Let's Make Healthy Change Happen.

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

VCHC
Vaughan Community Health Centre

3/24/2016

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

Over the past six years, Vaughan Community Health Centre (VCHC) has dedicated significant staff and management time to establish 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 continue to make great strides in improving access to care and the client experience.

The Vaughan CHC's 2016-2017 QIP is aligned with VCHC's vision for client-centred care 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.

Since VCHC's inception in February 2009, VCHC has served at least 15,000 clients in primary care services and social programs and community capacity initiatives that focus on health promotion and education. Primary care services include chiropody, physiotherapy, counselling, nutritional services, COPD and diabetes education and management. The client experience survey focuses on feedback regarding access to primary care services and social programming. In addition, clients are asked to evaluate our social programs. Thus, VCHC's focus on quality improvement has been implemented across the Centre.

QI Achievements From the Past Year

The QI achievements from the past year are the following:

-We have started and will continue to educate our clients on the importance of calling into the Centre to schedule an appointment as soon as they have been discharged from the hospital. This has helped us to reach the 86%, however, please keep in mind that this percentage is based on the number of clients that do call us to inform us of their discharge. We hope that the Hospital Report Manager (HRM) will be functional soon so that we can receive hospital discharge notifications for all our clients.

-As of March 2015, VCHC has signed up for access to the HRM. In July 2015 the primary care providers and medical secretary team were trained to use the HRM system. Once the HRM is operational, the VCHC will strive to ensure that clients discharged from hospital will be seen within 7 days of hospital discharge.

-The Registered Practical Nurse (RPN) completed female pelvic exam course and will start to see clients this year. In the previous year, the RPN is did not receive calls from clients asking about their lab results; our clients have learned that 'no news is good news'. The RPN is now calling clients only when she receives the order from the MD/NP to follow-up with clients for instructions on next steps in their care.

-We are continuing to do well on providing timely access to primary care services. Feedback from the client experience surveys is positive, overall. We had made 2 improvements based on clients' feedback: 1) we have rearranged the space in the secondary wait area and increased the number of chairs available for seating; and

2) we have added in information about the light exercise program in the monthly program calendar to indicate that the program is accessible for clients in wheelchairs; our community health worker also promotes this message to clients calling in to inquire about the program.

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 continue to 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 was originally identified as a key stakeholder in providing referrals to South West York Region Health Link (SWYRHL) and accepting new clients with high needs referred by SWYRHL. We did identify a number of clients for this service and referred several for case coordination. VCHC has also received and accepted several referrals from the SWYRHL. However, with the participation on the SWYRHL working committees, it has become apparent that SWYRHL enrollment via VCHC primary care does not meet SWYRHL intake targets. As such, the SWYRHL intake focus has shifted to hospital identification of high need clients for SWYRHL referral. The SWYRHL has been restructured and now has 2 committees: Steering Committee and the Community Circle; both committees are attended by the VCHC staff. The VCHC representation on SWYRHL committees has become more of an advisory capacity rather than facilitating coordination of referrals.

Engagement of Leadership, Clinicians and Staff

Over the past 6 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, Chronic Disease Team, Health Promotion Team, Medical Secretary Team and Management Team. In addition, one client had been actively engaged in the development and monitoring of the QIP since 2014. We have recently extended our invitation to another client to participate in the Quality Improvement Committee. One of our physicians is taking the clinical lead role and the Director, Programs and Services is coordinating and leading the quality improvement initiatives across the Centre.

Intensive meetings were established during the development of the 2016-2017 QIP and quarterly meetings have been scheduled to monitor progress of the 2016-2017 QIP.

Participation on the QI Committee has allowed for primary care team learning and skill development with a positive influence on practice change. The results of the client experience survey are reviewed by the Quality Improvement Committee on a quarterly basis and those results and ideas for improvement are shared and discussed with the primary care team. For the 2016-2017 QIP, the VCHC will strive to share the results of the client experience survey and the improvements made with our clients on a quarterly basis.

Patient/Resident/Client Engagement

VCHC clients are actively engaged in quality improvement initiatives at VCHC, via the following:

- Monthly client survey information is requested focusing on timely access to primary care and clients' satisfaction in receiving primary care services and in attending health promotion programs. Summary feedback is reviewed quarterly by the

QI committee and improvements to current practice are made where feasible and appropriate.

- As mentioned above, 2 clients are now actively engaged in the development and monitoring of the QIP. The clients attend on site quarterly Quality Improvement Committee meetings and their feedback is utilized to identify possible QI initiatives or improvements to current practice.

