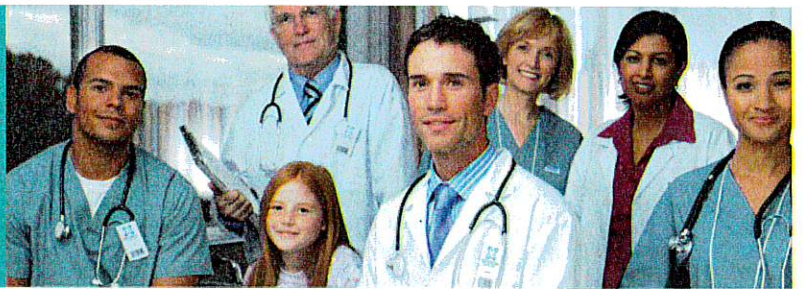


Let's Make Healthy
Change Happen.



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



3/26/2018

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.

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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 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 2018-2019 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 2018-2019 QIP, the VCHC Diabetes Education Team will focus on providing effective wound care to Diabetes clients. Specifically, the team will identify the work flow and documentation guidelines required to effectively track the percentage of clients with Type 2 Diabetes who have had a diabetic foot ulcer risk assessment. In addition, the VCHC will continue to 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. Also, the VCHC will 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.

Describe your organization's greatest QI achievements from the past year

In this past year, the VCHC have committed much clinical staff's time and resources into enhancing the clinical skills of the Registered Practical Nurse (RPN) so that she is working to her full scope of practice in supporting the Physicians and Nurse Practitioners. A small QI working group met on a regular and frequent basis to plan and implement PDSAs (Plan/Do/Study/Act cycles) on various RPN tasks such as contacting clients for test results; providing injections and immunizations; reviewing recall lists for preventative cancer screening; triaging, etc. The time commitment and dedication to the RPN-QI work have resulted in the RPN being able to save the Physicians and Nurse Practitioners a significant amount of time on some administrative and clinical tasks so that they can focus on providing direct client care. As a result, the RPN's support enabled the clinical team to meet the panel size and achieve the targets.

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.

Collaboration and Integration

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, and we have served 204 non-insured clients for this fiscal year. Recently, we have partnered with the Ontario Shores Centre for Mental Health

Sciences to deliver cognitive behavioural therapy to clients of local physicians who are living with mild to moderate anxiety and/or depression. We have partnered with the Black Creek Community Health Centre to provide access to retinal screening for people living with Type 2 Diabetes. We have started to collaborate with several dentists in York Region who have volunteered to provide pro-bono dental care services to our clients. The Arthritis Society continues to deliver onsite arthritis education and management to our clients and community members. In May 2017, we collaborated with Mackenzie Health-Richmond Hill Hospital to provide shared IT services for the VCHC.

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 has the responsibility of approving the Quality Improvement Plan and monitoring the progress of the Plan.

Population Health and Equity Considerations

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. 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.

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. The Diabetes Education Team has completed webinars on Indigenous Cultural Safety Training and is reaching out to Indigenous communities in northern Ontario to provide services via OTN. We are providing priority access to primary care services for clients living with HIV-AIDS. We continue to provide bus tickets to clients at a discounted cost to help them get to appointments and programs at the Centre. We have partnered with the Community Legal Clinic of York Region to provide free and accessible legal services to low-income VCHC clients and community residents.

Access to the Right Level of Care - Addressing ALC

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.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

The VCHC has a small number of clients who use opioids for pain treatment. Our Physicians use the Best Practice Guidelines to prescribe opioids for clients and the prescription is usually for short-term use. Physicians have opioid contracts with some of our clients. Clients are encouraged to use alternative treatments such referral to pain clinics, physiotherapy, smoking cessation and exercise programs.

