Let's Make Healthy Change Happen.

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

Centretown Community Health Centre
Centre de santé communautaire du Centre-ville

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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

In June 2010, the Ontario Government passed the Excellent Care for All Act. Initially this legislation was designed to help support hospitals to further improve the quality and safety of care they provide through tools such as Quality Improvement Plans (QIP). In January 2013, Primary Care Organizations, such as Centretown Community Health Centre (CCHC) were required to develop QIP as well.

This is CCHC's fifth QIP. It provides a meaningful way for CCHC to clearly articulate its commitment of quality to community, clients, volunteers and staff as well as demonstrate its model of health and well-being. This model is unique to CHCs, focusing on an interprofessional approach and social determinants of health. CCHC's QIP is focused on creating a positive client experience and delivering high quality services and programs to respond to the changing needs of its community.

The QIP for CCHC is aligned with and built upon CCHC's Strategic Plan and other regional and provincial reporting requirements, including multi-sectoral accountability agreements with the Champlain LHIN and accreditation standards. Within both CCHC's Strategic Plan and the QIP, the concept of quality and providing the most appropriate accessible care, services and support to individuals and communities is an underlying foundation. In keeping with the previous year, the 2017-18 QIP focuses on effective, client centred, timely and equitable care and is aligned with the objectives and goals of the current Strategic Plan. For example CCHC's strategic plan looks at initiatives to address health equity for marginalized populations, and numbers of Francophone, New Canadian and transgender clients accessing the centre's services.

QI Achievements From the Past Year

Enhancing Client centred service and support via Community Support Worker Team:
In the fall of 2016 CCHC successfully implemented a new Community Support Worker (CSW) Team, following an initial pilot and evaluation. The team was implemented to increase access to services for vulnerable and marginalized clients along with promoting a safe and welcoming environment through a client centred approach. Now with these CSW positions CCHC has flexible roles and cross-coverage in order to meet the needs of clients seeking information, resources and support in the moment when they present. A more detailed description is outlined in the Integration and Continuity of Care section.

Health equity for trans clients:
In early 2016, Centretown CHC began exploring ways to address its lengthy wait list for Trans Health services (8-10 month delay for limited services and 70+ clients on our centralized waiting list). In order to better meet needs, CCHC made the following model changes in November 2016, that reflected both client and trans community feedback, and were consistent with WPATH best practices and Sherbourne Clinic protocols:

- Eliminate hormone readiness assessments by counsellors and move to in-person intake appointments whereby counsellors take an in-depth history, determine the client's goals and connect them to the appropriate resources (including ongoing counselling if applicable)
- Commence a Trans Health clinic focused on hormone initiation
- Hire a Community Support Worker dedicated to supporting trans clients

More information about our Trans Health Clinic are outlined below in the Equity section.

Community Diabetes Education Program of Ottawa'S Group Program Quality Improvement Process:
The Community Diabetes Education Program of Ottawa (CDEPO) provides individual diabetes management and group education to community-based adults with type 2 diabetes and prediabetes. Pre-existing Group Education (GE1), was provided in 3 weekly 3-hour sessions, was largely didactic, and unreflective of learner needs, resulting in declined services, long wait times and high attrition rates. Led by an internal staff Program Development Working Group, CDEPO used Fisher's Tri-Level Model of Self-Management and Chronic Care, AADE7 and learning theory to revise GE1 to improve access to and satisfaction with evidence-based, client-centred Group Education (GE2) with behavior change at its core. Educator Guides with learner objectives, plain-language handouts, and teaching methods (e.g. videos, quizzes, case studies) were developed to reflect adult learning principles. Team members were involved in the review and evaluation of all materials. In GE2 people take one "Understanding Diabetes" 3 hour session, then select from a menu of six workshops (healthy eating, carbohydrate counting, being active, meters & medications, healthy coping and reducing risks) to reflect their learning priorities and desired pace. Workshops focus on practicing skills and developing action plans for each behaviour. Understanding Diabetes was piloted at 3 sites over 4 months with mixed-method evaluation used and afterwards the decision was made to implement and evaluate GE2 across all sites. We are currently doing further research to evaluate the delivery of the program in terms of how well it is meeting original objectives and aligned with the teaching guide. However, preliminary indications are that with more frequent offerings of group education (over fewer sessions) wait time has decreased and there is higher turnout.