-Clients' evaluations of social programs are reviewed and discussed by the Health Promotion Team at planning meetings twice per year and efforts are made to integrate the clients' feedback into future or existing programs.

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 : David Rubin
Quality Committee Chair or delegate : LoAn Ta-Young LoAn Ta-Young.
Executive Director / Administrative Lead: Isabel Araya
CEO/Executive Director/Admin. Lead _____ (signature)

2016/17 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

Vaughan Community Health Centre Corporation 206-9401 Jane Street, Vaughan, ON L6A 4H7

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	Improve rate of cancer screening.	Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years	% / PC organization population eligible for screening	See Tech Specs / Annually	91505*	71	78.00	Effective April 1, 2016, the panel size for the MDs/NPs have increased substantially and so, the team will work toward meeting the CLHIN target of 78% with the larger panel size.	1)Identify the clients that are due/overdue for FOBT screening and educate clients about the importance of the FOBT recall appointment and RPN's role in this	1. MD/NP use the recall list to identify clients due/overdue for FOBT screening and send an order to RPN 2. MD/NP to educate clients on benefits of having the test and RPN's role in FOBT screening 3. Medical Secretary Team to book the appointment for due/overdue clients based on recall list as identified by MD/NP	1. Track the # of FOBT kits supplied to clients by the RPN 2. Track # of education sessions completed by MD/NP 3. Track # of times Medical Secretary Team called clients for FOBT screening	1. At least 30% of clients on recall list will be contacted and supplied the FOBT kit per quarter 2. One education session per quarter or as needed 3.Medical Secretary Team to call the client once to book the appointment.	VCHC is observing that for some clients the Medical Secretary Team have to call them at least 3 times to book an appointment for FOBT. Some clients either do not want to book the appointment or they do not show up for the appointment. To improve in this area, VCHC would like to educate clients about the importance of the FOBT test and cancer screening, in general. It is believed that once clients are made aware of the importance of screening, they will likely book the appointment and come in for the test. This will also reduce the time required from our Medical Secretary Team in booking these appointments. The RPN will also be providing the FOBT kits and instruction to the clients.
		Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years	% / PC organization population eligible for screening	See Tech Specs / Annually	91505*	84	86.00	Effective April 1, 2016, the panel size for the MDs/NPs have increased substantially and so, the team will work toward meeting the CLHIN target of 86% with the larger panel size.	1)Identify the clients that are due/overdue for PAP screening and educate clients about the importance of the PAP recall appointment and RPN's role in this	1. MD/NP use the recall list to identify clients due/overdue for PAP test and send an order to RPN 2. MD/NP to educate clients on benefits of having the test and RPN's role in PAP testing 3. Medical Secretary Team to book the appointment for due/overdue clients based on recall list as identified by MD/NP	1. Track the # of PAP tests completed by the RPN 2. Track # of education sessions completed by MD/NP 3. Track # of times Medical Secretary Team called clients for PAP testing	1. At least 30% of clients on recall list will be contacted and the PAP test is completed per quarter 2. One education session per quarter or as needed 3.Medical Secretary Team to call the client once to book the appointment.	RPN is certified and has completed the PAP exam course.
	Improve rate of HbA1C testing for diabetics	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months	% / All patients with diabetes	Ontario Diabetes Database, OHIP / Annually	91505*	CB	CB	Currently, VCHC is not able to accurately pull the statistics from EMR system (NOD) for number of HbA1c test results received as the LOINC process for linking labs is not working. This process is currently under development by the AOHC with NOD. We will aim to provide this test to at least 50% of diabetes clients aged 40 years or over.	1)Identify clients with diabetes aged 40 or over that have not received HbA1c test results within the past 12 months	1. MD/NP to continue to order HbA1c test for diabetes clients 40 years or over. Once the LOINC is operational, and if VCHC's current performance in providing at least 2 or more HbA1c tests to diabetes clients is below 50%, then the MD/NP will review the recall list of clients who do not have HbA1c test results. 2. MD/NP to order tests for those clients with no test results	Track the # of clients with at least 2 or more HbA1c tests results received	If VCHC's performance is below 50%, then for each quarter, MDs/NPs will order the HbA1c test for at least 30% of clients on recall list who do not have the test completed	The success in receiving accurate data on the HbA1c test results received will be dependent on LOINC being functional in NOD. Once LOINC is functional, VCHC's current performance percentage will be identified NOTE: HbA1c tests may also be ordered by specialists other than VCHC MDs/NPs and therefore, MDs/NPs may have to review OLIS (Ontario Lab Information System) also.
