Ontario Health
Quality

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 25, 2020

OVERVIEW

Access Alliance Multicultural Health and Community Services (Access Alliance) is a community-governed agency. It provides community-based primary health care to vulnerable (socially and medically) people with a focus on immigrants, refugees, and racialized communities. Our care and support is inter-professional and team based. It ranges from prevention to intervention with strength in quality improvement, interpretation, research, knowledge mobilization and evaluation.

Access Alliance implements a Continuous Quality Improvement (CQI) approach, which is collaborative, integrated, scientifically sound, and impact-oriented. We systematically gather evidence from our electronic medical record database, through annual Client Experience Surveys and quarterly Community Reference Group (CRG) meetings to inform our work. We incorporate the 'Quadruple Aim' of the Health (Quality) Ontario approach:

• Value and efficiency - We use the CQI approach to identify the root causes for any issue, reduce waste in the system, and to maximize resources for impact-oriented change.

• Patient experience – We place the patient and their community at the centre of our work in order to plan the best possible quality of primary care, by the correct service providers, at the correct time.

• Provider experience – Service providers are involved in and lead QI and planning processes of the agency.

• Population health – Access Alliance is envisaging how to improve health equity among distinct population groups, as well as how to improve the health of the overall population. We respond to the community, and they participate in agency wide and program specific planning processes. We also support community-health organization capacity across the province around equity-informed planning and evaluation practices.

Access Alliance has three service locations in Toronto, each in a different sub-region and connected to a different Ontario Health Team (OHT) - all at various stages of development. Our report reflects our QI activities as an organization and the QI work we engage in with CHC and OHT partners. Our participation in the West End Quality Improvement (WEQI) initiative, a regional CHC collaborative QI platform, is also highlighted in this report.

DESCRIBE YOUR ORGANIZATION'S GREATEST QI ACHIEVEMENT FROM THE PAST YEAR

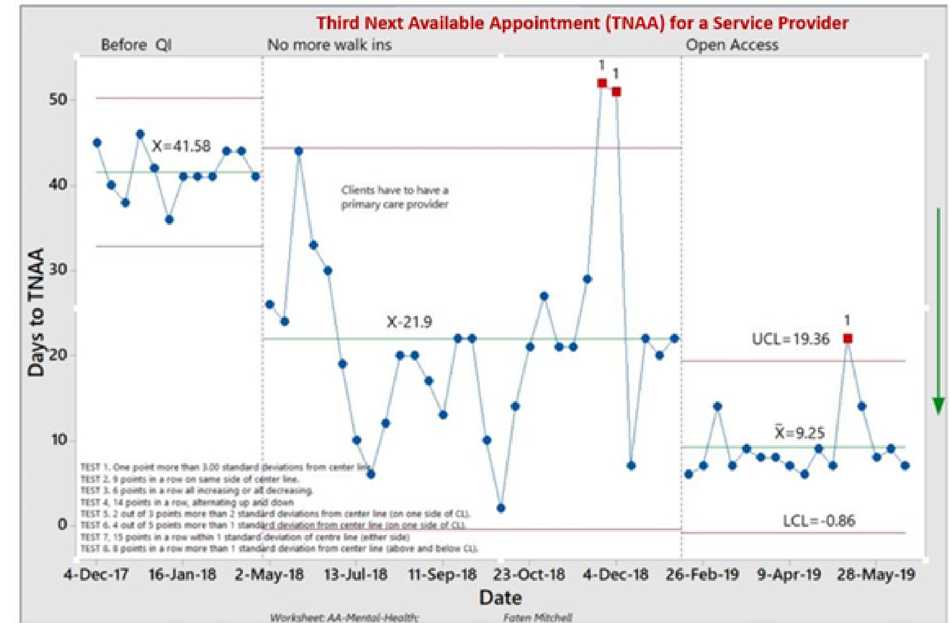
Access Alliance has a number of quality improvement initiatives in the area of primary care, allied health care, and community programs. In this report, we are highlighting the experience of the Therapist Team in implementing their own QI initiative.

Over the last two years, Access Alliance needed to transform their mental health service delivery model in order to respond to the increased demands for counselling therapy services. Within Access Alliance's interdisciplinary health care team, lengthy wait times prevented clients from accessing needed mental health care services from the therapist team and impeded referrals from

Primary Care. The therapist team reported feelings of stress resulting from an inability to respond appropriately to the needs of their clients. Primary Care was having to refer clients externally as they were unable to refer clients internally due to wait times.