Population Health

Cancer screening: Primary Care undertook a review over the summer of 2016 to better understand decreasing quarterly performance for Breast Cancer screening. Initial data reports indicated that our Q1 performance was 52% and our Q2 performance was expected to be at 45%. Only some of this decrease could be explained by an upper age limit change that was not reflected in the reporting system until Q2. We reviewed all eligible cases where this screening was outstanding and determined that a lot of clinical work had been done and documented but, due to ongoing challenges with our EMR, had not been documented in a way that could be recognized by the reporting system. We corrected/updated 175 of the 371 cases reviewed, which led to a projected Q2 performance of approximately 72%. Those clients who truly had overdue screening were then contacted about pursing a mammogram.

The same exercise was repeated for outstanding colorectal cancer screening cases and cervical cancer screening. We determined that our performance was also much better than reported. For colon cancer screening several clients were actually ineligible due to being on a repeat colonoscopy schedule that was longer (often 3, 5 or 10 years) than the time interval for fecal occult blood test screening, which is 2 years. This means their ineligibility needed to be re-entered every 2 years to remove them from our denominator of eligible cases. For cervical cancer screening, we performed data quality clean up and then began recalling clients overdue for a pap. We look forward to continuing this work during our 2017-18 QIP.

Hep C: By end of fiscal year CCHC will have hosted two Hepatitis C fibroscan clinics onsite. Using diagnosis codes from our electronic medical record we identified people with Hep C and booked them in for a fibroscan. Given how expensive treatment is, a fibroscan is required to determine whether a client has the level of liver fibrosis to be eligible for covered treatment. The scans are typically performed in the hospital however this is often a barrier for access for

many clients because of lack of resources to get to and navigate the hospital system and/or due to stigma they experience in a hospital setting. We also participated in research to determine whether our care adheres to the 2015 consensus guidelines from the Canadian Association for the Study of the Liver. Findings are currently under review now.

Equity

Health Equity is embedded in the CHC model and our values. Since 2014, CCHC has made significant progress in formalizing internal policy, generating staff awareness and education, and updating recruitment processes with a focus on health equity. CCHC has developed a Health Equity Policy with associated procedures to monitor progress and our Health Equity Action Team continues to promote quality of service delivery through a health equity lens. From a Human Resource perspective, CCHC has embedded health equity training into new staff and board orientations, and modified HR recruitment policies and practices to ensure a more inclusive workplace.

Given its importance, we had two Health Equity indicators on our 2016-17 QIP. The indicators assessed our quality of care and delivery of services to vulnerable populations (including Francophone, New Canadians and trans* clients), and populations with complex care needs. For the 2017-18 QIP CCHC will continue to focus on the uptake of our new sociodemographic registration form, which was rolled out in July 2016. The data from this form inform us on the clientele we are serving and helps us to create a welcoming environment for all our clients and provide culturally competent care. In previous QIPs, CCHC has scored well over 90% on our indicator about consideration of a client's personal situation when providing care/support. Given our consistently high performance we will be retiring this indicator from our 2017-18 QIP but will continue to monitor it via our annual client survey. In its place, we have selected an indicator on Trans Health.

Trans Health Clinic: Due to high service demands and long wait times Centretown CHC reallocated funds temporarily in order to pilot a Trans Health Clinic focused on initiating hormones for clients who wish to medically transition. The clinic commenced December 2016 and will run until the end of June 2017 for one half day per week. Our goal is to reduce barriers to accessing hormones for trans clients who want to medically transition, both in terms of actual wait time and number of appointments. Currently very few physicians in the Ottawa area initiate hormones and we know from literature that suicidality is higher while clients wait for hormones.
As a new clinic, we want to continuously improve the model to meet the needs of clients. We are measuring several indicators to evaluate the effectiveness of the clinic and the clinical team meets weekly to debrief about what is working well and what could be improved. As well, we are offering a survey to clients to complete anonymously after each visit to provide us with rapid feedback. The survey questions are modeled after the Ottawa CHCs' annual client survey and adapted to the specific goals of this clinic.
As of February 8, 2017, 24 unique clients accessed the clinic during this timeframe, most with more than one visit. Approximately 85% of clinic clients have primary care providers. The age range is 18-43 and the mean age is 24. We have selected this as an indicator for our F17/18 QIP as we will measure clinic indicators and perform a full analysis on the outcomes of this pilot.

Syrian Refugee Response: Centretown Community Health Centre, alongside other agencies, participated in the primary health care response for the influx of Syrian refugees (1087 Government Assisted Refugees plus privately sponsored Syrian

refugees) who arrived in the Ottawa between late December 2015 and April 2016. CCHC collaborated with another CHC to go into the temporary lodging sites (hotels) to provide primary care and early years services. We also ran a weekly "hub clinic" from January 2016 to end of June 2016 to perform clients' initial medical assessments (IMA). In order to provide quality services for these clients we developed clinical templates to ensure we were performing comprehensive screening and immunizations. We also developed a tracking mechanism to ensure clients received follow up visits, were then matched with a primary care provider for ongoing care, and had their IMA health information transferred to their new provider (upon consent). In total we saw approximately 160 Syrian refugees via our IMA hub clinics. 100% of the clients we saw were connected with an ongoing primary care provider, 58 of whom were absorbed into a provider's practice at CCHC.

