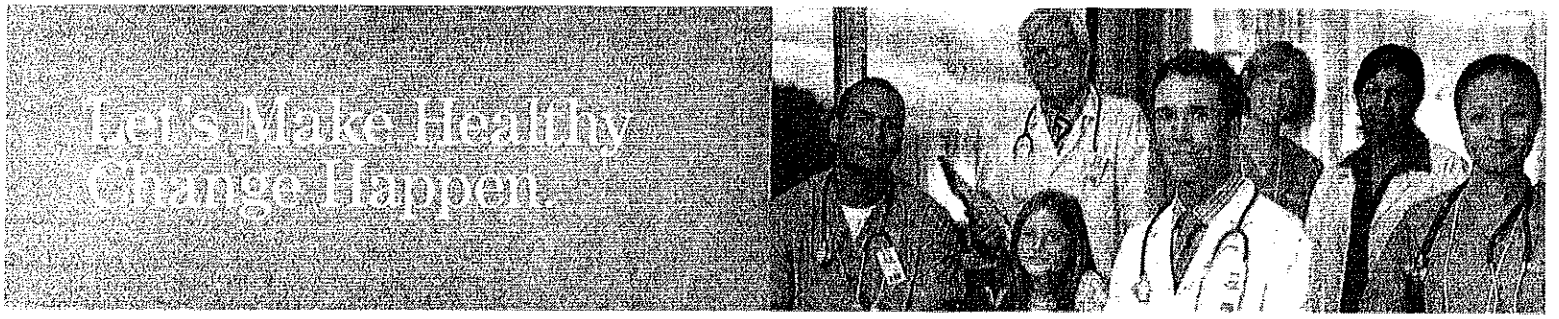

2013/14 Quality Improvement Plan for Primary Care organizations in Ontario

VCHC
Vaughan Community Health Centre
Member of Vaughan Health Campus of Care

March 31, 2013

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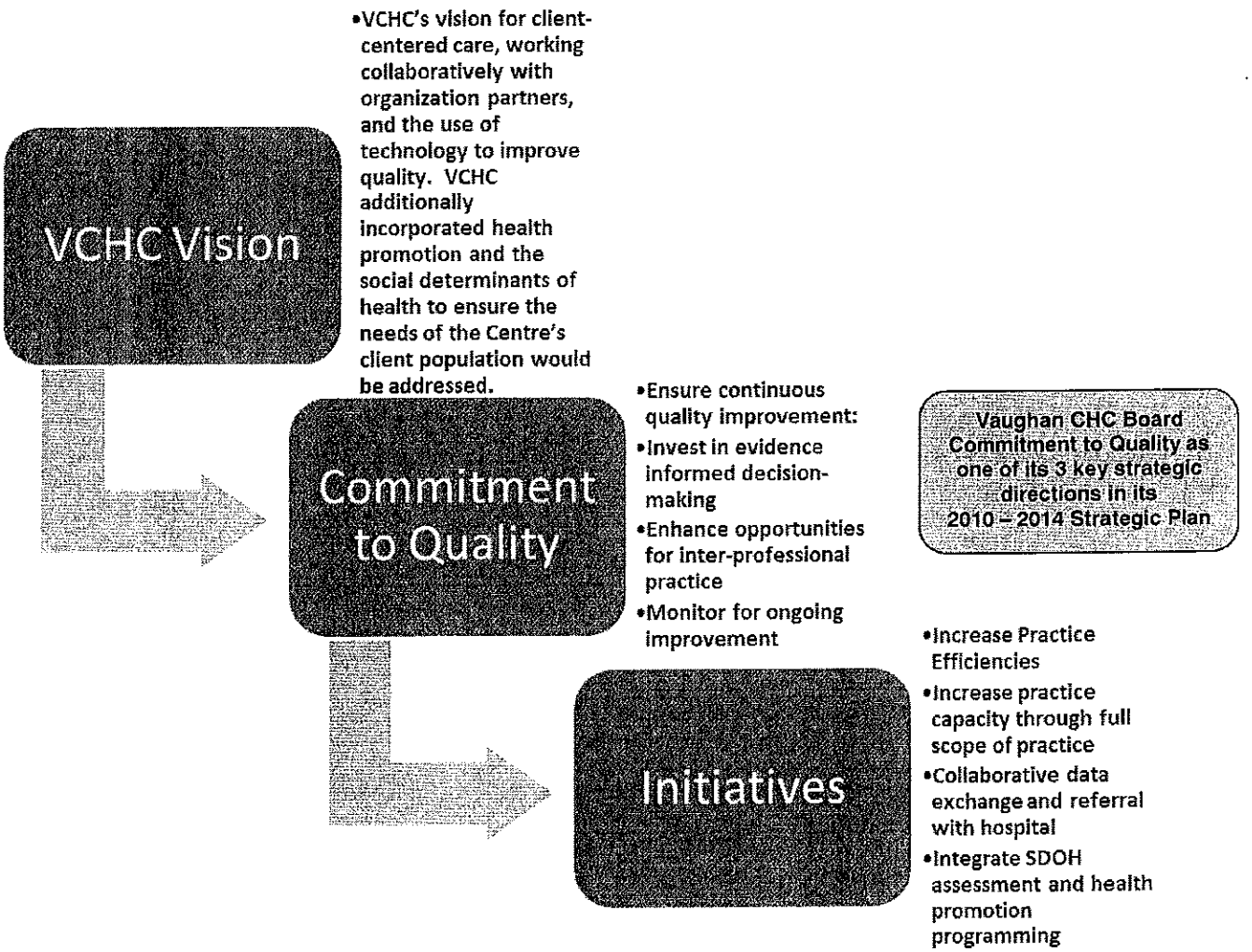
Fig. 1 Alignment of VCHC vision with Commitment to Quality with Quality Improvement Initiatives



