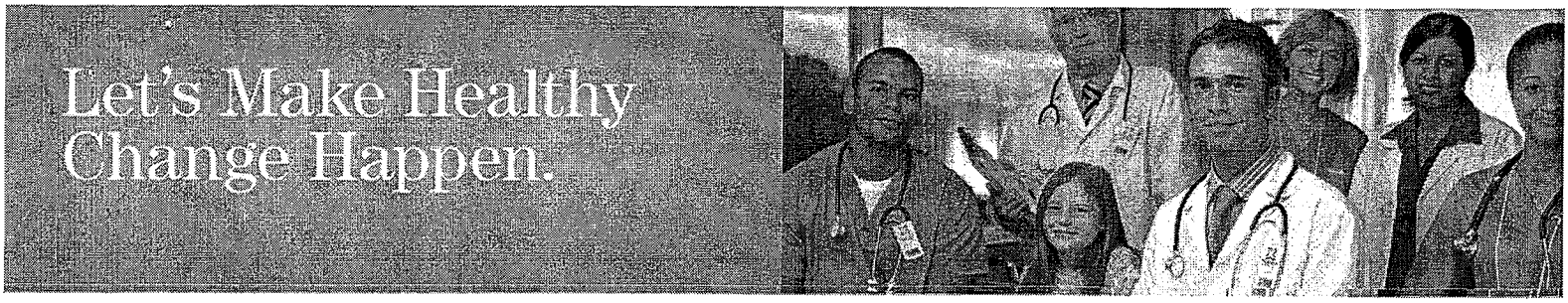

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

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

3/27/2014

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 HQO (if required) in the format described herein.

Ontario

Overview

Over the past four years, Vaughan Community Health Centre (VCHC) has dedicated significant staff and management time to explore and develop a sound quality improvement program. This has been an exciting learning process and has guided practice change to enhance the client experience at our Centre. We have ensured that clients' presence has been included at the Quality Improvement (QI) Committee and their feedback is reflected in our QIP planning. We believe we have made great strides in improving access to care and the client experience.

The Vaughan CHC's 2014-2015 QIP is aligned with VCHC's vision for client-centred care, working collaboratively with organization partners and the use of technology to improve quality. Our quality improvement (QI) initiatives continue to be guided by the VCHC's key strategic direction of ensuring continuous quality improvement by investing in evidence-informed decision-making, enhancing opportunities for inter-professional practice and monitoring for ongoing improvement. This is also in alignment with the quality improvement requirements for accreditation.

The 2014-2015 QIP continues to focus on the following:
1) Advanced access methodology to increase the availability of provider time so that clients can be seen by their provider when they need to be seen

2) Have Registered Practical Nurse (RPN) working to full scope of practice
3) Explore options for and expand group medical visits

4) Collaborate with Southwest York Region (SWYR) Health Link to establish a referral process so VCHC clients who meet the SWYR Health Link Criteria receive appropriate services within the local Health Link.

5) Collaborate with Mackenzie Health to ensure that discharge notes are sent to us on a timely basis so our clients can be seen by their primary care provider within 7 days
6) Survey clients to monitor three main components: a) that they have an opportunity to ask their MD/NP questions about their recommended treatment, b) that they are involved in decisions about their care and treatment, and c) that their MD/NP spends enough time with them during their visit.

Since its inception in February 2009, VCHC has served 11,000 clients in primary care services (including chiropody, physiotherapy, counselling, nutritional services and diabetes education and management), access to social programs and community capacity initiatives that focus on health promotion and education. VCHC not only focuses on being client-centred for access to primary care services but also access to all other services across the CHC. This broader focus is reflected in our client survey.

Of the 11,000 clients served, VCHC currently has 3,321 clients actively being seen by a MD/NP. 86 clients being seen by a MD/NP had responded to our last client survey. Results

indicate that clients are satisfied with our primary care services while we are striving to meet the Third Next Available Appointment (TNA) within 0-3 days. We have concerns about sustaining this access to care target. Clients have already complained about shorter appointment times (e.g. 20 minute appointments; 15 minute appointments for some episodic visits) and the consistent implementation of the late policy which have each contributed to our ability to meet the access to care improvement target.

