Let's Make Healthy Change Happen.

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

South Riverdale COMMUNITY HEALTH CENTRE

3/26/2018

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

South Riverdale Community Health Centre's (SRCHC) Quality Improvement Plan is aligned with the organization's Strategic Plan, Operational Plan, the Multi-Sector Service Accountability Agreement (M-SAA) with the Toronto Central Local Health Integration Network (TC LHIN) and the agency's balanced scorecard monitoring framework.

SRCHC's mission is to improve the lives of individuals that face barriers to health and well-being. The organization will meet its mission through focusing on leading system transformation, maximizing positive impact in communities through collective action and strengthening organizational capacity. We are committed to leading systems change by both building an organizational culture that focuses on quality and working in partnership with a range of organizations to deliver services/programs that enhance care pathways and reach across the continuum of care.

The agency's Quality Improvement Framework focuses on the application of a health equity approach to help increase access, reduce barriers and improve health outcomes for priority populations. SRCHC's quality improvement objectives for the upcoming fiscal year are:

- Expand access to primary care and health promotion supports, with a focus on priority populations including individuals with mental health/substance using/medically complex conditions; people living with chronic diseases, newcomers and people living in poverty;
- Apply an equity framework to providing access to high quality, team-based, client-centred health care;
- Strive towards and promote equitable health outcomes for priority populations;
- Work at the systems and operational level, leveraging partnerships to support initiatives that enhance service integration and improve care transitions, to ensure clients are able to access the right care at the right time in the right place;
- Develop structures, systems and innovative approaches to engage service users in evaluating and co-designing how services/programs are delivered; and,
- Ensure information management tools are able to provide timely access to data that supports QI activities and accountability.

A New Electronic Client Record

It is important to note in the introduction that there are a number of challenges and risks that have been identified that may limit the execution of SRCHC's Quality Improvement Plan in FY 18/19. In April 2017, SRCHC was selected by the Association of Ontario Health Centers to be a beta site for a new electronic client record. Over the last year the team at SRCHC has worked with the AOHC and Telus to validate the transition of data from our current system to the new electronic client record and ensure the product meets the needs of provincial CHC evaluation framework and operational reporting requirements. The roll out of the product has been delayed and the expectation is that we will go live May 2018. During the transition period, we will lengthen appointment times as staff adapt to new workflows and encountering practices. The agency will also need to redesign SRCHC's robust data extraction system to support the development of timely reports for practice-level population health management, accountability agreements and quality improvement initiatives.

Describe your organization's greatest QI achievements from the past year

Clinical: Access

At SRCHC we are committed to applying a QI approach to onboarding new clients and linking them to a range of supports to address the determinants of health. Since April 2017, SRCHC has accepted 700 new clinical clients. Onboarding new clients, with complex needs is intensive work that represents approximately 1 in 5 clinical encounters during the year. New clinical clients have on average four clinical encounters as staff work to assess needs, develop care plans and link them to other services and supports at SRCHC. Within the first year, new clients have over 24% of their encounters are with allied health (social work, Diabetes RN/RD, physiotherapist etc.)

As we onboard new clients, an organizational priority has been to work with community partners to co-locate services to provide supports to individuals who face barriers to accessing care. We have expanded off-site low threshold programs (for example, a new clinic in Chester School and expanded services at the City Adult Learning Centre).

One of the barriers to expanding open access appointments was the perception that although SRCHC had developed minimum coverage guidelines, the rules were not always being applied and this was leading to problems for timely access for clients and a distributed workload for clinicians. However, when we looked at the data, the coverage guidelines were being met and clients were getting access to appointments in a timely manner. Therefore, the team did a root cause analysis exercise and from this developed a workflow that outlines how clients access services, the role of the administrative team, the triage process and clarified how we ensure seamless back-up for vacation coverage etc.

We also continue to build capacity across the clinic for same day appointments, the key challenge SRCHC faces is that a large number of clinicians work part-time and we also operate a number of specialized and off-site clinics. As of January 2017 all clinicians have advanced access/same day availability in their schedule and this year, at our main site, over 3,000 client visits were booked the same or next day Our goal, is to begin to work to increase this number by 10% to 3,300 in FY 18/19. In addition, SRCHC is optimizing the use of phone appointments (over 2,000 calls in the first nine months of FY 17/18) to monitor clients, answer questions and provide health advice.

