Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 30, 2025

CommunitiCare Health

Ontario Health

OVERVIEW

CommunitiCare Health (CCH), formerly West Toronto Community Health Services, is a first-of-its-kind-in-Ontario community health care agency providing a single point of contact for primary care and community health and support services, home care and community mental health services with supportive housing. Formed by the 2021 amalgamation of Regeneration House Inc., Storefront Humber Inc. and The Four Villages Community Health Centre, we are a new model of community care in West Toronto, offering a unique blend of community support, community mental health and addictions services, primary health care and home care.

Our 2025/2026 Quality Improvement Plan is aligned to two of our strategic priorities:
1) Ensuring a connected client journey, and
2) Improving population health.
We have taken an agency-wide approach to developing Quality Improvement Plan (QIP) initiatives that are pertinent to our three service areas: Primary Care and Allied Health, Mental Health and Addictions Supportive Housing and Case Management, and Home Care and Community Supports.

The CCH Board of Directors has a central focus on quality and holds the Chief Executive Officer accountable for quality performance. The QIP forms one component of the organization's quality-related work. CCH views quality as strategy and is building a foundation and culture of quality using a "Whole System Quality" approach with focused work occurring in each of the core areas of Quality Assurance, Quality Control, Quality Planning and Quality Improvement.

ACCESS AND FLOW

CCH is committed to increasing access to care to achieve at least 100% of expected access to care performance and providing team-based care at the right time at the right place. We have implemented a number of initiatives to achieve that end:

1) We have implemented a first point of contact function within the organization where prospective clients have access to information on CCH services and can get connected to all CCH services, where previously multiple points of contact were in place for each individual service area.

2) We are seeking to analyse data on reasons for hospitalizations and emergency visits among Home Care and Community Support clients to understand reasons for these hospital encounters and identify ways to prevent them from occurring, helping to ease pressures on hospital emergency departments and inpatient beds.

3) We have expanded our Interprofessional Primary Care Team to add 2 new physicians and nurse practitioners, and are in the process of recruiting a third, doing our part to reduce the number of people in West Toronto without a primary care provider.

4) Our primary care intake process has been streamlined to now involve a single phone call that ends with a first medical appointment scheduled

5) Same day/urgent primary care appointments and same day primary care triage for time-sensitive issues are available for primary care clients

6) We have partnered with Unity Health (St Joseph's Health Centre) and Dr. Ayaz Kurji to provide access to psychiatry services, including on-call psychiatry support for primary care teams, to allow timely assessments and supports to the care team, ensuring timely follow-up and consultations for clients.

EQUITY AND INDIGENOUS HEALTH

By its very nature, CCH has been built to target the needs of underserved populations:

• Our primary care services are provided through the Community Health Centre (CHC) model which focuses on improving the health and well-being of populations who have traditionally faced barriers accessing health services because of geographic isolation or cultural or language barriers and who have a higher burden or risk of ill health due to socio-economic status, age, social isolation, mental health issues, gender, sexual identity/orientation, or other factors

• Our mental health and addictions services focus on providing housing and supports to this underserved and vulnerable population

• To best meet the needs of our clients who face health issues and/or have chronic health conditions due to challenges with the social determinants of health, CCH has purposefully integrated the core community health and support services that are funded by the MOH/OH allowing CCH to provide full "wrap around" community health and support services to keep our clients healthy at home and living in the community.

At the same time, we know we can always improve. As part of our 2024/25 QIP, CCH worked to implement a new equity data collection tool, and we are now starting to use that data to better understand our client populations and their needs. We also implemented equity, diversity and inclusion training across all of our services areas in the last year.

