Let's Make Healthy Change Happen.

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

VAUGHAN COMMUNITY HEALTH CENTRE

3/30/2017

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

The Vaughan Community Health Centre (VCHC) continues to dedicate significant staff and management time to focus on the quality improvement program. In addition, our Quality Improvement (QI) Committee now includes two client representatives who actively provide feedback into the planning, implementation and monitoring of the Quality Improvement Plan (QIP). The QI Committee ensures that client feedback from the client experience survey is reviewed and improvements are made, where appropriate and feasible.

The Vaughan CHC's 2017-2018 QIP is aligned with the VCHC's vision for client-centred care and the quality improvement initiatives are guided by the VCHC's key strategic direction of ensuring continuous quality improvement through investing in evidence-informed decision-making and enhancing opportunities for inter-professional practices. For the 2017-2018 QIP, we continue to focus on having the Registered Practical Nurse (RPN) work at full scope of practice and provide shared care to our clients, in collaboration with the Physicians and Nurse Practitioners. The RPN's full support will enable our team to continue to improve on providing timely access to primary care services for our clients. We will continue to ask for clients' feedback on services received and will be exploring strategies to increase clients' uptake of the electronic survey. The VCHC will also be focus on increasing the performance of the Physicians and Nurse Practitioners in providing primary care services to clients within 7-days of their hospital discharge. We will continue to educate clients and their caregivers on the importance of informing the Centre about their hospital discharge as soon as they are home from the hospital. We will track the reasons for clients not being able to see their Physician or Nurse Practitioner within 7 days post-hospital discharge and we will aim to address those barriers.

QI Achievements From the Past Year

The Registered Practical Nurse (RPN) left the Centre in July 2016 and it had been quite challenging to replace the position. The quality improvement activities for the RPN were put on hold until January 2017 when we hired the new RPN. The absence of the RPN validated for us the importance of the RPN role in providing valuable support to the Physicians (MDs) and Nurse Practitioners (NPs)in primary care services.

Although it was challenging to not have the support of the RPN, the MDs and NPs continued to be client-centred and provide quality primary care services to clients in a timely manner. Results of the client experience survey indicated that our clients felt they were involved in decisions about their care and treatment, had an opportunity to ask questions, and that their providers spent enough time with them during their visits. In addition, we listened to our clients' feedback and made improvements, where feasible, such as making the chiropody services more accessible to our clients for follow-up appointments.

Population Health

The Vaughan CHC serves vulnerable clients who experience barriers in accessing primary health care services. In addition to serving seniors, youth and clients experiencing mental health and addiction issues, we make it our priority to serve clients who are non-insured (e.g. do not have access to the Ontario Health Insurance Plan). We have advocated with local hospitals to provide access to specialists for our non-insured clients at rates comparable to OHIP. To date, we have service agreements with 4 hospitals. We also work with various local

specialists, midwives and lab and diagnostic imaging centers to ensure that our non-insured clients receive the care they need.

Equity

At the Vaughan CHC, we deliver primary health care services and social programs through an equity lens. Clients have access to language interpretation services, as needed, for their one-on-one visits with the primary health care team and in social programs. Our service agreement and client experience survey are translated into the top 5 main languages spoken by our clients. We provide education and resource information in various languages, where feasible. Bus tickets are provided to clients at a discounted cost to help them get to appointments and programs at the Centre.

We have incorporated an equity lens into our quality improvement initiatives through cultural competency training for our staff. Specifically, the Physicians, Nurse Practitioners and Allied Health Professionals have received training to enhance their knowledge base and skills in providing primary health care services to clients living with HIV-AIDs. The Community Health Workers are receiving training on how to reach out and deliver programs to the LGBTQ community and clients living with HIV-AIDS. The Diabetes Education Team is reaching out to northern Indigenous communities to deliver diabetes education and management services via OTN. They are currently completing webinars on Indigenous Cultural Safety Training.