Improving Health Outcomes: Tele-Ophthalmology Program

In 2014, South Riverdale Community Health Centre, in partnership with Dr. Michael H. Brent, Chief of Retina Services at the University of Toronto, received funding from the Toronto Central LHIN to develop a mobile screening program to assess the retinal health of individuals diagnosed with diabetes. Mobile screening clinics have been organized where a Clinic Assistant uses a mobile digital camera combined with optical coherence tomography (OCT) to perform retinal screening and the images are uploaded to a secure server using Ontario Telemedicine Network (OTN). The driver of this strategy is the recognition that access to optometrists and ophthalmologists is difficult for individuals with diabetes who live in certain neighbourhoods with high rates of diabetes and lower rates of screening. This year, the program expanded and now provides services at ten locations across the City of Toronto. Over 50% of clients screened have been diagnosed with pathology and 26% of clients have been diagnosed with Diabetic Retinopathy. The team also continues to work at optimizing the electronic medical record to support patient education and improve outcomes through the implementation of a recall system for ongoing retinopathy screening. Currently, approximately 20% of appointments are for annual recalls for screening.

Diabetic Foot Care: DECENT Program

The DECNET Program (Diabetes Education Community Network of East Toronto) provides counselling, education and support services at SRCHC, as well as a host of community satellites/locations through formal and informal partnerships. Services are available to adults with Type 2 Diabetes and Pre-diabetes, as well as specific at-risk communities with an emphasis on increasing access for individuals with mental health and/or substance use challenges and community members who might otherwise experience barriers to health and health care including newcomers/immigrants and individuals who may be homeless.

Over the last 18 months, the team have been working to develop a framework that provides a consistent approach to foot care within the diabetes program. The team has developed protocols to provide foot care education, assessment and treatment. This work has entailed:

- developing a training program for DECNET nurses, SRCHC pays for diabetes nurses to get the Advanced Foot Care Certification;
- designing a referral pathway to chiropody/primary care for clients with diabetic ulcers ;
- implementing a recall system for annual foot assessments;
- establishing a mentoring/ consultation system between Diabetic Nurses and Chiropody to support the management of client care; and,
- creating two work groups that are aligning SRCHC's policy and practices for infection control for foot care to ensure with provincial and national best practice guidelines.

In the first three quarters of this fiscal SRCHC's DECNET team completed 358 diabetic foot assessments and chiropodist have had almost 200 encounters where they have treated diabetic foot ulcers (this is a 30% increase over last year). This year the goal of the team is to focus on using a variety of health education materials to increase awareness of the importance of foot care and preventing ulcers, develop system with new EMR to track recalls for clients, referrals and encountering details for foot assessments. In addition, we have established an inter-professional work group who will be looking at building internal capacity for managing wound care, including diabetic foot ulcers. Also, our work will be supported with the provision of funding from the Toronto Central LHIN to purchase off-loading devices used to treat diabetic foot ulcers.

Resident, Patient, Client Engagement

At SRCHC, developing systems that support the active engagement of clients is central to the work of the organization. Client engagement happens at a variety of levels including governance, broader community engagement strategies and program design/delivery and evaluation.

Governance

As a community governed organization, SRCHC's Board of Directors can include individuals who access services at SRCHC. We also have an active membership. Membership is free and open both to individuals who live\work in the community and people who access services at the centre. Members have full voting rights (including at the Annual General Meeting) and can be nominated and run for election to the Board of Directors. In addition, clients/service users are involved in the development of the organization's strategic plan and other Board initiatives.

Engagement

SRCHC's goal is to foster a strong, attentive and empathetic culture that recognizes client and community engagement as the basis for improving quality of care. The centre continues to develop expertise in using innovative approaches to engage and reflect the experiences of communities who face barriers to health and

healthcare, including individuals with mental health and/or substance use challenges, experience complex /multiple social and health morbidities and newcomers. This year we talked with over 300 service users and spent over 80 hours listening to clients' stories about what services they use, what they like about programs and where SRCHC can make improvements. These results inform quality improvement activities and are reported to the Board of Directors, staff and to our community.