In order to reduce the wait time and improve mental health services for our clients, we embarked on a quality improvement journey. We developed an inter-disciplinary quality initiative that used LEAN methodology to understand root causes of the wait time. Based on the findings, we implemented a new process by developing a prioritization structure and an Open Access process. The prioritization structure ensured that clients with immediate needs were able to receive timely service and support. The development of an Open Access Model ensured that clients could call in and book an appointment within five days of their request. These system changes have significantly reduced the wait time and improved service delivery.

The attached figure demonstrates the impact of the Access Alliance's QI initiative on the wait time to see a counsellor therapist (measured using third next available appointment- TNAA) at Access Point on Jane during the time-period of December 2017 to May 2019. This univariate Control Chart was used to monitor quality of one indicator- Third Next Available Appointment. The chart contains a centre line that represents the mean value (X) for the in-control process. Two other horizontal lines, called the upper control limit (UCL) and the lower control limit (LCL), are also chosen to check if almost all of the data points will fall within these limits as long as the process remains in-control. The goal for this QI initiative was to reduce the wait time to between 14-28 days. The initiative was successful in reducing the wait time from 41.58 days to 9.25 days.



COLLABORATION AND INTEGRATION

(A) Integration with Three OHTs in Toronto

Access Alliance recognizes that partnerships are critical for creating positive change in the areas of access, health equity, and client engagement. To drive this forward, we are collaborating with three OHTs (because we have three primary care locations across the city), which are at varying stages of development.

1. East Toronto OHT (Status of OHT: Approved): Access Alliance is one of the four CHCs, comprising the East Toronto CHC Network, working with this OHT. The three others are South Riverdale CHC

(SRCHC), East End CHC, and Flemingdon CHC. SRCHC is one of the Anchor Partners of this OHT, and represents the East Toronto CHC Network. The network signed a MOU, to formalize their collaborative commitment. We have been working closely together and share a number of programs and initiatives. Looking ahead, the CHC network has developed a collaborative plan with shared priorities (e.g. collaborative QI, chronic disease programming, etc.). Collaborative work is also extended to hospitals and community partners, including with Michael Garron Hospital to reduce emergency department surge during flu season, as well as on COVID-19 pandemic planning. This OHT is striving for “A system without discharges. Characterized by a seamless continuum of care. Focused on population health. Programs tailored to our 21 local neighborhoods. Grounded in the quadruple aim.” Priority populations for this OHT partner CHCs include seniors, people with chronic health conditions, youth with mental health issues, and people experiencing substance abuse.

2. Mid-West Toronto OHT (in development): Access Alliance is working with our CHC partners and over 60 other agencies, in this OHT, regarding support and care for vulnerable populations that improves integration, transitions and continuity in care. Emphasis is being placed on client’s ability to navigate and self-manage their care. Additional emphasis is being placed the importance of active client participation in the design of the system and the commitment to building a system for vulnerable clients that will in turn work for all. Priority populations are frail seniors, and people with mental health / substance use or experiencing homelessness.

3. West Toronto OHT (in development): Access Alliance is working with CHCs and other agencies in the west end to develop a common vision, population and structure for what will become an OHT submission. Priority populations for this OHT partner CHCs include frail seniors, people with COPD, and seniors with mental health issues.

(B) Multi-agency collaborative approach to QI (WEQI)

Collaboration optimizes quality related efficiencies and improvements. In last year’s 2019-2020 QIP Narrative, Access Alliance highlighted West End Quality Improvement (WEQI) as our greatest achievement in quality improvement. The collaborative is made up of 6 CHCs that are jointly working on QI initiatives and developing effective practices to improve and maintain quality in the care and support of our client’s and to enable CHCs to have a stronger evidence based voice in primary care reform. In this way, pooling resources, selecting common areas of focus, and sharing learnings throughout were deemed the best way of maximizing the impact of our QI efforts.

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

As a CHC, we have developed expertise in effectively engaging clients and capturing the experiences of communities who face barriers to health and wellness. Patients/clients, as described in detail in last year's QIP, continue to be engaged in the agency's planning processes via key structures (e.g. Advisory Committees/Councils, Community Reference Groups, etc.) and mechanisms (a comprehensive, iterative Client Experience Survey process through which survey findings are contextualized through focus groups, and validated through designated discussions).