Integration & Continuity of Care

Working with our community partners as well as Mackenzie Health hospital and the South West York Region Health Link, our goal will be to ensure seamless transition between acute, primary and community-based services. Clients and caregivers will be educated about the importance of follow-up within a timely manner to enhance their transition to community care. We will continue to strive to ensure timely access to meet our clients' needs.

VCHC has already identified 7 clients that meet the eligibility criteria for the South West York Region Health Link. Those criteria include the following: 1) client has 2 or more chronic conditions such as chronic heart failure, chronic obstructive pulmonary disorder, diabetes, stroke, etc.; 2) client has an additional condition that impairs daily functioning or decision-making such as mental health, dementia, mobility or physical condition; and 3) client is 45 years and older, has had a previous hospital admission within the last 12 months and has limited caregiver support.

We will strive to develop an efficient client-centred process for referral that recognizes the importance of client-provider continuity. The success of this undertaking will be dependent upon Health Link infrastructure and access to the Hospital Report Manager.

In addition, continuity of service providers is a goal for VCHC social programs. We strive to ensure that programs are facilitated by consistent providers that enhance the client's comfort and experience within the group setting.

Challenges, Risks & Mitigation Strategies

Challenges and Risks	Mitigation
Need both client and provider buy-in for group medical visits approach	• Select provider and focused task for PDSA (e.g. female between 50-65 years for complete physical exam) • Select motivated providers to implement and provide feedback to team • Utilize experience of external providers that have already implemented group medical visits

Financial restraints may impact on production of client communication products for education on the importance of timely follow-up post hospital discharge	• Create internal brochures/flyers to distribute to clients at lower cost
There are currently no staff vacancies. If staff vacancies occur in the future it may mean that targets may not be reached	• Note as an assumption within the QIP • Assess where provider responsibilities can be delegated
Data required to measure timely access to primary care appointments post hospital discharge is presently not available	• Continue to participate on Health Link governance and operations subcommittee to ensure VCHC is actively engaged in process development • Advocate for prompt delivery of discharge notes from Mackenzie Health so data availability will help us ensure timely follow-up(e.g. Hospital Report Manager)

Information Management Systems

The Vaughan CHC has been using an electronic medical record system, Nightingale on Demand (NOD) since February 2013.

We have been able to generate specific searches for identified issues in NOD. We have identified 7 clients who meet the South West York Region eligibility criteria for referral; our highest service users at the centre; and to track supply/demand data for timely access to primary care and scheduling adjustments. As per this 2014-2015 QIP, we will run data queries in NOD to establish a base line and monitor Registered Practical Nurse (RPN) encounters for ordered or delegated procedures on a quarterly basis.

One dedicated staff has been assigned the task of updating and monitoring Third Next Available Appointment (TNA) and posting same on the VCHC dashboard. This dashboard is used to track a number of variables including unused appointment, panel size, etc. This information is used to guide decision-making about improvement initiatives.

In the near future, it is hoped that NOD will have the capability of linking to the Mackenzie Health Hospital Report Manager which will enable real time, relevant client health information so we can follow-up to ensure follow-up within 7 days of discharge.

Engagement of Clinical Staff & Broader Leadership

Over the past 4 years, VCHC has established and supported a Quality Improvement Committee. This Committee consists of representatives from all teams across the Centre e.g.

Primary Health Care Team, Diabetes Team, Health Promotion Team, Medical Secretary Team and Management Team. In addition, a client has been invited and actively engaged in the development and monitoring of the QIP. Two co-chairs have been established with a Nurse Practitioner taking the clinical lead role and the Programs and Services Director sharing the leadership.

Intensive meetings were established during the development of the 2014-2015 QIP and quarterly meetings have been scheduled to monitor progress of the QIP.