Service teams at SRCHC use a variety of approaches to engage clients. We have a number of client and community councils that support program planning and community engagement. For example, at SRCHC, a User's Work group meets every two weeks to support the design and delivery of our new Safe Consumption Service. In addition a Community Liaison Work Group has been created to ensure ongoing communication between South Riverdale Community Health Centre (SRCHC) and the community throughout the implementation and functioning of the supervised injection service. Another example is the program advisory committees at our new Harmony Hall program. The advisory committees are made up of service users who inform our programming for seniors in four key programming languages – Tamil, Bengali, Chinese and English.

Program Design: Staff with Lived Experience
Finally, SRCHC's client engagement work is supported by the agency's peer worker program. Workers with lived experience are hourly employees who have access to the organization's pension plan and paid sick time, as well as extensive on-the-job coaching and training supports. This employment provides service users with an opportunity to develop their leadership and employment skills which has had a significant impact on their quality of life and how services are delivered at SRCHC. Currently, 39 individuals (22% of staff at SRCHC) have lived experience and provide a variety of supports at SRCHC including peer engagement/support, health education, program design advice, group facilitation and self-management supports. This initiative has increased capacity to support quality improvement activities, the delivery of services, improved health outcomes for clients and is providing skill development/training for individuals with lived experience.
Program Design: Volunteers
SRCHC also has extensive experience training volunteers to support the delivery of programs. For example, SRCHC's Choose Health Program has 74 trained facilitators who deliver self-management programming working with 35 different health and social service organizations across the city of Toronto. The program integrates trained peer-led services where groups of 10 to 16 people learn from evidence-based skills and knowledge designed to empower them to live a healthy life.

Collaboration and Integration

SRCHC's Quality Improvement Plan focuses on integration and continuity of care, both at a systems and operational level. At the systems level, SRCHC continues to work with community partners at the TC LHIN Sub-LHIN planning tables. These planning tables allow us to work with partners to collectively improve the care pathways for the referral of unattached, complex patients who would benefit from team-based primary care.

Currently, we are working with the both the Mid East and East Toronto Sub-LHIN on a number of projects. IN the East Toronto SubLHIN we are working with Michael Garron Hospital and other community partners on coordinated interventions in the Oakridge's Community. Data from the hospital indicates that the Oakridge community has a significant number of individuals who have mental health and substance use challenges that account for a significant number of visits to the ER. SRCHC will look at expanding harm reduction programming in the community and work with individuals who access services to connect them to other community supports. We are also working to create a referral pathway from the hospital to SRCHC's COUNTERfit

program for individuals who have had a visit to the ER as a result of a drug overdose or other issues related to substance use.

In the Mid-east sub-region we are working with community partners to facilitate and coordinate a response to the overdose crisis through supporting the creation of overdose prevention sites including the Moss Park site through staff coordination and support.

Coordinated Care Planning and Service Agreements
Data from the most recent CHC practice profile for the City of Toronto(FY 16-17) indicates that SRCHC's SAMI, that measures client complexity , has increased to 1.63, meaning clients expected health care utilization rate is 64% more than the average Ontarian. 30% of our clients have ten or more co-existent health conditions that linked with worse health outcomes, more complex clinical management.

At the operational level, to improve outcomes and manage care for clients with complex health needs, SRCHC has over 50 service agreements with a variety of organizations that define roles, establish care pathways, set up coordination/communication structures and develop programming that meets the goals of individuals who face barriers to access and require supports of inter-disciplinary team-based care. Teams continue to focus on developing proactive plans in partnership with clients to anticipate care transitions both for health (specialists and acute care), social services, health promotion/health education and self-management supports. We also offer a range of practical supports that assist with care transitions including accompaniment to appointments, interpretation for clients, childcare, and help with transportation. (See equity section). In addition, SRCHC continues to work with community partners to integrate services into community hubs and other primary care models. For example, the DECNET team (nurses, registered detains and social worker) are integrated within primary care settings and see clients at 9 satellites across SRCHCs catchment (4 CHCs, 2 primary care settings, 2 Hospitals and 1 Family Health Team.) In the last 18 months over 2,000 clients have accessed the program at off site locations.