PATIENT/CLIENT/RESIDENT EXPERIENCE

At CCH, we have a multi pronged approach to receiving feedback around client and community experience. Client Advisory Councils are in place for each service area (Primary Care, Home Care and Community Supports, Mental Health and Addictions). Through these Councils, clients have provided input into program planning, our new website development and our strategic plan. The Councils have also reviewed the Provincial Declaration of Patient and Family Values and are working with our Director of Communications to tailor it for the clients and communities that CCH serves. We are also conducting our first coordinated client experience surveys across the organization. These surveys have both common questions across all three surveys to provide an organization-wide overview of client experience and unique questions for each service area to reflect the very different programming and client services provided. Once the survey results are received, we will assess results to identify areas for improvement and initiate project teams to address any identified improvements needed.

We have introduced a new Client Relations Lead role within the organization and have developed a single, streamlined client complaints and feedback process across the organization. This will help understand themes and trends across the organization and will help inform the development of future QIPs.

PROVIDER EXPERIENCE

CCH, like other healthcare organizations, is experiencing challenges with burn-out, employee absences due to illness, recruitment and retention. Fortunately, some health care professionals are attracted to working in the community in a team-based environment which has helped to address challenges with recruitment and retention. As part of our post-amalgamation work, CCH implemented an agency-wide staff survey to gather information on the experiences and needs of staff. Several organization-wide opportunities for improvement were identified through this survey, particularly in the areas of communication and innovation. In response to staff feedback, we have:

- Implemented a Staff Advisory Group, meeting quarterly, to provide a dedicated forum for staff input and feedback on organizational initiatives
- Begun implementing a CCH intranet to better share information with staff.

SAFETY

CCH has processes in place to report, respond to and follow-up on client incidents. Once such an incident occurs, the first priority is to ensure the client(s) involved are safe and receive any immediate care or supports required. Supports required by any staff or other clients involved or witnessing the incident are also provided. Incident reporting and debriefing, and any additional information gathering occur thereafter by the appropriate Manager/Director. Incidents are reviewed to identify root causes and any actions required to prevent such incidents from reoccurring in the future. Client safety incidents are also reviewed for trends; when trends are identified this may generate additional action items to reduce certain types of incidents, including providing additional education to staff, changing care processes or other interventions.

PALLIATIVE CARE

CommunitiCare Health does not directly provide palliative care services to our clients. We do liaise and connect with hospital, hospice and other palliative care teams to ensure needed care is in place for our clients, including support for family members and loved ones, while we continue to provide primary care and other services. Outreach was made to a local community hospice provider to have CCH offer a community hospice coordinator to link with the local hospice provider – these conversations are on-going.

POPULATION HEALTH MANAGEMENT

CCH's commitment to population health is clearly reflected in our strategic plan through our Strategic Priority 3: 'Improving Population Health Through a Concerted Focus on Health Inequities.' Initiatives supporting this Strategic Priority include:

• Leading and coordinating the Solo Practitioners in Need Plus (SPIN +) initiative whereby clients of solo primary care providers who are not connected to allied health, rehabilitation, and home and community care support are able to access these services through CCH. Embedded care coordination through OH@Home is an integral part of this initiative.

• Participating in the Toronto West Ontario Health Team (OHT) program making services available to two Toronto Community Housing buildings in our catchment area. The majority of residents in one of the buildings are Somali and Korean, while the other comprises Ukrainian, Spanish and Polish communities

• Allocating funding from the Hip and Knee Osteoarthritis Conservative Management Pilot 2 communities with limited to no access to rehabilitation services (served by Unison Health and Community Services and Black Creek Community Health Services) to provide access to the GLAD (Good Life with Arthritis) program for black communities and people of colour.

• Operating a satellite food bank in partnership with the Daily Bread Foodbank since 2020; a significant proportion of clients using this service are people of colour.

