Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario (2015-2016)

CENTRAL TORONTO
Community Health Centres

4/6/2015

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

Central Toronto Community Health Centres has been providing care for our communities through a history of over 40 years of investments in partnerships and collaboration. The idea for the centre was conceived by students belonging to the Student Health Organization of the University of Toronto (SHOUT) who wanted integrated health services and training delivered by an interdisciplinary health care team. They started providing clinical care in 1969 in the Alexandra Park area of Toronto. Central Toronto Community Health Centres' work today continues to be shaped by our history in interdisciplinary teams and a vision of providing integrated, responsive and accessible care to individuals and communities challenged by complex health conditions twinned with social and economic barriers that do not enable access to good health and quality of life. Hence, as we respond to the diverse health needs of our clients and communities, we are mindful of their social context and always strive to be an ally in promoting social justice as well as the advancement of good health and public policies that will reduce our clients' social exclusion and marginalization.

Our priority populations are youth and adults who are homeless/under housed, immigrants, refugees, people who use substances, and/or have a mental health challenges. We offer a range of primary care, preventive health services and social supports, including dental, homeless and harm reduction services, counselling and case management supports, diabetes education, mental health services, chiropody and naturopathic care, and early year's services.

CTCHC strives to offer the full range of accessible services, supports and programs necessary to improve the quality of life of clients and community. At CTCHC we respect every individual's choices and believe that everyone has a right to be treated with dignity and respect and to enjoy an environment that is free from discrimination and harassment. We work to ensure that our services and community activities are carried out in ways that welcome, reflect and respect diversity and that people from all communities can participate fully in all aspects of CTCHC. Hence, we have a strong commitment to quality of care and to quality improvement that is responsive to the needs of our community of clients.

Objectives of QIP
The objectives of our QIP are to improve the client experience and to align quality improvement with our organization-wide strategic plan and directions, as well as linked with our TC LHIN Accountability Agreement indicators. We will do so by focusing on three areas:

1. Improve Access to Care
2. Improve quality of care for clients through coordination with other service providers
3. Improve client experience and satisfaction

Integration & Continuity of Care

Our plan builds on our values and looks for ways to improve access to our services in a timely manner, to strengthen the integration of services and the continuity of care for our clients, as well as reaching out to those we serve to determine if we are making a difference. In the past years, we have established strong partnerships with a range of community support services to enable the sustainability of our primary care interventions and to facilitate the coordination of care and the provision of other determinants of health support for our clients that bolsters the success of our clinical intervention and the quality of life for our clients.

We have also had strong collaborations through our Health Links and see this as a vehicle through which we can deepen our collaboration and care coordination with hospitals, solo-practice doctors and community partners. This process also allows us to increase access and quality of care for our priority populations (at risk and homeless, youth, those with mental health and substance use, and immigrants and refugees). As well it has allowed for patients in the Heath Links process to provide awareness and education to providers about what they need to improve the quality of care they receive.

We have been engaged in numerous quality improvement and access to care initiatives as strategies for better integration of care provision among providers and for maintaining continuity of care for clients. The work of the Centre and that of our Health Links is aligned with our QIP objectives they include:

• Providing off-site primary care clinics in community spaces such as shelters, drop-in centres for the homeless and youths at risk, hence increasing access to care for marginalized populations;

• Providing a "People In Need Clinic" with a goal to improve access for populations who are unable to keep appointments and who need medical or psycho-social supports, specifically those who are not registered patients of the Centre;

• Providing Same Day Access for urgent care needs of clients;

• Participating with 6 CHC and over 35 local physicians as a major referral site for solo-practitioners, specifically through our Health Links projects like SPIN (Solo Practitioners in Need) and RED (Rapid Referral from Emergency Departments), whereby our Centre and two other CHCs and two UHN hospitals support rapid attachment of vulnerable and complex client to primary care in our Centres or undertake to improve the coordination of care for such clients. This immediate connection to primary care has been show to decrease hospital readmission rates;

• In 2015/16 we will integrate the development of coordinate care plans working with CCAC to improve the care to complex and vulnerable clients;

• Adopting a range of counselling modalities to ensure timely and responsive services, particularly exploring in 2015/16 the integration of a same-day single-session counselling model as a way to stabilize clients who otherwise might end up in the emergency departments;

• CTCHC also continues to collaborate formally with other health centres, hospitals, community mental health agencies and the TC LHIN through the formerly Coordinated Access to Primary Care for the Homeless ED (CATCH - ED) aimed at integrating transition supports for patients from the ED and inpatient units back out to longer term community services and primary care with a role of improving care and reducing ED visits.

Challenges, Risks & Mitigation Strategies

CTCHC challenge in delivering against the 2015/2016 QIP are:

1. Ability to fill vacancies in our clinical roles (NP's & Dr's). Vacancies in these roles directly impact our ability to provide access to primary care services. Staff changes can happen unexpectedly and this can impede the ability to provide continuity of care and keep improvement initiatives on track. To manage this risk we have identified a pool of candidates for locum roles who would provide quick access to clinicians to cover gaps in clinical staffing and provide bridging support during the search to fill vacancies with permanent hires.

