Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 27, 2024

VAUGHAN COMMUNITY HEALTH CENTRE

Ontario Health

OVERVIEW

The Vaughan Community Health Centre (VCHC) continues to dedicate significant staff and leadership time to focus on the quality improvement program. In addition, our Quality Improvement Committee includes client representation and ensures client feedback from client experience surveys is reviewed and improvements are made, where appropriate and feasible.

As part of the 2023/24 QIP, the Committee began to review sociodemographic data. Specifically, we tracked the percentage of eligible clients who completed PAP tests stratified by racial/ethnic groups. As part of this work, we learned that VCHC's sociodemographic completion rate for individuals eligible for PAP tests is complete, fluctuating between 99%-100%. This provided us with confidence to review data for completion of PAP tests stratified by racial/ethnic groups.

In addition, we learned that the number of individuals eligible for PAP tests will fluctuate each quarter, therefore it was important for us to be able to collect data for multiple quarters to be able to identify trends in completion rates. These learnings and achievements are important, as it sets the foundation for the continuation of our work as part of the 2024/25 QIP.

Specifically, in the 2024/25 QIP, we will be focusing on racial/ethnic groups who have a lower percentage of PAP completed; specifically, where the difference between the group with the highest percentage of PAP completed and the lowest percentage of PAP completed is more than 10%. To reduce this gap, we will identify the barriers in accessing PAP tests and work with the racial/ethnic groups to address those barriers.

For the 2024-2025 QIP, the VCHC will focus on 3 quality improvement priorities: 1) access and flow; 2) equity and 3) experience. We will measure and implement improvement activities for a) client perception of timely access to care; b) percentage of staff who have completed relevant equity, diversity, inclusion and anti-racism education; c) percentage of clients who responded to sociodemographic questions across the organization; d) percentage of clients who report feeling comfortable and welcome; e) percentage of clients who state they are involved in decision making about their care; and f) percentage of clients who have completed PAP test stratified by racial/ethnic group.

ACCESS AND FLOW

In the 2024/25 fiscal year, we will be focusing on primary care clients' perception of timely access to care by determining the percentage of clients who report that the last time they were sick or had a health problem, they received an appointment on the date they wanted. To determine areas for improvement, we will continue to track same day access to care and the reason for why individuals are not booked for the same day appointment.

ADMINISTRATIVE BURDEN

The VCHC implemented Ocean software, which is an online appointment booking portal, that allows clients to schedule certain appointments directly with their provider. In addition, providers or staff can send secure messaging to clients to remind them of appointments, share e-forms and more. This has improved workflow efficiencies for our reception staff as it has reduced the volume of incoming calls from clients requesting appointments.

We are using other features of Ocean platform such as referral and other services including specialists, specialized clinics, and diagnostic imaging available through Ocean, which is integrated into our electronic medical records (EMR). Within our EMR we have built-in forms and utilize eFaxes to fax referrals to specialists and diagnostic imaging facilities. Other features of the system enable providers to extract information for consultation letters and for documentation.

As an extension to the software, we also have Ocean self- check in Kiosk, to encourage clients to self-check in without having to see reception staff to inform them of their arrival. Since Ocean is embedded in our EMR, the provider is informed of client's arrival in real time. We are continuing our work with Ocean platform and have established a working group to strategize and improve online appointment booking workflow.

EQUITY AND INDIGENOUS HEALTH

-The VCHC Board of Directors endorsed the Health Equity Charter established by the Alliance for Healthier Communities and work is in progress to identify areas of focus using Health Equity Charter Self-Assessment tool, which will align with the Health Equity Workplan.

-As part of VCHC's commitment to health equity we will be submitting the 2024-2025 Health Equity Workplan to Ontario Health Central.

-In alignment with our Health Equity Workplan, and as part of our 2024/25 QIP, we will continue to build on the findings from the 2023/24 QIP and further our understanding of the experiences of racial/ethnic groups who have a lower percentage of PAP completed, where there is a greater than 10% difference compared to the racial/ethnic group with the highest percentage of PAP completed. In addition, we will implement a training plan on equity, diversity, inclusion, and anti-racism for staff.

-The Leadership Team and staff at our Northern York Region location have completed Indigenous Cultural Safety training and we will continue to look for opportunities to train more staff.

PATIENT/CLIENT/RESIDENT EXPERIENCE

The Vaughan CHC incorporates client feedback into quality improvement activities. As part of the Quality Improvement Committee, we have client representatives who provide input and feedback into the activities of the QIP. Clients provide feedback on services through client experience surveys across program and service areas. The feedback is reviewed and discussed at team meetings and efforts are made to integrate clients' feedback into future or existing programs or services.