• Beginning construction of a third Primary Care site at 209 Mavety Street to provide interprofessional team-based care to the Junction neighbourhood, repurposing a vacant police station and repurposing it as a community asset thanks to the work of the Junction Commons Project who conducted the initial feasibility study, community engagement and ultimately partnered with CCH to implement

• Expansion of our interprofessional primary care team as a result of funding received from the Ministry of Health to address the shortage of primary care practitioners; as a result of this work we are receiving referrals from the Centre for Addictions and Mental Health (CAMH) to our expanded primary care team and we are

currently working with LOFT Community Services to explore how the expanded primary care team can support LOFT clients
• Contributing to health system planning so resources can be better allocated to achieve the goals of the quintuple aim: enhance patient experience, improving population health, reduce costs, improve the work life of providers and achieve health equity
o We are doing this by establishing key partnership to address gaps in services, streamline access to services and care pathways and make services available on-site where possible

CCH's amalgamation in 2021 has enhanced our capabilities to work with a population health focus and provide a more comprehensive set of services to our client populations. Some of our work providing more comprehensive services include:
• Mental Health and Addictions supportive housing clients are now receiving chiropody services from our Primary Care team
• The Primary Care services Integrated Community Based Care team works with seniors in our Home and Community Support Services programs to provide group programming such as Strong and Steady which helps reduce the risk of falling
• Our Primary Care rehabilitation team provides OT/PT assessments to some of our elderly clients receiving Home and Community Support Services.

ADMINISTRATIVE BURDEN

CCH has continually identified ways to streamline our processes and reduce the administrative burden on our clinical team members over several years. Improvements made in these areas include:
• Creating standardized templates for joint appointments (e.g., for well-baby and well-child visits) allowing a common charting tool to be populated and used by team members from multiple disciplines
• Incorporating check boxes and other tools into the primary care Electronic Medical Record (EMR), allowing clinical team members to quickly select common diagnostic codes increasing the completeness and accuracy of diagnostic information and reducing the need for duplicate coding processes
• Clinicians can identify "favourite" templates used frequently in the primary care EMR, to more quickly find and open the templates they need for charting
• The primary care EMR dashboard has been enhanced to include information on upcoming screening due for clients (e.g. cancer screening, the need to update health equity data, etc.)
• Primary care teams use eReferral workflows wherever they have been established, though there are still some services not available in eReferrals
• The CCH EMR is used for secure messaging with clients and among primary care team members and is also used to send personal health information between providers and clients when appropriate consents and permissions are in place
• Selected, key team members within the primary care circle of care and who work for other organizations (e.g. Ontario Health at Home Care Coordinator, Psychiatry staff from Unity Health (St. Joseph's Health Centre) and private practice, diabetic care staff from LAMP Community Health Centre) have access to the CCH primary care EMR which reduces the need to, and delays associated with, send client records to these team members
• Referrals to the primary care team are received through efax, which has replaced traditional fax machines in regular day-to-day operations
• Primary care team members also have access to or use:
o eConsults through the CCH EMR
o Ontario Laboratory Information System to access lab reports

o Health Report Manager to access hospital discharge reports, other hospital reports, diagnostics reports, etc.
o Electronic prescribing
• For new primary care clients, registration, health equity data collection form and medical history (information required for intake) are all automated, completed digitally and populate the EMR once they are completed, eliminating the need for paper forms and manual data entry by staff
• QR codes are used to launch a primary care intake form that can be completed on a phone for potential clients interested in medical services; the information automatically populates a tool to enable staff to follow-up with those potential clients and track data collection
• Conducting a trial of AI Scribe, used during primary care appointments to create physician/nurse practitioner notes; this was positively received by physician and though the trial has ended, CCH is exploring options to implement this tool on a permanent basis

Our next improvements to streamline processes and reduce administrative burden on clinical team members include:
• Piloting the use of tablets:
o During first appointments with patients who do not have access to or do not use digital technologies, to complete intake forms which then automatically populate the EMR
o To complete various assessments forms digitally, which then automatically populate the EMR

CONTACT INFORMATION/DESIGNATED LEAD

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OTHER

No other comments

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 **March 30, 2025**

Rachel Conway, Board Chair

Lisa Dess, Quality Committee Chair or delegate

Tariq Asmi, Executive Director/Administrative Lead

Alfred Ng, Other leadership as appropriate