Overview of Our Organization's Quality Improvement Plan

Overview

Vaughan CHC's QIP uses the MOH/HQO template for primary care. The provincial system priority objectives and indicators were assessed to intersect with VCHC's vision for client-centered care, working collaboratively with organization partners, and the use of technology to improve quality. VCHC additionally incorporated health promotion and the social determinants of health to ensure the needs of the Centre's client population would be addressed.

Our Quality initiatives have been guided by a key strategic direction over the past 3 years to Ensure continuous quality improvement:

- Invest in evidence informed decision-making
- Enhance opportunities for inter-professional practice
- Monitor for ongoing improvement

Focus

The objectives of the QIP

1. Expand on previous implementation at VCHC of advanced access methodology to increase the availability of provider time to see more clients.
   - Practice capacity will increase through implementing full scope of NP and RPN practice that responds to recent changes in applicable regulations; and
   - Practice efficiency will be increased through improved referral and scheduling processes; and
2. Co-ordinate health promotion programming to address the needs of the top 1% complex clients, especially related to the social determinants of health such as poverty and social isolation.

Use of the Electronic Medical Record (EMR)

The Vaughan CHC fully uses an electronic medical record system and transitioned to Nightingale on Demand (NOD) in February 2013.

Regarding Access and Integration, the EMR will be used to identify the top 1% clients, with selected conditions, who are at risk of frequent use of expensive health care resources, such as the hospital and emergency. The use of Nightingale on Demand – Hospital Manager will be reviewed for its capacity to integrate between the hospital and Community Health Centre EMRs.

Integration and continuity of care

VCHC will work closely with the hospital to identify most complex VCHC clients who are in emergency, being admitted, or being discharged. The hospital would then notify VCHC so the Centre can follow up with the client for an appointment within 7 days.

- **Practice/community profile**

  VCHC conducts regular community consultations to assess the changing demographics, health issues and use of resources by the population within its catchment area. Client surveys are also completed annually. Results help guide the direction of programming, services and Centre policy.

  The community consultations and survey results in 2010 showed, for example, that 75% of clients need access to care in a language other than English. VCHC subsequently requested and received LHIN funding, in partnership with Mackenzie Health, to assess the need for language services in hospital, primary care and community services settings. A conceptual model was developed to support decision-making about language services in these organizations. VCHC purchased new technology last year to support language interpretation as needed by providers and clients.

- **Chronic disease management and prevention**

  The commitment to quality improvement is a key component of The 2007 *Ontario Framework for Preventing and Managing Chronic Disease*, stating, "Best practices in implementing Framework elements continue to evolve. Organizations need to foster a culture of quality improvement to identify innovative and effective delivery strategies, based on new best evidence, that are most effective in preventing and managing chronic disease. Initiatives could include continuous learning forums and systematic use of quality improvement tools. Quality improvement from the top levels to the front lines needs to be promoted and be a part of job descriptions and performance appraisals."

  The mandate of VCHC is focused on an inter-professional approach to addressing the complex needs of clients with multiple chronic conditions, secondary prevention of complications, maintaining levels of wellness. Activities include one-on-one encounters as well as group programming; specialty clinics, such as for diabetes management, are also available.

  The top 1% clients with complex needs will be identified based on selected key chronic conditions such as COPD, Diabetes, Asthma, Mental Health and Addictions, and Cardio-Vascular System and monitoring. The initiative to see these patients within seven days of discharge from hospital will ensure proper continuity as part of a best practice approach for clients with chronic conditions

- **Accountability management**

  At the operational level, VCHC has a work plan that itemizes each initiative, responsibility, and timeline, using a PDSA cycle approach to plan, implement and evaluate the initiative. The staff team meets every 2 months to review the work plan, and to make changes as necessary. Versions of the work plan are tracked to ensure that indicators are not missed.