2. Access to case management support and resources for such services is limited for the increasing numbers of clients with multiple and complex psycho-social needs. We continue to seek enhanced support in this area to embed case management supports in our primary care services which will reduce the time clinicians currently spend supporting clients with psycho-social needs, like social assistance, housing, and general systems advocacy. We continue to seek out resources, including partnerships and to re-organize functions within existing staff roles to respond to this client need. As this level of case management support in primary care clinics would increase our capacity to see more clients in our primary care service and enable better quality of care for this higher need population.

3. Integration of new EMR and Information Management. In May of 2014, Central Toronto CHC implemented a new clinical management system, Nightingale on Demand (NOD). Implementation challenges and restrictions in the new electronic medical record related to what data the system can collect and limitations with some functionality will make it more difficult to meet the targets and establish valid baseline data. We are seeking in 2015/16 to engage in a collaborative process with other CHCs to improve data collection and reporting. This will enable better data quality and improve comparative analysis and measurement of improvements.

Information Management Systems

In May of 2014, Central Toronto CHC implemented a new electronic medical record system, Nightingale on Demand (NOD). The transition had adverse impact on access for patients as during the implementation period we had to lengthen appointment times to facilitate provider learning on the new EMR. This drastically reduced the number of appointments we could offer, resulting in fewer clients seen in 2014.

Additionally, there remain issues with data collection and data quality as NOD requires more navigation by providers hence creating barriers in capturing all information needed to measure indicators. There are also some limitations with the reporting functionalities in NOD which limits our ability to run complex-cross tabulations or simple analysis on the range of socio-demographic profiles and clinical procedure. There has also been limitation in the vendor's ability to transfer the learnings and improvements to NOD in early adopter Centres system-wide. We continue to work with the system’s provider and the Association of Community Health Centres, the broker to improve the capabilities of the EMR and to improve its alignment with the work of larger health services with inter-disciplinary teams.

Engagement of Clinical Staff & Broader Leadership

The plan developed is informed by work plans and priorities developed and identified in the clinical team. Additionally the Plan is informed by the strategic priorities of the organization which was developed through a broad consultation process with staff, Board, clients and community partners. Additionally, we have implemented micro-feedback processes as a way to gather real-time feedback from clients thus enabling us to make timely improvements. We continue to conduct the annual Client Experience Survey as an additional way to gather overall feedback and input from our clients.

Additionally, CTCHC's balanced scorecard which integrates the QIP indicators, the accountability targets and the strategic directions are presented to the clinical team quarterly so they can inform the targets, problem-solve areas of challenges for the primary care indicators and provide insight for the organization's leadership on establishing quality improvement goals.

The leadership also develops and affirms the QIP that is presented to the Board for approval and adoption.

Patient/Resident/Client Engagement

As noted above Central Toronto conducts an annual Client Experience Survey; during the survey we engage a range of clients across all our program areas. We find the annual survey not be most responsive in enabling real-time improvements to issues of concern to clients. Hence, in 2015/16 we are seeking to conduct numerous smaller program specific engagement surveys. In 2014/15 we initiated engagement with our neighborhood businesses, community services and the local police division, as a way to proactively engage and positively problem-solve issues related to use of our community spaces by clients who are homeless, living with mental health and substance use issues. We intend to continue this in 2015/16 and will likely engage local residents next through the local neighbourhood associations. All this leads to improved community relationships, an informed community about Central Toronto CHC and better connections with our services.

Accountability Management

CTCHC has a balanced scorecard system for monitoring our QIP and the Strategic plan. The QIP indicators that we have developed are integrated into the scorecard and management reviews and reports the results to the Board of Directors on a quarterly basis for the purposes of monitoring and accountability. The Board in 2014 also created a Quality and Performance Committee of the Board which will have responsibilities for reviewing, monitoring and reporting on the QIP.

Other

Changes to 2015/16 Indicators: CTCHC will be changing its indicators, particularly those in the area Population Health. The Centre currently report as part of its Toronto Central LHIN Multi-Sectoral Accountability Agreement (MSAA) on cancer screening targets. We seek to improve access to cancer screening for breast, colorectal and cervical cancers and to test utilization of the new EMR to improve screening. At this time we believe it is premature to continue to include the Population Health indicators as stated. Reducing the incidence of cancer mortality is a substantive goal, but not one that CTCHC alone can directly accomplish by measuring the percentage of eligible patients/clients who are up-to-date in screening for breast, colorectal and cervical cancer. The objective and measure/indicator are incongruous for several reasons:

- The objective of reduced incidence of cancer does not necessarily correlate to observing the percentage of individuals who are up-to-date with screening.
- Screening is a measure to detect cancer; it does not necessarily reduce its incidence. In fact, increased detection arguably increases incidence.

CTCHC would recommend that a more appropriate objective is to increase access to regular screening for a specific kind of cancer and/or target population. This can be measured by looking at the percentage of eligible individuals who are up-to-date with screening. This change would addresses factors that are directly within CTCHC's and other CHC's control.

Sign-off

Board Chair: Kelley Myers
Clinician Lead: Shivanee Nadarajah
Executive Director: Angela Robertson