Workplace Violence Prevention

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 _____ (signature)
Quality Committee Chair or delegate Lo An Ta Young (signature)
Executive Director / Administrative Lead Isabel Acaya (signature)
Other leadership as appropriate _____ (signature)

2018/19 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	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Effective	Effective transitions	Percentage of patients who have had a 7-day post hospital discharge follow up. (CHCs, AHACs, NPLCs)	P	% / Discharged patients	See Tech Specs / Last consecutive 12 month period	91505*	49	67.00	The VCHC is receiving hospital discharge notifications from some hospitals but not the local hospital. The VCHC is continuing to rely on clients to inform the Centre after they have been discharged from the hospital for selected conditions. We are continuing to work towards meeting current target of 67%		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.	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	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	Continue to track the number of clients seen within 7 day post hospital discharge in the EMR. 2. Continue to track the discharge notifications from hospitals, clients or MDs/NPs	VCHC's success in being able to provide primary care to clients within the 7-day post hospital discharge depends on hospital notifications and clients in a timely manner.
	Wound Care	Percentage of patients with diabetes, age 18 or over, who have had a diabetic foot ulcer risk assessment using a standard, validated tool within the past 12 months	A	% / patients with diabetes, aged 18 or older	EMR/Chart Review / Last consecutive 12 month period	91505*	CB				1) To track the number of clients who have completed a Diabetic Foot Ulcer Assessment (DFU) within 12 months in EMR	1. Diabetes team to identify the workflow for when to assess DFU (e.g. at initial intake or other) and clear guidelines for documentation in the EMR.	1. To create a reportable field in the Chiroprapist and RN template to track if a risk assessment was completed (e.g. date, when and by whom) for new and existing clients seen one-on-one. 2. Define the workflow for clients who have not completed a risk assessment at initial intake.	1.a) By May 2018, a template will be created in the RN and Chiroprapist Clinical template. 1.b) On a monthly basis track the number of DFU risk assessments completed by the RN and Chiroprapist. 2. By May 2018, the workflow will be defined for clients who have not completed a risk assessment at initial intake.	Currently, the Chiroprapist completes the DFU risk assessment during the client's initial appointment. The RN is starting to complete the annual foot exam for clients who have no present foot concerns. The team does not have a consistent workflow and clear guidelines for documentation in the EMR.
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?	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	91505*	85.37	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.	1. Survey at least 25 random clients per month using various methods: a) hard copy; b) e-copy via iPad or provide a link to complete the survey online; and c) email distribution to clients 1x year in October.	Track the number of surveys completed by clients on a quarterly basis 1.b. Track the number of clients who stated that they feel they are always/often involved in decisions about their care and treatment.	At least 25 surveys are completed each month 1.b. In each quarter, work towards having 96% of clients who stated 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.	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	91505*	51.97	52.00	As per the 2017 Quality & Primary Care Report, the CLHIN's timely access to primary care has remained at 48.1% since 2016. We would like to maintain our target of 52% and continue to work towards meeting this target. This target will be challenging to achieve as the MDs/NPs are continuously expanding their panel size.		1) The Registered Practical Nurse (RPN) to work at full scope of practice and provide shared care to clients	RPN to continue to call clients for test results; provide injections; immunizations; review of recall lists for cancer preventative screenings (e.g. colorectal, cervical, breast cancer); phone triaging, etc. 2. Explore and identify other ordered/delegated medical procedures for the RPN	Track RPN's performance within the scope of practice and RPN encounters for other ordered/delegated medical procedures on quarterly basis. 2. Plan and implement PDSA for ordered/delegated medical procedures	The RPN completes 500 encounters per quarter.	
											2) 2. Sustain increased access to medical appointments by continuing to decrease the length of appointment where feasible and use advanced access booking.	2 a) Continue to schedule 15-minute episodic visits for identified specific client conditions. b) Ensure advanced booking is in place for each MD/NP	2 a) Continue to track the number of 15-minute episodic visits scheduled per provider per week. b) Medical Secretary Team to continue to implement advanced booking for each MD/NP on a daily basis	2 a) At least 3, 15-minute visits are booked appropriately per week per provider b) Aim to keep TNA (Third Next Available Appointment) close to 0-3 days per MD/NP per week	
											3) 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 25 random clients per month using various methods: a) hard copy; b) e-copy via iPad or provide a link to complete the survey online; and c) email distribution 1x year in October.	3. Track the number of clients who stated that 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 were able to see their MD/NP within 0-1 day when they were sick.	