French Languages Services (FLS): CCHC continues to actively pursue its FLS designation to officially reflect its services' response to the needs of francophone members of our community. Our executive director is a champion for francophone health equity and, in 2015-16, was appointed to the Provincial Advisory Committee on Francophone Affairs as well as chaired the Canadian Association of CHCs' National French Language Health Services Working Group.

Integration and Continuity of Care

The Ottawa area CHCs have a longstanding history of collaborating with each other and with other community partners for service delivery. We participate in forums to support and promote the ongoing improved coordination of services for marginalized populations. Some examples include:

- Participation as a local/regional CHC representative on various standing and ad-hoc committees and network tables, including work with Children's Hospital of Eastern Ontario, The Ottawa Hospital, Ottawa Local Immigration Partnership, Alliance to End Homelessness, Ottawa Children & Youth Mental Health Services and Regional Geriatric Advisory Committee.
- Participation with Health Links 5 at the Steering Committee level and at an operational level as care coordinator roles begin to be developed
- Representation on the Vulnerable Seniors Partnership, which focuses on role clarification, systems gaps and improving referral processes across sectors including CHCs, CCAC, acute care hospitals, Ottawa Public Health, and geriatric specialty services.
- Working with community partners including Inner City Health, shelters, day programs, mental health agencies, harm reduction service providers, and other CHCs for integrated services for clients who are homeless/unstably housed.
- Participation on the advisory planning committee for the transformation of early years services in Ontario.
- Working with other organizations including Ottawa Public Health, CHCs in the Ottawa area and the LHIN on immigrant health issues.
- All Ottawa CHCs are collaborating on the next strategic plan, set to begin in 2018. Four Ottawa CHCs, including CCHC, continue to work together on objectives from our current shared strategic plan (since 2012). One such objective is improved access to Trans* Health Services.

Trans Health Planning:
This year, CCHC advocated for and received funding in order to establish a time-limited Champlain Regional Planning Table for Trans, Two Spirited, Intersexed and Gender Diverse Health, Mental Health and Social Services. The membership includes Trans Health Information Ottawa (THIO), Centretown Community Health Centre (CHC) on behalf of Ottawa CHCs, Children's Hospital of Eastern Ottawa, Family Services

Ottawa, Champlain Local Health Integration Network, Royal Ottawa Mental Health Centre, Seaway Valley Community Health Centre (CHC), Youth Services Bureau of Ottawa and an equal number of community representatives. The final report and recommendations are forthcoming in the spring of 2017.

Pregnancy and Substance use:
Interdisciplinary members of our primary care and early years teams (RN, NP and MD) also partnered with colleagues at the Royal Ottawa Substance Use and Concurrent Disorders Program, and the Ottawa Hospital Department of Maternal Fetal Medicine and the Division of Midwifery to provide holistic services for pregnant people who use substances. They developed the ORACLE Collaborative Pathway in order to coordinate services and support in a client-centred manner and environment: "Prenatal care for this population is often provided in high-risk pregnancy units - separate from addiction treatment and community based services. Furthermore, these clients often require multiple visits to specialized services that are fragmented among different sites - creating possible barriers to accessing care. Engagement can be challenging due to limited financial and social supports and in some cases a lack of communication between sites and service providers. These factors frequently lead to people presenting irregularly for prenatal care and/or having their first clinical visit in later stages of pregnancy. Additionally, fears of losing custody of their child, feelings of guilt about substance use, concern regarding stigmatization, and the pervasive nature of poverty all create barriers to the access of comprehensive prenatal services…In an effort to optimize care, the ORACLE Pathway facilitates collaboration between service providers in the areas of specialised addiction treatment and counselling, comprehensive community based antenatal care, outreach nursing, midwifery and specialist obstetric services".

Internally, CCHC is strongly committed to integration and continuity of care. At a client level this year the mental health and primary care teams co-developed a strengths-based coordinated care plan for clients. This work was piloted by a few staff champions across teams and then the tool and learnings were presented to the teams. The tool will continue to be embedded into practice throughout the next year.