Over the past four years, various staff outside the QI Committee has been involved in testing change ideas via PDSA cycles. The Medical Secretary Team has been involved in monitoring supply and demand for the MDs/NPs and tracking TNA. The RPN has made small tests of change to increase her scope of practice such as doing follow-up calls for normal lab results and therefore, eliminating the need for a face to face visit with providers and assisting NPs in well child/new baby visits. The MDs/NPs have trialled 15 minute episodic appointments. One MD has piloted her routine visit appointment length to be reduced from 30 minutes to 20 minutes. One NP and the RPN have trialled group medical visits for smoking cessation clients.

These opportunities have allowed for team learning and skill development with a positive influence on practice change. Moreover, quality improvement is a standing item on the weekly Primary Health Care Team's meeting agendas.

Accountability Management

Continuous quality improvement is a key strategic direction for VCHC. The VCHC Board has a standing Quality and Risk Management Committee that approves and monitors VCHC's annual QIPs. The Quality and Risk Management Committee of the VCHC Board of Directors, has been very supportive of the Centre's quality improvement initiatives. The Committee has been monitoring the QIP and expects regular updates on progress achieved. These updates are reported to the Board of Directors by the Committee chair.

Operationally, VCHC Management has demonstrated a strong commitment and a vigorous leadership to the successful implementation of quality improvement initiatives. Financial and staff resources have been allocated to foster successful learning opportunities and major changes have been achieved to enhance timely access to primary care services for clients. The QIP is posted on the Centre's website for view by the public.

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

Tony Carella, Board Chair

Joanne Anderson, Clinician Lead

Isabel Araya, Executive Director / Administrative Lead :

Instructions: Enter the person's name. Once the QIP is complete, please export the QIP from Navigator, and have each participant sign on the line. Organizations are not required to submit the signed QIP to HQO. Upon submission of the QIP, organizations will be asked to confirm that they have signed their QIP.

VCHC - Quality Improvement Plan for 2014-2015.