Integration and Continuity of Care

The Vaughan CHC collaborates with various community partners to ensure access to continuous primary health care services for our clients. We work with local hospitals and specialists to provide access to specialty care for our non-insured clients. We have partnered with the Aids Committee of York Region to provide primary health care services to clients living with HIV-AIDS. The Arthritis Society delivers onsite arthritis education and management to our clients and community members. The group exercise programs delivered by Circle of Care and the Bernard Betel Centre keeps the seniors in our community active and healthy. In addition, the Vaughan CHC has reached out to diverse community leaders and organizations to establish an oral health coalition. The goal of the coalition is to advocate for access to affordable oral health care services for low-income adults.

Access to the Right Level of Care - Addressing ALC Issues

The Vaughan CHC is a community partner in the South West York Region Health Link. We have accepted and will continue to accept new client referrals from the SWYR Health Link. Specifically, our Physicians have provided primary care services to clients in the Home First program who are referred to us by the Central Community Care Access Centre.

Engagement of Clinicians, Leadership & Staff

The Vaughan CHC continues to have an active Quality Improvement Committee comprised of staff representatives from teams across the Centre e.g. Primary Health Care Team, Chronic Disease Prevention and Management Team, Health Promotion Team, Medical Secretary Team and Management Team. One of our Physicians is taking the clinical lead role and the Director of Programs and Services is coordinating and leading the quality improvement (QI) initiatives across the Centre. Staff representation on the Committee has enabled the Committee's quality improvement activities to move forward as there is buy-in from staff. There are several staff designated to collect data for QI activities.

The Quality Improvement Committee meets every 3 months to review the progress of the Quality Improvement Plan activities and results of the client experience survey. Ideas for improvement are discussed and implemented, where feasible and appropriate. The results of the client experience survey are shared with the various teams across the Centre and displayed on the bulletin board for our clients to review.

In addition, the Vaughan CHC Board of Directors have the responsibility of approving the Quality Improvement Plan and monitoring the progress of the Plan.

Resident, Patient, Client Engagement

The Vaughan CHC engages clients in quality improvement initiatives at the Centre. We have two client representatives on the Quality Improvement Committee who are actively engaged in the development and monitoring of the Quality Improvement Plan. They attend onsite quarterly Quality Improvement Committee meetings and their feedback is incorporated into the quality improvement activities or improvements to our current practice. Clients are also asked to share their feedback on primary health care services received and satisfaction with social programs via the client experience survey. In addition, clients are asked to evaluate the social programs. Their feedback is reviewed and discussed at team planning meetings and efforts are made to integrate clients' feedback into future or existing programs.

Staff Safety & Workplace Violence

The Vaughan CHC has taken the following steps to monitor, reduce and prevent workplace violence:

1) Policies on providing a harassment-free workplace, workplace accommodation and anti-discrimination have been developed and reviewed with staff.
2) Staff has received anti-harassment training focusing on the definition of workplace harassment, the roles and responsibilities of employees, supervisors and management and reporting and investigation of workplace harassment.
3) Supervisors have received specific training on how to conduct a proper investigation into a workplace harassment complaint.

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
Executive Director / Administrative Lead : Isabel Araya

