Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 15, 2024

PARKDALE QUEEN WEST Community Health Centre

Ontario Health

OVERVIEW

PQWCHC's mission is to provide equitable, accessible healthcare for people when, where and how they need it. We have a very high SAMI at 2.0 and have been at 85% of our panel target for two years. Our priority populations include individuals who experience houselessness, are uninsured, identify as Indigenous, identify as trans, and individuals who use drugs.

This past year, we focused on improving our clients' access to care. Given our high panel size, it can be challenging for our clients to book timely appointments. We have improved our RN triaging systems and increased the number of same day urgent appointment slots while continuing to take on new clients.

A team of clinicians is exploring the development of a child/youth trans program, as the need for safe and supportive primary care for trans youth is great. We have developed a trans youth advisory committee to inform the development of the program.

We continue to focus our cancer screening efforts on our most marginalized populations, including cervical cancer screening within the Hungarian/Roma community in Parkdale.

And this year we began a lower limb preservation project by looking at barriers to increasing our rates of annual foot assessments for our clients with diabetes.

Our quality improvement strategies and work continue to be supported by our participation in the West-End QI Collaborative (recently re-named to We Energize Quality Improvement), a joint initiative of PQWCHC, Access Alliance CHC, Davenport-Perth CHC,

Unison CHC, and Regent Park CHC. The WEQI collaborative continues to develop best practice within CHC settings in order to improve our performance related to the key MSAA indicators, including timely access to primary care, and screening for cancer.

ACCESS AND FLOW

Our Mobile Health Clinic delivers primary care to several shelters and congregate living spaces in our catchment area. An evaluation of the program was completed in the summer. 36.7% of the respondents noted that had it not been for the mobile health services, they would have sought care at the ED; 18.4% would have not sought care at all. In addition to providing care through our mobile clinic, we have clinicians who attend a number of other organizations to provide on-site care to clients who are less likely to come to our centre; e.g., Parkdale Activity Recreation Centre, Soujourn House, Sprott House, Y House, Central Toronto Youth Services.

We increased access of primary care for our Indigenous clients this past year by having one of our NPs be available on Fridays on our first floor during the Niiwin Wendaanimak program, and by setting aside spaces in our dental program on Thursdays for Indigenous clients. This has encouraged more engagement in primary care with one of the goals being diversion from the ED.

PQWCHC is partners with UHN and The Neighbourhood Group to run the Stabilization & Connection Centre. The Centre opened in December 2022 and provides a space for individuals experiencing the effects of alcohol or drugs, who are medically stable, to rest for up to 24 hours and be connected to services. One of the goals is to divert individuals who might otherwise wait in the ED, freeing up space in the ED and enabling EMS to get back on the road. The average wait time in the ED for EMS can be 3-4 hours; the average time to drop off an individual at the Stabilization & Connection Centre is 10 minutes.

ADMINISTRATIVE BURDEN

Innovations to reduce the admin burden felt by our team require funding and there is no funding to be found. We are fortunate to engage with e-referral at no cost to us, although only about 10% of our referral base is on e-referral, resulting in us having to maintain two workflows, one for those who accept e-referrals and another for those who don't. Online appointment booking, while convenient for clients who have the digital access to use it, is quite administratively burdensome for the practice. We applied for a grant to explore the use of AI scribes although what would really help is an AI tool to complete the many forms our clients request from us, mostly related to income supports (we understand those tools do not exist yet). Like all EMRs, there are advantages but also burdens to the number of items to click off, coding to complete, etc. in order to gather data to be used for population health planning, and these tasks are born by the clinician.

We would note that at a recent meeting with OH regarding data security, the OH lead was focused on hospital data security (wasn't familiar with CHCs, AHACs or NPLCs). It is not clear to us if data security is expected to be managed at the OHT-level, with funding flowing from hospitals to community, or if community agencies, including CHCs, are expected to self-fund both digital innovations and data security through some other method.

EQUITY AND INDIGENOUS HEALTH

All staff and management participate in ARAO and Indigenous Cultural Safety training. This year, as part of the recognition of National Day of Truth & Reconciliation, a team of staff and managers ran an engagement with the staff to explore the ways we have advanced reconciliation and the work that still needs to be done. From that, we have developed an action plan for moving forward that includes:

1. Increasing opportunities for ongoing learning and reflection related to the work of reconciliation and decolonization
2. Creating Indigenized pathways and supports within and between programs for Indigenous clients and community
3. Continuing our work with Kwewok Nakhii consulting services to formulate a vision and plan for the Niiwin Wendaanimak program to have greater leadership and organizational support that is Indigenous-led
4. Incorporating tools and processes for new projects or organizational work that ensure that impacts on Indigenous staff and clients are formally considered and how Indigenous voices and perspectives can be included in the process
5. Engaging our two unions to discuss if current labour relations practices reflect TRC calls and how we could jointly work toward that goal.