Aim		Measure							Strategy				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performa	Target	Target justification	Planned improvement initiatives (Change Methods		Process measures	Goal for change ideas	Comments
Access	Access to primary care when needed	Percent of patients/clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	% / PC organization population (surveyed sample)	In-house survey / TBD	91505*	45.6	45.6	We would like to continue to monitor the Third Next Available Appointment (TNA) to ensure client access to medical care. Currently our TNA of 0-3 days is 71% which we will work towards maintaining. As such, the goal of 45.60% for measuring same or next day access is realistic. 45.60% is the percentage of clients surveyed that responded positively to the survey question -- 45.60% of clients surveyed stated that they are able to see a MD/NP on the same day or next day, when needed.We are presently measuring TNA weekly by an assigned staff person. This information is shared weekly with the Primary Care Team and is posted on the dashboard with comments explaining variances. We feel that measuring same or next day access is in contradiction to evidence that supports TNA as 0-3 days as target time frame for client access to care. The qualitative data from the client survey measures only same or next day access. This measure is too narrow in contrast to quantitative data such as TNA as 0-3 days.	1)Want to sustain and continue to have RPN working to full scope of practice.	1. RPN will provide normal lab result feedback to clients when requested by clients. 2. RPN will perform medical procedures within scope of practice or upon medical order, ie. suture removal, dressing changes, immunization. 3. RPN assisting in facilitation of group medical visits, ie. smoking cessation.	1. RPN will track number of clients calling in for result feedback on quarterly basis. 2. Track number of RPN encounters for ordered/delegated medical procedures on quarterly basis. 3. RPN to assist with implementation of group medical appointments as determined by lead facilitator.	No baseline data available at this time. Baseline could be established after first quarter. 1. RPN will document encounters with clients for result feedback. Encounter reports will be requested from EMR NOD system by DMC for result visits on quarterly basis. 2. Track RPN encounters in EMR NOD system. Request DMC to prepare encounter report quarterly for RPN encounters for specified medical procedures. 3. Every 3 months, facilitate group medical visit (smoking cessation). Explore expanding type of group medical visits.	
									2)To sustain increased access to medical appointments by exploring the feasibility of decreasing length of appointment.	1. Add in 15 minute episodic visits for identified specific client conditions. 2. Trial of 20 minute regular appointments by MD to enhance number of appointments per week. 3. Providers will contact clients by telephone for investigation results to reduce need for face to face encounters.	1. Track the number of 15 minute appointments scheduled per week. 2. Determine the number of appointments above baseline of "56" per week. 3. 30 minutes of time blocked off for telephone result follow up per day per provider.	1. At least 2, 15 minute visits are booked appropriately per week. 2. Stretch goal: 18, 20 minute extra appointments per week for one provider (MD) 3. MD/NPs able to contact at least 2 clients during each 30 minute telephone call time per day.	1. Need for 15 minute episodic visits are dependent upon seasonal demand ie. flu season, school immunization programs. 2. It is likely that extra 20 minute appointments will be extended into a longer appointment on occasion ie. complex senior client and for physical exams. It may be challenging to sustain 20 minutes appointments on a longer term basis.
									3)To continue to explore options for and expand group medical visits	1. Enhance recruitment from primary providers for smoking cessation group medical visit. 2. Facilitate monthly smoking cessation group medical visits with a minimum of 3 clients. 3. Consult with external providers already working in group medical visit framework to explore offering urgent drop in group visits. 4. Within primary care team, explore process required for group visits for physicals.	1. Number of clients referred for smoking cessation. 2. Number of clients attending smoking cessation group visits on monthly basis. 3. PDSA for drop in urgent group visit trial. 4. PDSA for group physical visits for females/age 50-65 years of age.	1. Minimum referral of 10 prior to starting group smoking cessation group visits. 2. 3 clients per group in attendance to make it more efficient than individual appointments. 3. Trial (PDSA) of weekly drop in urgent group visit x 2 month (8 times)to determine if cost effective. 4. 4 female participants during a one hour group visit. 30 minutes with group for preventive care education and then 30 minutes with provider for examination.	Will need clinical team and client "buy in" for group physical exams to proceed. Group physical visits will require extensive scheduling organization for 4 providers.
									4)Add one open-ended question to client survey providing opportunity for feedback on how access to medical appointments has impacted on their medical care.	1. Add this question to the access section of the client survey for clients seeing MDs and/or NPs. Will request client contact information to allow further follow-up to explore feedback and client suggestions for improvement (e.g. interview) 2. Survey 10 random clients per month.	1. Number of surveys that have written feedback in the open-ended question. 2. Number of clients actually contacted for follow-up. 3. Possible strategies to enhance access to client care.	1. 1 respondent will have written feedback per month 2. 1 respondent will be contacted per month 3. Client feedback will be considered to improve access	This is giving us an opportunity to learn from clients who may additional comments about access.
Integrated	Timely access to primary care appointments post-discharge through coordination with hospital(s).	Percent of patients/clients who saw their primary care provider within 7 days after discharge from hospital for selected conditions (based on CMGs).	% / PC org population discharged from hospital	Ministry of Health Portal / TBD	91505*		100	We have identified 7 clients that meet criteria for Health Link. Our improvement focus for 2014-2015 will be on the process for following up with these 7 clients. It is anticipated that hospital notification to primary care provider of client admission to hospital will be established in the near future with implementation of Health Link strategies and Hospital Report Manager. This will ensure that primary providers are alerted to their client's discharge status and enable access to the client's hospital records. Access to hospital record by primary care is being developed but at this time is not yet functioning. Once notification has been received from acute care setting, the VCHC will be able to contact clients and schedule an appointment within 7 days of discharge.	1)Continue to participate on Health Link governance and operations subcommittees to ensure VCHC is actively engaged in establishing efficient processes for referral to primary care post discharge.	1. Attend Health Link subcommittee meetings as called to provide primary care perspective and enhance ease of referral process post discharge and advocate for prompt implementation of the Hospital Report Manager. 2. Develop internal procedures and processes (who, when, how) for discharge reporting from acute care setting for clients with selected conditions. 3.RPN and medical secretaries will ensure that an appointment is made available for clients with selected conditions within discharge timeframe.	Success in this measure will be dependent upon the implementation of the Health Link referral service and the Hospital Report Manager. 2. Written procedures/process mapping developed for Health Link referrals. 3. Number of contacts made by Health Link and Hospital Report Manager to VCHC RPN to advise of client discharge. Number of clients with selected conditions able to be seen within 7 days of discharge.	Upon notification from Health Link and Hospital Report Manager, 100% of clients with selected conditions will be seen within 7 days of discharge from hospital.	Success of this dimension will be dependent upon HealthLink infrastructure and acute care setting access to medical records by primary care.
									2)Client and caregiver education regarding the importance of primary care visit within 7 days post discharge from hospital.	1. Inform new clients with selected conditions at intake and on Client Service Agreement about follow up with primary care within 7 days of discharge from hospital. 2. Primary care providers will inform clients with selected conditions that it is advised that they book a follow up appointment with provider within 7 days of hospital discharge. 3. Create client communication products (magnet, brochure, poster) to be posted within VCHC to inform clients of need to book follow up appointment after hospital discharge.	1. Client Service Agreement for new clients will be modified to include information about post hospital follow up recommendations. 2. List of clients with selected conditions will be generated from the EMR NOD and provided to their primary care providers who will inform them of the follow up process. Develop data collection process for providers to track the number of clients informed of this follow up process (may be HealthLink registration form). 3. Magnets, posters and brochures produced in several languages and distributed to relevant clients and posted in clinical area.	1. 100% of new clients with selected medical conditions will be informed at intake of follow up process and Client Service Agreement signed. 2. 100% of clients with selected conditions will be included on primary care provider list for follow up. 100% of clients who meet the SWFR eligibility criteria will be referred to the local Health Link by primary providers. 3. 100% of VCHC clients that register for Health Link will be provided with communication products regarding follow up process.	Access to all clients with selected conditions may be limited by barriers to accessing clinical setting ie. homebound, transfer to facility out of district.