PROVIDER EXPERIENCE

Like many organizations, the VCHC continues to be impacted by staffing challenges. To maintain staff wellbeing and reduce burnout, we continue to offer a hybrid work schedule. That is, staff have a flexible schedule to work onsite and offsite during the week. In addition, we assess staff's overall wellbeing by conducting an annual staff wellbeing survey, reviewing the feedback, and implementing the changes, where feasible. As a result of the recent feedback, we are offering staff to use onsite gym equipment, when not in use by clients. We are redesigning a space to provide staff with a comfortable, safe space to use for their individual needs such as debrief, mental health break, religious practices and more. We will continue to collect staff feedback and make changes as needed and where feasible.

SAFETY

To ensure VCHC promotes a safe environment for clients and staff, when there is an incident, an incident report is created, and staff involved takes the appropriate measures to work with the clients in addressing the issue. The incident is discussed at Joint Occupational Health & Safety Committee and team meetings, without identifying client information, to evaluate the situation, and identify strategies to prevent future recurrence, and make plans to implement those strategies.

POPULATION HEALTH APPROACH

The VCHC has partnered with various organizations to address population health:

-The VCHC has been the lead agency in implementing the High Priority Communities Strategy (HPCS) in the City of Vaughan to support the Province's COVID-19 pandemic response and recovery efforts. Specifically, our goal is to support the broader community in geographic areas of highest levels of material deprivation and a higher concentration of racialized and diverse communities. This includes increasing awareness for preventive cancer screening in older adults living in high priority areas. A team of community ambassadors have been recruited to provide awareness and education on the importance of preventive health.

-The VCHC is a partner of the Western York Region Ontario Health Team (WYR-OHT), we have supported the work of the Collaborative QIP. In particular, we focused on the planning and implementation of the indicator regarding increasing access to preventative cancer screening (PAP, Mammogram, FIT).

-In partnership with the WYR-OHT, VCHC contributed to the community response for asylum seekers residing in Vaughan and provided episodic healthcare appointments to the residents.

-VCHC has partnered with the Northern York South Simcoe (NYSS) Ontario Health Team to deliver primary health care services to unattached residents and the homeless community in Georgina.

CONTACT INFORMATION/DESIGNATED LEAD

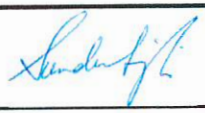
Ana Khatchatourian, Senior Manager of Programs & Services