Engagement of Clinicians, Leadership & Staff

The development and monitoring of the QI Plan is the responsibility of SRCHCs Quality Improvement Committee (QIC), which has representation from Board, clients and staff. The QIC reports to SRCHC's Board of Directors on a semi-annual basis and the QI indicators are incorporated into the Board's balanced scorecard monitoring report. At the operational level, staff are engaged in a number of QI Work Groups that are responsible for applying QI principles to program planning/delivery, enhancing health outcomes for clients and improving efficiencies and effectiveness.

SRCHC's Clinical Team has implemented a model of diversified clinical leadership that promotes shared accountability for decision making. The team this year has worked on a number of projects to support staff working to full scope of practice and help clarify roles and build agreements about team based care and consultation processes. This upcoming year the Clinical Leads will work to support the integration of a midwifery program into primary care and ensure that the new electronic client records supports inter-team communication, encountering support etc.

Population Health and Equity Considerations

Organizational Vision

SRCHC's vision is an empowered, healthy and thriving community where everyone belongs. We strive to improve the lives of people who face barriers to physical, mental, spiritual and social well-being. We do this by meaningfully engaging our clients and communities, ensuring equitable access to primary health care and delivering quality care through a range of evidence informed programs, services and approaches. The development and management of programs is guided by our values: health equity, social justice, inclusion & respect, holistic approach, meaningful community engagement, and evidence informed practice. In this section, we will highlight how the organization incorporates a population health and equity lens in all aspects of our work including programming, operational investments and our involvement in research projects.

Priority Populations

At SRCHC services are designed to meet the needs of priority populations. Over the past 6 years we have deepened and expanded our capacity to work with newcomer communities, individuals living in poverty, clients who experience chronic illnesses, and individuals who use substances and /or have serious mental health challenges both diagnosed and not. The organization has three teams that focus on population health issues: Urban health Newcomers and Families; and Chronic Disease, Prevention and Management. In April 2017 SRCHC integrated with Harmony Hall Seniors Service (HHSS). This provides an opportunity for collaboration in taking a population health approach to providing services to specific populations (in this case those 55).

To address population health needs, SRCHC works with a range of multi-sectoral partnerships (with over fifty service agreements) to enable the organization to provide a continuum of services and programs at ninety points of access in East Toronto. Community programs include primary care, health promotion and illness prevention, food access and security, and environmental health promotion programs. Interdisciplinary teams of health care professionals, as well as staff with lived experience, and other sectoral partners in education, settlement, public health housing, food security and recreation work together to help people dealing with complex health needs to support behaviour change to prevent illness and encourage positive health outcomes in highly vulnerable communities disproportionately impacted by poverty.

Midwifery Program

SRCHC has been working for the last three years with community health centers in the East End of Toronto, as well as local midwives to develop a proposal for an alternate funding arrangement for an integrated midwifery program that SRCHC would lead and operate. The proposed program will integrate a team of midwives within two Community Health Centres (CHCs) with clinical pathways to two others. We expect the midwifery team will work to an expanded scope of practice that would include sexual health care beyond the childbearing year and well-infant care up to 1 year; and the program will allow us to create a centralized referral pathway for other east end CHC's, pregnant non-insured women and 2SLGBTQI clients who want to access the midwifery program.

Organizational Systems: Reducing Barriers to Access

Despite gentrification, at SRCHC last fiscal year, 67% of individuals who access programs live in poverty. Over the years, SRCHC has a developed a number of cross-organization supports that help individuals access programs and services. In FY 16/17 we provided :

- over 22,000 TTC tokens to low-income clients to help them attend appointments, specialist visits etc.;

- 1,300 hours of childcare supports provided to allow caregivers to attend group and individual appointments; and,
- 947 appointments where we accessed phone-based translation and over 1,000 hours of in-house translation.

Research
Finally, SRCHC is one of two CHCs in Canada that are participating in an international research study coordinated by the Health Systems Performance Research Network at the University of Toronto. The purpose of this research is look at examples of "early adopters" that have begun efforts to achieve improvements in health by addressing the social determinants of health. The team is going to focus on operational complexities that drive successful integration of services, inter-team collaboration and intersectional partnerships to improve client experience, quality of care, reduce or maintain costs, and ultimately improve the health of populations.

Access to the Right Level of Care - Addressing ALC

System
South Riverdale Community Health Centre continues to work with hospital and community partners to improve transitions across the system. Our work at Toronto East Sub-LHIN regional planning tables supports this work. At the operational level there has been improved communication, planning and coordination between hospital, primary care and TCLHIN Community Care Access Centres. We continue to work with coordinators to link individuals from priority populations to connect with primary care and also assist with the development of care plans for complex clients and attend on-site case conferences that support transitions and discharge planning for clients.