2017/18 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

Vaughan CHC Corporation 206-9401 Jane Street, Vaughan, ON L6A 4H7

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Effective transitions	Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions.	% / Discharged patients with selected HIG conditions	CIHI DAD / April 2015 - March 2016	91505*	58.7	67.00	The VCHC is starting to receive hospital discharge notifications from 2 hospitals but not the main local hospital. So, the VCHC is continuing to rely on clients to inform the Centre after they have been discharged from the hospital for selected conditions.	1.Utilize the Hospital Report Manager (HRM) for timely notification of clients' hospital discharge to ensure 7-day follow-up with their primary care provider after discharge.	1.Upon receiving the hospital discharge notification via HRM or from a client's phone call, the Medical Secretary Team to schedule an appointment for the client to see his/her MD or NP within 7 days of the hospital discharge.	1.On a monthly basis, track the following: a.# of discharge notifications received and from which hospital b.# of clients informing VCHC of their hospital discharge c.Total # of clients called to offer an appointment w/n 7 days; of that total, track the # of clients who actually booked the appointment and the # of clients who refused to book an appointment and their reason for refusal d.# of clients actually seen w/n 7 days post-discharge and for which health condition e.# of clients actually seen greater than 7-days post-discharge and for which health condition	1.By April 30/17, a template for 7-day post-hospital discharge is created in the EMR to track the information (a-e); information is reviewed on a monthly basis; work towards meeting the target for each month.	1.VCHC's success in being able to provide primary care to clients within the 7-day post discharge is still partly dependent on clients informing VCHC of their discharge from the hospital.
									2.Continue to educate clients and their caregivers regarding the importance of being seen by their primary care provider within 7 days post discharge from the hospital.	2.Continue to educate clients and their caregivers via posting information on the VCHC website, bulletin boards, tv monitors in the reception areas, welcome package for new clients; and providers to inform/remind their clients of contacting the Centre as soon as they come home from the hospital.	2.Ask clients on the Client Experience Survey if they are aware of the importance of informing the Centre as soon as they are home after being discharged from the hospital, and also how they become informed of this information.	2.Ongoing messaging to clients of the importance of being seen by their primary care provider within 7 days post discharge from the hospital; ensure all new clients are informed of this. For each quarter, at least 50% of clients surveyed indicate that they are aware of having to inform the Centre about their hospital discharge.	2.Clients' ability to come in to the VCHC for an appointment within 7-days post-hospital discharge may be limited by barriers such as being homebound, having appointments booked with multiple specialists, not feeling well enough to come in for the appointment, etc.

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Patient-centred	Person experience	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 2016 - March 2017	91505*	93.13	96.00	The MDs/NPs are continuously working towards meeting their panel size which has increased. This target may be challenging to achieve within the larger panel size while still being able to provide timely access to primary care services for clients.	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.	1a. Survey at least 40 random clients per month using either hard copy or electronic version 1b. Assign one student in the morning and another in the afternoon to be in the secondary wait area to promote the use of the iPad to complete the survey and to provide support to clients as needed; put the survey on the VCHC website. 1c. Update the QI bulletin quarterly to share results with clients and encourage feedback	1a. & 1b. Track the number of surveys completed by clients on a quarterly basis (hard vs. electronic copies). 1c. Track the number of clients that state they feel they are always/often involved in decisions about their care and treatment.	1a. & 1b. At least 30-40 surveys are completed each month; at least 10-15% of those surveys are completed electronically by clients. 1c. In each quarter, work towards having 96% of clients state that they feel they are always/often involved in decisions about their care and treatment.	
Timely	Timely access to care/services	Percentage of patients and 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 / April 2016 - March 2017	91505*	51.97	52.00	As per the Measuring Up 2016 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 our target of 52% which is slightly above CLHIN's current performance. This target will be challenging to achieve as the	1.The Registered Practical Nurse (RPN) to work at full scope of practice and provide shared care to clients	1.Plan and implement PDSAs on: contact clients for test results; injections; immunizations as per school's request; review of recall lists for cancer preventative screenings (e.g. colorectal, cervical, breast cancer); phone triaging, etc.	1.Track RPN's experience in performing the PDSAs and RPN encounters for ordered/delegated medical procedures on quarterly basis.	1.Continue from Jan 2017 to until RPN is working at expanded scope of practice; collect baseline for RPN encounters per quarter.	
									2.Sustain increased access to medical appointments by continuing to decrease the length of appointment and reduce the need for a face-to-face visit, where appropriate and feasible	2.2.1 Continue to schedule 15-minute episodic visits for identified specific client conditions; 2.2 Continue to block off 30-minutes for phone calls per day per provider; providers to make telephone contact with clients for issues requiring follow-up such as abnormal test results, prescription renewals, client requests for health advice or health education, etc.	2.2.1 Continue to track the number of 15-minute episodic visits scheduled per provider per week; 2.2 Continue to track the number of clients contacted per provider per quarter	2.2.1 At least 3, 15-minute visits are booked appropriately per week per provider; 2.2 At least 96 clients are contacted via telephone per provider per quarter, to reduce the number of face-to-face visits.	

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								achieve as the MDs/NPs are continuously expanding their panel size.	3.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.	3.Survey at least 40 random clients per month using either hard copy or electronic version	3.Track the number of clients that state they are able to see their MD/NP within 0-1 day when they were sick.	3.In each quarter, work towards having 52% of the clients surveyed report that they are able to see their MD/NP within 0-1 day when they were sick.	