools - We have integrated the SPICT tool for early identification of patients on a palliative trajectory and have developed a reminder in our EMR to identify clients eligible for screening.
3. Group based programming - We have engaged in providing group education around advanced care planning and end of life care to our community members and clients, with a goal to offer this session quarterly.

POPULATION HEALTH MANAGEMENT

Part of our organizational vision is to be immersed in community. To that end, we are integrated closely with the Oxford OHT, including representation as a member on the Leadership and Strategy Council, and on several Communities of Practice. Beyond this, we engage in various intra-and cross-sectoral partnerships with the goal of identifying and taking action to address population-based health needs for equity deserving groups. As a member of various community-based committees and tables, we contribute to strategic planning related to resource allocation, service pathway planning, and service integration in our area.

One central example of a collaborative project that will care for the unique needs of people in our community is the successful collaborative for a Homelessness and Addiction Recovery and Treatment Hub (HART Hub) in Oxford County. We look forward to implementing the HART Hub alongside our partners to improve access and outcomes for those experiencing homelessness and addiction in our community.

ADMINISTRATIVE BURDEN

We continue to use nearly all available supportive technologies that reduce administrative burden for our primary care providers, e.g.:

- Electronically fillable, and auto-populated custom forms, and documentation stamps within our EMR
- AI Scribe documentation support technology
- OCEAN MD:
 - o Automated appointment reminders
 - o Secure patient messaging
 - o E-referral
- Ontario Laboratory Information System (OLIS)
- Health Report Manager (HRM)
- Prescribe IT
- Clinical Connect (CC)

This year we will participate in the Oxford OHT's AI Scribe Pilot, where structured feedback will be elicited from our PC providers regarding their experience with AI Scribe. We will also turn our focus towards expanding the reach of these supportive technologies by encouraging adoption by our Allied Health & Social Care Teams.

CONTACT INFORMATION/DESIGNATED LEAD

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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 on **April 1, 2025**

Brad Hammond, Board Chair

Zach Hollingham, Quality Committee Chair or delegate

Randy Peltz, Executive Director/Administrative Lead

Other leadership as appropriate

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of new patients/clients/enrolments	O	Number / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	95.00	125.00	Our target is based on increasing last year's performance by ~30%	Tillsonburg District Memorial Hospital, Oxford County, Woodstock Hospital

Change Ideas

Change Idea #1 Refine our existing intake process to reduce administrative burden utilizing supportive technologies

Methods	Process measures	Target for process measure	Comments
1. Create an intake team 2. Review existing process 3. Integrate supportive technologies however possible (i.e. OCEAN; Scribeberry; HRM; Clinical Connect) 4. Draft refined process 5.	1. Intake process refined & adopted 2. Number of completed applications received 3. Number of intake appointments booked	1. Intake process refined & adopted by June 2025 2. 100 fully completed applications received by September 2025 3. 100 intakes appointments booked by January 2025	

Change Idea #2 Re-establish relationships and referral pathways from internal programs and appropriate community partners

Methods	Process measures	Target for process measure	Comments
1. Reconnect with community partners to identify appropriate clients for primary care attachment 2. Establish referral pathways from the above partners 3. Finalize primary care application form with input from partners & our staff 4. Provide feedback on incomplete or inappropriate referrals	1. Number of community agencies we have successfully connect with to provide information about our primary care intake process 2. Number of community agencies we successfully receive appropriate primary care referrals from 3. Number of internal programs we receive appropriate primary care referrals from	1. We will connect with 5 partner agencies by June 2025 2. We will receive fully completed appropriate primary care referrals from 4 partner agencies by September 2025 3. We will receive fully completed appropriate primary care referrals from all of our internal programs who encounter unattached clients 3.	

Measure - Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Patient/client perception of timely access to care: percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	85.71	90.00	Our target is based on improving last year's performance by ~5%	

Change Ideas

Change Idea #1 Refine primary care telephone triage process

Methods	Process measures	Target for process measure	Comments
1. Gather feedback from clinical staff, administrative staff, clients, and leadership 2. Strike a working group to prepare a new process 3. Gather feedback on the draft process, and refine it 4. Implement the new process 5. Evaluate outcomes	1. New telephone triage process completed by August 2025 2. New telephone triage process implemented September 2025 3. Client experience surveys (with specific question re: triage) to determine impact & solicit feedback	1. We will complete our new telephone triage process by August 2025 2. We will implement our telephone triage process by September 2025 3. We will complete 100 client experience surveys by December 2025	

Change Idea #2 Implement & evaluate formalized primary care provider coverage model

Methods	Process measures	Target for process measure	Comments
At the end of fiscal year 2024/25 we created a formalized primary care provider coverage process which we hope will reduce the burden on our primary care providers and expand access to same day appointments for our clients who have urgent episodic issues. This year, we will: 1) Implement our coverage model 2) Evaluate outcomes 3) Revise the model as necessary with input from clients, staff, and leadership	1. Full model implementation 2. Provider experience surveys complete 3. Client experience surveys complete	1. The model will be fully implemented effective the first week of April 2025 2. We will complete 10 provider experience surveys by August 2025 3. We will complete 100 client experience surveys by December 2025	

Change Idea #3 Physiotherapist (PT) as first point of contact for primary care clients presenting with musculoskeletal concerns

Methods	Process measures	Target for process measure	Comments
1. Establish a model for PT as first point of contact, in collaboration with the primary care physiotherapist and primary care team. 2. Create a pilot process to implement the proposed model (e.g. for one type of presentation, to start (e.g. back pain or joint pain)) 3. Implement the pilot process 4. Evaluate, refine, and scale the process as appropriate	1. Model established 2. Process established 3. Number of clients seen by PT as first point of contact 4. Feedback from clients	1. Our model will be established by June 2025 2. Our pilot process will be established by July 2025 3. We will implement the Pilot by September 2025 4. We will serve 20 clients with this process by October 2025 5. We will receive feedback from 15 clients by November 2025	

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

April 1, 2025