  Strategically, a progress report on implementation of the objectives related to quality is reported semi-annually to the Quality Improvement and Risk Committee of the Board, and annually to the full Board of Directors as part of its review of strategic directions.

  Any significant incidents regarding client safety is reported at the next Board meeting; or sooner if warranted.

  The QIP is posted on the Centre's website for view by the public.

- **Challenges and risks**

Challenges and Risks	Mitigation
Onerous number of indicators	- Ensure limited, prioritized, clear, measurable indicators - Don't invent new indicators when others that are equally appropriate are available
So many external pressures may stretch resources too thin, or staff may not have the requisite technical knowledge and skills	- Be proactive to manage pressures - Purchase service for coaching, technical knowledge and skills where not yet available on the team
There are currently no staff vacancies. If staff vacancy occurs in the future it may mean that targets cannot be reached	- Note as an assumption within the QIP - Assess where provider responsibilities can be delegated
Data required to measure indicators is not available; for example, from the hospital	- Advocate for data availability. - Identify leading indicators if actual measures and data are not available
LHIN may focus its resources on the organizations functioning within the approved Healthlinks; so, for example, other organizations may not have the additional support to improve their EMR connections	- Learn from the experience of the currently approved Healthlinks

Our Improvement Targets and Initiatives

Please see the Excel Spreadsheet attached – to be mailed to (QIP@HQOntario.ca).

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan

Tony Carella
Board Chair

Joanne Anderson NP
Clinician Lead

Isabel Araya]
Executive Director/Admin. Lead

Primary Care Quality Improvement Plan Template

Vaughan Community Health Centre 2013/14

AIM		MEASURE				CHANGE			
Quality dimension	**Objective**	**Measure/Indicator**	**Current performance**	**Target for 2013/14**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
Access	Access to primary care, when needed	**Timely access to primary care, when needed:** Percent of patients/clients able to see a doctor or nurse practitioner by the third next available appointment, when needed.	TNA = 0 to 3 days	Maintain	QIIP (Quality Improvement and Innovation Parternship) recommended target	1. RPN working to full scope 2. Review appointment follow-up process re scheduling next appointment 3. Decrease length of appointments as possible for some clients or reason for visit 4. Increase use of telephone 5. Group multi-family member visits 6. Use of secondary exam room 7. Review scheduling of staff coverage 8. Implement new regulation re NP Collaborative practice 9. Increasd referrals to health promotion programming	1. Allocate coaching resource to help team response - prioritize - use PDSA cycle to implement and evaluate change	Increase provider availability through increased efficiencies, expanded function to full scope of practice, and increased connection to health promotion programming	
Integrated	Timely access to primary care appointments post-discharge through coordination with hospital(s).	**Primary care visits post discharge*:** Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions; including post natal, post surgery/suture removal, COPD, Diabetes, Asthma, mental health and addictions, cardio-vascular system and monitoring	Currently unknown	100% with exceptions for those clients who are discharged to LTC or who move out of town	The target is dependent on the availability of information from the hospital about clients with the selected conditions	1. Prioritize intake of new clients referred from hospital	Engagement process of whole clinical team and of clients and families	Implement new processes for identifying clients and inter-organization communication regarding the transitions of care	
						2. Implement process to use RPN to triage and assess post d/c clients for referral to appropriate primary care provider		Update job description and introduce to the clinical team	
		Return vistis/admission to hospital within 30 days	Currently unknown	Benchmark current experience		Explore role and function for an in-hospital primary carenavigator for case management.	Continue to express interest to be a HealthLink partner	Participate in a HealthLink	
Patient-centred	Receiving and utilizing feedback regarding patient/client experience with the primary health care organization.	**Patient/client engagement:** How often are you involved to the extent that you want to be in decisions related to your care?	87% strongly agree or agree 0% disagree or strongly disagree	Objective is to maintain performance	Will hold at this level until compare with peers	1. Compare with peer CHCs 2. Team recognition to support continued focus	Through RDSS (Regional Decision Support Specialists)	Communication to the RDSS to support comparison across CHCs and primary care	
		The staff explains things in a way I can understand	96% strongly agree or agree 1% disagree	"					
		Having enough time: When you see your doctor or nurse practitioner, how often do they or someone else in the office spend enough time with you?	85% strongly agree or agree 1% disagree	"					
	Equity/SDOH	Social programs are relevant to the needs of VCHC's top 1% high users.	Currently unknown	Benchmark current experience		Survey top 1% VCHC clients re programs that would assist health maintenance	Health Promotion Team - March to July 2013	Develop and implement new processes	

* data will be available on the Health Data Branch Portal for organizations with rostered patients