Patient-centred	Receiving and utilizing feedback regarding patient/client experience with the primary health care organization.	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) give them an opportunity to ask questions about recommended treatment?	% / PC organization population (surveyed sample)	In-house survey / 2014/2015	91505*	85.8	86	As we are striving to maintain our TNA 0-3 days, it may be challenging to have a higher percentage of satisfaction from our clients.	1)Utilize interpretation services to ensure that clients have the opportunity to ask questions about their recommended treatment in their own language	1. Provider to notify medical secretary when interpretation services are needed via telephone or in person. 2. Medical secretary responsible for interpretation services will garner verbal feedback from clients and service providers about experience with interpreter.	1. Track number of requests for interpretation. 2. Track feedback from clients and service providers re quality of service; modify list of interpreters based on feedback to ensure excellent service.	1. 100% of client and/or service provider requests for interpretation services will be met within timeframe required, i.e. telephone access during clinic visit. 2. 50% of client face to face feedback received re interpreter services. 80% of service provider feedback received.	The target percentage identified will be within a corridor of +/- 10% (e.g. 76-96%).
		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?	% / PC organization population (surveyed sample)	In-house survey / 2014/2015	91505*	79	75	As we are striving to maintain our TNA 0-3 days, it may be challenging to have a higher percentage of satisfaction from our clients.	1)Continue to survey a random selection of clients about this dimension on a monthly basis.	1. Survey 10 random clients per month. On quarterly basis, summary findings of survey will be reported to Quality Improvement Committee for monitoring purposes and identification of future improvement strategies.	1. The number of surveys completed by clients on a quarterly basis. Track percentage of client feedback whether they feel that they are always/often involved in decisions about their care and treatment.	50% of clients requested to complete survey will respond. 79% of clients will indicate they are always/often involved in the decision making about their own care/treatment.	The target percentage identified will be within a corridor of +/- 10% (e.g. 65-89%).
		Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) spend enough time with them?	% / PC organization population (surveyed sample)	In-house survey / 2014/2015	91505*	89	89	As we are striving to maintain our TNA 0-3 days, it may be challenging to have a higher percentage of satisfaction from our clients.	1)To continue to monitor Cycle Time and Red Zone to ensure that providers spend enough time with clients during their visit.	1. Annual cycle time data collection with all primary care providers. 2. Calculation of red zone time will be then be derived and shared with providers to ensure meeting HQO targets.	1. Cycle time forms will be distributed by medical secretaries for one week per year per provider. 2. Red zone calculations will be derived by medical secretaries upon collation of cycle time data and shared with primary care providers.	1. Cycle time less than 60 minutes per visit. 2. Red zone time more than 50% per visit. (HQO targets)	The target percentage identified will be within a corridor of +/- 10% (e.g. 79-99%).