Patient Experience	Improve Patient Experience: Opportunity to ask questions	Percent of respondents who responded positively to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office give you an opportunity to ask questions about recommended treatment?"	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91505*	91.44	92.00	Effective April 1, 2016, the panel size for the MDs/NPs have increased substantially and so, the team will work toward maintaining the current target within the larger panel size. This target may be challenging to achieve within the larger panel size.	1)Continue to survey randomly selected clients on a monthly basis and share the results with clients to encourage and further engage the clients to provide feedback. Ask a student to facilitate the survey via ipad-one at each reception area	Survey 15 random clients per month and 7 out of 15, to be completed electronically. On quarterly basis, summary findings of survey will be reported to clients and QI committee for monitoring and identification of future improvement strategies.	Track the number of surveys completed by clients on a quarterly basis (hard vs electronic copies). Track percentage of client feedback whether they feel that they are always/often given the opportunity to ask questions about recommended treatment.	90% of clients will indicate they are always/often given the opportunity to ask questions about recommended treatment	The target percentage identified will be within a corridor of +/- 10% (e.g. 80-100%).
	Improve Patient Experience: Patient involvement in decisions about care	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 / April 2015 - March 2016	91505*	88.52	90.00	Effective April 1, 2016, the panel size for the MDs/NPs have increased substantially and so, the team will work toward maintaining the current target within the larger panel size. This target may be challenging to achieve within the larger panel size.	1)Continue to survey randomly selected clients on a monthly basis and share the results with clients to encourage and further engage the clients to provide feedback. Ask a student to facilitate the survey via ipad-one at each reception area	Survey 15 random clients per month and 7 out of 15, to be completed electronically. On quarterly basis, summary findings of survey will be reported to clients and QI committee for monitoring and identification of future improvement strategies.	Track the number of surveys completed by clients on a quarterly basis (hard vs electronic copies). Track percentage of client feedback whether they feel that they are always/often involved in decisions about their care and treatment.	90% 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. 80-100%).
	Improve Patient Experience: Primary care providers spending enough time with patients	Percent of patients who responded positively to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office spend enough time with you?"	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91505*	89.13	90.00	Effective April 1, 2016, the panel size for the MDs/NPs have increased substantially and so, the team will work toward maintaining the current target within the larger panel size. This target may be challenging to achieve within the larger panel size.	1)Continue to survey randomly selected clients on a monthly basis and share the results with clients to encourage and further engage the clients to provide feedback. Ask a student to facilitate the survey via ipad-one at each reception area 2.To continue to monitor Cycle Time and Red Zone to ensure that providers spend enough time with clients during their visit.	1.Survey 15 random clients per month and 7 out of 15, to be completed electronically. On quarterly basis, summary findings of survey will be reported to clients and QI committee for monitoring and identification of future improvement strategies. 2.1. Annual cycle time data collection with all primary care providers. 2.2 Calculation of red zone time will be then be derived and shared with providers to ensure meeting HQO targets.	1.Track the number of surveys completed by clients on a quarterly basis (hard vs electronic copies). Track percentage of client feedback indicating the MD/NP always or often spend enough time with them during their visit. 2.1. Cycle time forms will be distributed by medical secretaries for one week per year per provider. 2.2 Red zone calculations will be derived by medical secretaries upon collation of cycle time data and shared with primary care providers.	1.90% of clients will indicate that the MD/NP always/often spends enough time with them during their visit. 2.1. Cycle time less than 60 minutes per visit. 2.2. Red zone time more than 50% per visit. (HQO targets)	The target percentage identified will be within a corridor of +/- 10% (e.g. 80-100%).
Timely	Improve 7 day post hospital discharge follow-up rate for selected conditions	Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions.	% / PC org population discharged from hospital	DAD, CIHI / April 2014 – March 2015	91505*	86	85.00	Currently, VCHC is not receiving discharge notifications from the Hospital Report Manager. However, we will aim to achieve 85% as in previous year. The target percentage corresponds to the number of clients who informed VCHC post discharge from a hospital and VCHC is able to see the clients within the 7-day post discharge. Our current performance of 86% is based on 14 clients who informed VCHC of their discharge and VCHC was able to see 12 of those clients within the 7-day post discharge from the hospital.	1)When it is fully functional, utilize Hospital Report Manager (HRM) to facilitate notification of client admission and discharge from hospital to ensure 7 day follow up with primary care provider after discharge. 