Access to the Right Level of Care - Addressing ALC Issues

While our organization is not directly involved in specific ALC initiatives, we actively participate in discussions and collaborations related to client discharge from hospital and/or transition to another care environment. Through our work on the Vulnerable Seniors Partnership (VSP) and as a site with a Primary Care Outreach (for Seniors) team we are regularly abreast of the ALC challenges facing the Champlain region and work at both a systems level and client level to support our seniors requiring or facing transitions between different sectors of health care. For instance, the VSP is currently reviewing discharge policies and protocols at different hospitals in Champlain (both acute care and complex continuing care hospitals) to see how we can improve inter-agency communication and gaps. CCHC also actively engages with CCAC and the LHIN on the change management process for implementing the recommendations from Patients First.

At the client level our primary care team, especially our Seniors Outreach team consisting of nurses and community health workers, coordinates with various partners such as discharge planners at the hospital, CCAC, homecare services, caregivers and other providers to ensure there is are safe discharge/transfer plans that appropriately consider individuals' health needs and social situation.

Engagement of Clinicians, Leadership & Staff

The shared quality improvement goals and commitments are informed through consultations with clinical staff and the leadership team. Regular updates on QIP progress occur at staff and board meetings. Interdisciplinary front line staff also play a key role in the planning and implementation of quality initiatives and change ideas.

As we prepare for a new strategic plan for 2018, we held a joint board-staff session to discuss together the trends and challenges faced by our clients and community, and brainstormed opportunities on the role CCHC could play. We also administer a routine anonymous staff survey every 36 months to seek feedback and assess employees' satisfaction in several domains of their work life. The survey is coordinated with other Ottawa CHCs so that comparisons can be made and trends identified across sites. The survey was recently conducted late 2016/early 2017 and preliminary results were shared with staff in March 2017. The results will be further analysed by teams and the management team. This information will be used to inform quality improvement initiatives.

Resident, Patient, Client Engagement

CCHC is focused on creating a positive client experience, and delivering high quality services and programs to respond to the changing needs of its community. Within the QIP, CCHC has maintained high achievement related to patient-centred care, scoring over 90% on indicators within our in-house survey on aspects such as: patients/clients having opportunities to ask questions about recommended treatment and being involved in decisions about their care. The annual in-house client satisfaction surveys are also used to inform CCHC's operational plan, including shifts in programming.

This year we also participated in the Be Well Survey, along with various other members of the Association of Ontario Health Centres (AOHC). The survey is designed to collect data on the wellbeing needs of our clients and communities. It was available in 5 languages and 258 surveys were completed at CCHC, of those 85% were clients of the centre. Raw data has been received and more detailed analysis is forthcoming on cleaned data.

We continue to look into other avenues for gathering client feedback. In preparation for our next strategic plan we have reviewed local and client data, and performed several community consultations. A series of guided discussions took place between July and September 2016 involving approximately 220 individuals. This involved asking clients and community members about what we do to support them and their family, what issues they face, and what we could do better and how we could be more welcoming. We also engage our clients with key consultations on health service planning, such as Trans Health services, and Health Links and Patients First consultations.

Finally, the composition of our board of directors and board committees, such as our Quality Improvement Action Team, includes residents of the community, some of whom use our centre's services and provide valuable feedback on our programs. We have over 300 volunteers who are residents of our community, and many of whom also use our services.

Staff Safety & Workplace Violence

CCHC complies with all legislated requirements related to staff safety and workplace violence, and reports back to the Board on this routinely. CCHC has an Occupational Health and Safety committee with joint membership from employees and

management to review workplace safety matters. Occupational Health and Safety is also one of the areas focused on in the staff survey.

Workplace inspections occur monthly, with identified issues actioned by the appropriate manager/director. A workplace violence risk assessment was also conducted this past year. In June 2016 CCHC received a routine workplace inspection from the Ministry of Labour (MOL). A final report was received early July with no outstanding orders and no further orders issued. MOL inspectors nonetheless provided helpful feedback on areas of workplace safety in which CCHC could improve. Those suggestions have been implemented and/or are actively being pursued.

Throughout the change management process from a security guard to a client navigator/community support worker position there have been several evaluations and check points with staff and clients to obtain feedback. Recommendations related to increased training, staffing coverage and modifications to the physical environment have been pursued and continue to be monitored. For instance, in 2015 Centretown CHC introduced Non-Violent Crisis Intervention training for all staff. We have embedded it within our mandatory training for all new employees where it is applicable to the nature of their work and actively monitor when staff are due for refresher training. The transition to a client navigator/CSW has led to a reduction in incidences as situations that could have potentially escalated were avoided or diffused with appropriate client-centred engagement and support.

Contact Information

To learn more about our QIP, please feel free to contact Lynsey James (Director of Primary Care) - Quality Improvement Action Team management liaison at ljames@centretownchc.org or 613-233-2317 x2123.

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
Quality Committee Chair or delegate
Executive Director / Administrative Lead
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)