Tony Carella, Board Chair

Isabel Araya

Isabel Araya, Executive Director

Joanne Anderson

Joanne Anderson, Clinician Lead

AIM		Measure							Change				
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Patient-centred	**Receiving and utilizing feedback regarding patient/client experience with the primary health care organization.**	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) give them an opportunity to ask questions about recommended treatment?	% / PC organization population (surveyed sample)	In-house survey / 2014/2015	91505*	85.9	86	As we are striving to maintain our TNA 0-3 days, it may be challenging to have a higher percentage of satisfaction from our clients.	1)Utilize interpretation services to ensure that clients have the opportunity to ask questions about their recommended treatment in their own language.	1. Provider to notify medical secretary when interpretation services are needed via telephone or in person. 2. Medical secretary responsible for interpretation services will garner verbal feedback from clients and service providers about experience with interpreter.	1. Track number of requests for interpretation. 2. Track feedback from clients and service providers re quality of service; modify list of interpreters based on feedback to ensure excellent service.	1. 100% of client and/or service provider requests for interpretation services will be met within timeframe required, i.e. telephone access during clinic visit. 2. 50% of client face to face feedback received re interpreter services. 80% of service provider feedback received.	The target percentage identified will be within a corridor of +/- 10% (e.g. 76-96%).
		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?	% / PC organization population (surveyed sample)	In-house survey / 2014/2015	91505*	79	79	As we are striving to maintain our TNA 0-3 days, it may be challenging to have a higher percentage of satisfaction from our clients.	1)Continue to survey a random selection of clients about this dimension on a monthly basis.	1. Survey 10 random clients per month. On quarterly basis, summary findings of survey will be reported to Quality Improvement Committee for monitoring purposes and identification of future improvement strategies.	1. The number of surveys completed by clients on a quarterly basis. Track percentage of client feedback whether they feel that they are always/often involved in decisions about their care and treatment.	80% of clients requested to complete survey will respond. 79% of clients will indicate they are always/often involved in the decision making about their own care/treatment.	The target percentage identified will be within a corridor of +/- 10% (e.g. 69-89%).
		Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) spend enough time with them?	% / PC organization population (surveyed sample)	In-house survey / 2014/2015	91505*	89	89	As we are striving to maintain our TNA 0-3 days, it may be challenging to have a higher percentage of satisfaction from our clients.	1)To continue to monitor Cycle Time and Red Zone to ensure that providers spend enough time with clients during their visit.	1. Annual cycle time data collection with all primary care providers. 2. Calculation of red zone time will be then be derived and shared with providers to ensure meeting HQO targets.	1. Cycle time forms will be distributed by medical secretaires for one week per year per provider. 2. Red zone calculations will be derived by medical secretaries upon collation of cycle time data and shared with primary care providers.	1. Cycle time less than 60 minutes per visit. 2. Red zone time more than 50% per visit. (HQO targets)	The target percentage identified will be within a corridor of +/- 10% (e.g. 79-99%).