In addition, our Mental Health team is interested in exploring ways to decolonize mental health services.

We have applied for funding under the OH Black Health initiative to hire two NPs to work primarily with the migrant clients (most from African countries) who have overwhelmed the shelter system over the last year. While the Red Cross is now supporting these clients who are sheltered in two hotels in North York, Black Creek CHC has done quite a lot of work with these clients and our mobile health unit has assisted in providing supports, as well.

PATIENT/CLIENT/RESIDENT EXPERIENCE

We engage clients and communities in a number of ways:
- we conduct an annual client experience survey
- we conduct program evaluations that focus on client experience: this year, we completed an evaluation of our Managed Alcohol Pilot Project, and UHN worked with us to complete an evaluation of our Mobile Health Clinic
- our Safer Opioid Supply program has a client advisory group
- we have a seniors' advisory group
- we have a new trans youth advisory group
- our Parkdale site has engaged the local community in community meetings to better understand neighbourhood issues related to the clients we serve
- we engaged some of our clients with diabetes to help inform our lower limb preservation project
- our Safe Consumption Services have engaged with the local police divisions, particularly in presentations to new recruits, to provide information on stigmatization of drug use, the purpose of SCSs, and how the police can better work with our agency. After a COVID pause, we are also starting our SCS community advisory groups again.

PROVIDER EXPERIENCE

While a high SAMI score results in an expectation that the organization will care for fewer clients (high acuity requires more individual client attention), there is a feeling among primary care providers that the calculation does not adequately address the incredible administrative burden of caring for high-needs clients, in addition to the increasing client expectation for email "care" between appointments, and of expected involvement in OHT-level initiatives and organizational QI projects. In the past, involvement in projects was a nice break from the routine, day-to-day work and while there is provider commitment to continuous improvement, it can feel like a burden, another task added to the many already on the list.

In addition, our providers tolerate a high degree of escalated client behaviours that many organizations refuse to tolerate. Our providers understand that those who are the most marginalized are rarely heard and so raising their voices is the only way they know how to be heard. The recognition of this does not decrease the anxiety and weariness that providers feel as a result of these behaviours.

To better support all staff, we offer staff Crisis Intervention & Prevention training. We have also trained a group of staff to offer critical incident support. This is particularly important as the number of client incidents involving self-harm and violence (verbal and physical) has increased over the last several years.

For our harm reduction teams in particular, we have organized grief groups to help support staff after the loss of a client. A Grief Committee organizes events to memorialize clients we have lost while still respecting privacy and confidentiality.

SAFETY

There have been no reported adverse events to clients as a result of medical interventions/care.

This is the second year in which we have seen a significantly increased number of overdoses, both inside and outside of our Safe Consumption Service, and harm reduction and clinical staff respond to these. We are establishing a series of drills at each of our two main sites to practice medical emergency response and these drills involve both clinical and harm reduction staff. For harm reduction staff working in the sheltering hotel sites, regular training is provided to respond to overdoses.

Second to the toxic street drug supply, the other significant patient safety issue PQW clients face is the lack of permanent shelter/supportive housing beds. The number of clients living on the street because of a lack of permanent housing is unacceptable. We continue to advocate for more permanent, RGI (Rent-Geared-to-Income), supportive housing and to that end, are exploring the possibility of building RGT units over top of our Parkdale site's building.

POPULATION HEALTH APPROACH

As a member of the Mid-West Toronto OHT and co-chair of the Quality & Evaluation Working Group, PQWCHC has been involved in developing the Mid-West OHT's cQIP (see that document for further details on population-based planning and projects).

PQWCHC has been involved with several other collaborative projects to advance population health:
1. Mid-West Toronto OHT project on the Congestive Heart Failure Quality Based Program with UHN, Sinai Health, Women's College and Unison CHC.
2. Mid-West Toronto OHT COVID recovery program (Open Door).
3. Mid-West Toronto OHT Steering Committee on Lower Limb Preservation.
4. One of the authors of Ontario Health's Black Health Plan for Ontario and the tri-Chair for the Black Health Plan Table (Angela Robertson).
5. Working with Toronto Public Health to increase access to the Low Income Seniors Dental Program.
6. Parkdale Infant Nutrition Security Targeted Evaluation Project (PINSTEP) to increase access to lactation supports, including a recent 5-year evaluation conducted by U of T researchers with some PQWCHC staff.
7. Working with Toronto Shelter Services, Inner City Health Associates and other partners to ensure healthcare needs of unsheltered individuals are met.

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

Quality Committee Chair or delegate

Executive Director/Administrative Lead

Other leadership as appropriate