During development of the OHT partnership, we are advocating for the application of co-design principles to ensure that the voices of patients/clients/caregivers and residents are actively incorporated into program/service planning as well as QI initiatives. Such a practice will not only have an impact on service provision, but it will simultaneously contribute towards an effective transition of the system through empowering the broader community. To this end in the Mid-West Toronto OHT development meetings we advocated for full co-design principles and practices to be utilized. Locally, we did a community health needs assessment (CHNA) for Rockcliffe-Smythe using a co-design process. Members of the Community Reference Group volunteered as 'Community Animators' for supporting the activities. They were trained for collecting data and data security and reached other community members through their established networks.

WORKPLACE VIOLENCE PREVENTION

Yes, workplace violence & harassment is a strategic priority for the organization.

• Board & Senior Management annually sign an OHS Policy statement to provide and maintain a healthy and safe workplace for all (posted on OHS bulletin boards across sites)
• Board & Labour Management Committee receive annual reports on general OHS items, training conducted throughout the year, incidents and complaints from staff/clients, compliance with major legislation such as Bill 168 etc.

The Workplace Violence and Harassment Prevention Program includes:

• Various policies, protocols and procedures: (a) workplace, domestic violence, bullying, harassment, sexual harassment, discrimination (b) managing difficult/disruptive client behaviour, (c) terminating client/non-client relationships.
• Evaluation and implementation of corrective action; e.g. monthly hazard inspection report has a section asking employees if they have concerns about violence related issues; control measures in place include assistance buttons, use of gates & restricted areas access.
• Reporting and investigation processes & Annual Risk Assessments (using Preventative and Risk Assessment Forms).
• Quarterly, JOHS Committee reviews reports on incident statistics to monitor conditions and improve on existing prevention strategies.
• Annual & On-boarding Training and education for workers:

o Review of Workplace Violence & Harassment Policies and procedures including available tools such as assistance buttons, paging codes, reporting forms, availability of Employee Assistance plans for employees
o Annual group training for front line staff on conflict management/resolution and de-escalation techniques (and as needed, one-on-one to provide assertiveness training)
o OHS Handbook has a section on Violence, Harassment and Psychosocial Hazards in the Workplace
o Annual lockdown drills, who and how to respond to assistance button alarms etc.

As our current processes are working effectively, our goal is to sustain and maintain these practices.

ALTERNATE LEVEL OF CARE

CHCs recognize that Alternate Level of Care (ALC) is a cross sector challenge, which is driven primarily by hospitals. Access Alliance is doing its fair share in terms of addressing this challenge. CHCs are working individually and as a sector to strengthen preventative care through full team-based care, and by creating pathways and processes for reaching vulnerable populations in order to provide them with on-going primary care. Regional CHCs are also working jointly to identify the opportunities for effective alternate levels of care that fit with the CHC model of care.

For example, Access Alliance provides a walk in service along with 5 CHC partners that allows Non-Insured residents to access a PCP and also be connected to primary care through the walk-in. Providing the walk in for NI residents mean they only have to go to the emergency room when appropriate.

Access Alliance will work with partners to support the home visit program for frail seniors with complex health conditions, one of a number of initiatives which supports keeping clients in their own home. In addition, we started working jointly on designing plans to improve standards and processes of practice, to offer walk-in models for our clients as well as unattached vulnerable populations, and to establish a process to follow-up on clients/patients when released from hospital. In this way, the CHC network will continue to build collaboration with the East Toronto OHT to address systems pressure on alternate level of care.

VIRTUAL CARE

Many of the CHCs in the region use the same EMR and most are moving to adopt PSS. We are working together to explore utilizing this EMR for virtual care, which could include online booking, etc. Many CHCs currently make use of eConsult available through OntarioMD and other platforms. Access Alliance is looking forward to any partnership opportunity for working in this area, considering the model that our MDs/NPs are salaried.

Access Alliance has an efficient Language Services department, which provides interpretation services to our clients, and offers an immediate phone interpretation via the Remote Interpretation Ontario (R.I.O) Network. This is a means of virtual care, and represents an existing support that allows this service to be taken up by other providers.

CONTACT INFORMATION

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OTHER

• We are in a transition phase for shifting our electronic medical record system from NOD to PSS. We're developing some processes, in consultation with partner CHCs, to make the new system more efficient to improve quality of our programs and services.

• We are collecting data on health equity indicators from our clients and reporting to TC LHIN. We are using the gathered information as (i) an accountability item to the HQO (e.g. same day/next day appointment), (ii) an evidence-informed dashboard to improve the quality of the programs and services, and (iii) a learning opportunity. This is one of the ways to establish the Learning Health System for the best use of data.

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 ________________________________

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Board Chair

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Quality Committee Chair or delegate

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Executive Director/Administrative Lead

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Other leadership as appropriate

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