2.To continue to educate the clients and caregivers regarding the importance of being seen by their primary care provider within 7 day post discharge from a hospital	1. IT infrastructure in place to implement HRM. 2. Develop internal procedures and processes (who, when, how) for booking follow up appointment for client within 7 days post discharge. 2.1. A combined information session on the 7-day discharge notification and the cancer screening will be provided by the MD/NP to clients 2.2 Ask for clients' feedback on their understanding of the information 2.3. phone calls from clients infoming VCHC of their discharge from the hospital	1. Continue to track in the EMR system the number of clients seen by our MDs/NPs within the 7-day post discharge from the hospital 2.1. Track the number of clients attending the information session 2.2 Track percentage of clients reporting a better understanding of the importance of being seen by their MD/NP post-discharge and cancer screening appointments 2.3. Med Sec Team to track the number of clients with selected conditions calling in to inform VCHC of their discharge from the hospital	1.Work towards meeting the target of 85% 2.1. one information session per quarter or as needed with an attendance of at least 15 clients 2.2 Aim for 80% of clients reporting having a better understanding 2.3. collect baseline	1. VCHC's success in being able to provide primary care to clients within the 7-day post discharge is dependent on clients informing VCHC of their discharge from the hospital. The target percentage identified will be within a corridor of +/- 10% (e.g. 75-95%). 2.Access to all clients with selected conditions may be limited by barriers to accessing VCHC clinical setting ie. homebound, transfer to facility or family member out of our district.
	Improve timely access to primary care when needed	Percent of patients/clients who responded positively to the question: "The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone else in their office?"	% / PC organization population (surveyed sample)	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period available)	91505*	48.59	49.00	As per the Measuring UP 2014 Primary Care Report, currently 48.1% of those surveyed in the Central LHIN reported that they are able to see their primary care provider the same or next day when they were sick. We would like to maintain the target of 49% which is in alignment with the Central LHIN data. This target will be challenging to achieve as we expand our panel size. Our goal is to sustain timely access to primary care when needed. To achieve this access, we would like to continue to monitor the Third Next Available Appointment (TNA) of 0-3 days to ensure access to medical care. We would like to maintain our TNA target of 71%. We feel that measuring the same or next day access is in contradiction to evidence that supports TNA as 0-3 days as target timeframe for client access to care.	1)Registered Practical Nurse (RPN) to continue to work within scope of practice. 2)Sustain increased access to medical appointments by continuing to decrease the length of appointment, where appropriate and feasible..	1. As per instruction from the MD/NP, RPN to call clients back re: routine lab results and provide instructions for next steps 2. RPN to perform medical procedures within scope of practice or upon medical order, ie. suture removal, dressing changes, immunization. etc; 3. RPN to perform female pelvic exam upon medical order 2.1. Continue to schedule 15 minute episodic visits for identified specific client conditions. 2.2 Continue with one MD scheduled with 20 minute regular appointments to enhance number of appointments per week. 2.3. Providers will continue with telephone contact for issues requiring follow up (abnormal results, prescription renewals, client requests for health advice or health education, etc) to reduce need for face to face encounters.	1. Track the number of tasks received from MDs and NPs for RPN to call clients back re: routine lab results and instructions for next steps. The aim is for the higher the number of tasks received, the less time spent by MDs and NPs in contacting the clients. 2. Track number of RPN encounters for ordered/delegated medical procedures on quarterly basis 3. Track the number of low risk pelvic examinations completed (normal history, preventative screenings) by the RPN 2.1. Continue to track the number of 15 minute appointments scheduled per week per provider. 2.2 Determine the number of appointments above baseline of "56" per week for the one MD. 2.3. 30 minutes of time blocked off for telephone follow up per day per provider.	1. At least 20 tasks received from MDs/NPs for RPN to contact clients per quarter. 1.2. RPN will have at least 500 medical procedure encounters per quarter. 1.3. Pap test to be completed by RPN for at least 30% of clients identified by MD/NP on the Pap recall list per quarter 2.1. At least 3, 15 minute visits are booked appropriately per week per provider. 2.2 Sustain the 18, 20 minute extra appointments per week for one provider (MD) 3. MD/NPs are each able to contact at least 96 (2 calls x 4 days x 4 weeks x 3 months) clients by telephone during each quarter (30 minute telephone call time per day) to reduce the number of face to face encounters.	1.The logistical mapping of the RPN performing the female pelvic exam will be dependent upon exam room availability and client receptivity. 2.The success of telephone call time is greatly dependent upon the provider's ability to contact the client and whether the client is able to speak to the provider.