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 on

_____



Board Chair

Ana Khatchatourian

Quality Committee Chair or delegate

LoAn Ta-Young

Executive Director/Administrative Lead

Other leadership as appropriate

2024/25 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

VAUGHAN COMMUNITY HEALTH CENTRE

Vaughan CHC Corporation 206-9401 Jane Street, , Vaughan , ON, L6A4H7

AIM		Measure							Change			
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)												
Access and Flow	Timely	Patient/client perception of timely access to care: percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	CB	CB	Set target after collecting baseline data.	1)1. Update client experience survey and collect feedback from clients via survey. Set targets and measure results for questions. 3. Continue to update triage guidelines and ensure appointments are booked based on the guidelines and timelines identified. 2. Continue to triage clients' needs for appointments and schedule accordingly.	1. Survey clients of the primary healthcare team: A)by asking the following question: "The last time you were sick or were concerned you had a health problem, did you get an appointment on the date you wanted? - a. Yes; - b. No . B) by asking following up questions to obtian feedback regarding client's ability to obtain appointments related to acute health concerns. 2)Continue to reserve appointments for issues requiring same day attention. 3)Book client appropriately for issues requiring same day attention utilizing triage guidelines.	1. Collect client experience surveys (Reception Team) 2. Provide data on survey responses (Primary Healthcare Manager) 3. Pull data from EMR for appointments where medical conditions required same day attention. 4. Reception Team to track data on appointments that were not booked for medical conditions requiring a same day appointment (Data Management Coordinator and Reception Team Lead) 5. Clinical and Reception teams to continue to review and establish guidelines for effective triage of client needs. 6. Review weekly schedule to ensure reserved spots for urgent visits were utilized as per guidelines established.	1. Survey distributed to clients starting in April. 2. 90 surveys per quarter collected from clients of the Primary Healthcare Team. Baseline is established beginning of Q2. 3. Appointments are reserved for medical conditions requiring same day appointments and data is analyzed quarterly. 4. An average of less than 12 weekly same day/urgent care appointments not booked. 5. Guidelines established and utilized by Reception Team to schedule appointments appropriately
Equity	Equitable	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	25	70.00	VCHC plans to train at least 70% of its staff on relevant equity, diversity, inclusion, and anti-racism education.	1)1. Train at least 70% of staff on relevant equity, diversity, inclusion, and anti-racism education.	1. Develop a health equity plan that aligns with OH equity, inclusion, diversity and anti-racism framework, and existing provincial priorities which includes a plan to train staff.	1. Identify relevant equity, diversity, inclusion, and anti-racism education for different staff groups. 2. Share training plan with staff 3. Ensure enough time has been allocated for staff to receive training.	1. Relevant equity, diversity, inclusion and anti-racism training plan has been identified for staff. 2. Training plan is shared with staff. 3. Sufficient time has been allocated for staff to receive the training.
		Percentage of patients/clients who responded to at least 1 of the 4 specified sociodemographic questions among clients who had an individual encounter with the primary care organization.	C	% / clients age 13 years and older who had an individual encounter with the primary care organization within the most recent 1-year period	EMR/Chart Review / Most recent consecutive 12-month period	90	90.00	The target corridor set by the Alliance for Healthier Communities is 65% to 100%. The Alliance members have unanimously passed a resolution to advance sociodemographic data collection in our sector, with a goal of all member organizations having a 75% data completion rate by 2024. There are new sociodemographic indicators being introduced in March 2024, the VCHC will first collect baseline once the new indicators have been implemented in order to set target.	1)1. Implement the new sociodemographic form across the Centre. 2. Monitor the completion of sociodemographic information regularly.	1. DMC to upload the form into PSS; update of hardcopy forms; training of staff. 2. Supervisors to monitor their team members' performance on socio-demographic data collection and follow-up with staff for improvement, as required.	1. The Data Management Coordinator (DMC) to provide monthly report on socio-demographic data 2. Reception team to call and follow up on clients who have not completed socio-demographic questions. 3. Supervisors to follow-up with staff to review achievements after receiving the monthly report.	1. Sociodemographic information provided by DMC monthly. 2. Calls with missing sociodemographic information are contacted regularly. 3. Achievements are shared with staff.
Experience	Patient-centred	Do patients/clients feel comfortable and welcome at their primary care office?	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	CB	CB	The target corridor set by the Alliance for Healthier Communities is 90% to 100%. VCHC to set target after collecting baseline.	1)1. Collect feedback from clients via survey. Set targets and measure results for questions.	1. Survey clients by asking the following questions: a. I always feel comfortable and welcome at Vaughan CHC. - a. Yes - b. No b. How could VCHC create a more welcoming environment for clients.	1. Track the number of client experience surveys completed. 2. Track the responses to the survey question "I always feel comfortable and welcome at Vaughan CHC".	1. 90 surveys collected each quarter. 2. Target identified after Q1. Results measured against set target and target corridor set by the Alliance for Healthier Communities.
		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	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	86.59	90.00	The target corridor set by the Alliance for Healthier Communities is 90% to 100% . VCHC's performance from 23-24 fiscal year is 86% and thus VCHC will keep this as target and work towards the 90% target set by the Alliance for Healthier Communities.	1)1. Update client experience survey and collect feedback from clients via survey. Set targets and measure results for questions. Increase understanding of client experience through survey.	1) Reception team asks client the reason for visit and schedules appropriate length of appointment time for each client. 2) The physician/nurse practitioner encourages clients to ask questions, ask for clarification and ask what they want regarding their care and treatment.	1. Track the number of client experience surveys completed and the results for each question on a quarterly basis.	1. 90 surveys collected each quarter. 2. Aim to increase percentage of clients feeling always or often involved in decisions about their care and treatment to 90%.
		Percentage of recommended clients who received or were offered a cancer screening test i.e. PAP, stratified by racial/ethnic group.	C	% / PC organization population eligible for screening	EMR/Chart Review / April 1, 2024-March 31, 2025	CB	CB	Target corridor recommended by the Alliance for Healthier Communities PAP stratified by racial/ethnic group: the difference between the group with highest % of PAP completed and the lowest % of PAP completed is <10%.	1)1. Explore focused approached to reach clients with low completion rates for preventative cancer screening, specifically pap tests, stratified by ethnicity.	1. DMC to share data on clients who are due or overdue for pap tests. 2. The Registered Practical Nurse (RPN) reviews the recall list on a quarterly basis and identify clients who are due or overdue for pap tests. In addition to prioritizing contacting clients by pap test due date, RPN also prioritizes contacting clients of ethnicities with lowest completion rates. 3. Reception team to continue to recall clients due for pap tests. 4.Once the racial/ethnic group with the lowest percentage of PAP completed is identified and the difference is > than 10%, the RPN to call the clients to identify barriers in accessing PAP test. Other strategies will be identified and implemented to work with racial/ethnic groups in addressing the barriers.	1-4. DMC to pull a report on the number of clients stratified by ethnicity/racial group with the following statuses "declined, done, not addressed and total". DMC to exclude the ineligible clients.	1. At least 80% of all eligible clients were contacted to be offered a pap test. 2-4. Working towards reducing the gap between the group with highest % of PAP completed and the lowest % of PAP completed to be <10% by identifying barriers and implementing strategies to reduce barriers.