Partnerships
SRCHC has a number of unique partnerships that support the transition from hospital to community. For example, SRCHC accepts referrals for non-insured clients who have been hospitalized and need ongoing team-based primary care services. Another program that supports complex clients is the Toronto Community Hepatitis C Program (TCHCP). This program is a partnership between South Riverdale Community Health Centre, Regent Park Community Health Centre and Sherbourne Health Centre. It was established in 2006 to assist people living with Hepatitis C, who primarily use drugs and/or alcohol, and/or have mental health issues/illness, and/or HIV/HCV co-infection, and who have had difficulty accessing treatment and care. It is a multidisciplinary program offering medical care, treatment, support and education all under one roof. As this program has evolved staff have also developed supports for people dying from advanced liver disease or liver cancers. This program is sometimes the only social connection these clients have. Therefore, the clinical and case coordination staff work with the palliative team to support dying at home. The program has built capacity to provide education, planning and supports to manage end of life decisions for individuals who face barriers to health and social services.

Case Coordination
At an operational level for the most complex clients, SRCHC has case coordinators who help with referrals to community partners, coach the client to navigate the health care system and access care when at risk of, or experiencing, declining health and/or functional status. This year, we also expanded access to same day social work supports to help address crisis supports. We used open access principles for social service scheduling and between April and December 2017, there were over 1,500 same day encounters with members of SRCHC's social services team.

Finally, we have also seen an increase in demand for the agency's clinical home visit program to help decrease hospital readmissions and need for ALC beds (almost 800 visits in people's homes in first 9 months of FY 17/18.)

Transition from Hospital to Home

This year, we also looked at how we could use nursing to provide clinical case management supports for clients who are transitioning from hospital to home. The year we received project funding and were able to increase nursing resources at the clinic (.4fte). This allowed SRCHC to allocate dedicated resources to a number of QI projects including managing follow-up for clients who had been recently discharged from hospital. The QI team developed a workflow for follow-up that had the RN review incoming reports, identify discharge summaries and them follow up with clients via phone to review care plans and medications, provide coaching on managing health-related issues and, if warranted, book appointments, conduct home visits or schedule home visits with primary care clinicians.

We tried to track delays in receiving information from hospitals, the average delay was 4 days and the range was from 0 to 28 days. From April 1st 2017, to February 1st 2018 the Clinic Nurse followed up with 40 clients who had either been admitted to hospital or had been seen in emergency. The key challenge for SRCHC is coordinating discharge planning for clients who are marginally housed and do not have phones (12%) of individuals discharged from hospital. A number of strategies were used, including connecting with community partners in the circle of care, informing outreach workers and/or staff from Harm Reduction program to ask the client to follow up with the clinic. Seventy five percent of clients who we followed up with were booked to see a clinician and 15% of these visits were home visits. Twenty five percent of the follow-up clinic visits were for either wound care or for blood work. SRCHC believes that this is an important project that helped us divert clients from repeat emergency visits and in a number of cases we were able to able identify clients who needed medical case management and coordination. Our goal this year is to secure ongoing funding for nursing and work with hospital partners to improve the coordination of discharge planning for complex clients. Currently at SRCHC, the ratio of support staff (nursing, clinic assistants, and administration) to MD/NPs have an negative impact on the clinic's ability to meet the needs of clients. The provincial practice guidelines suggest a ratio of 2.5 support staff for one provider. Currently SRCHC's ration is 0.60 to one provider and indicates the challenges the clinic has in shifting some of the clinical case management work that physicians and/or NPs to other members of the clinical team.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Harm Reduction Services

Twenty years ago, in response to the harms associated with drug use and its criminalization, SRCHC began to offer harm reduction programs and services. This program has expanded since that time and the agency provides an extensive range of services for people who use drugs and who often struggle with health and social challenges including poverty, trauma, incarceration/criminalization, multiple chronic physical and mental health conditions, and social isolation.

COUNTERfit, SRCHC's harm reduction program, is one of the largest harm reduction supply distribution services in the City and one of the most comprehensive harm reduction programs. It distributes close to 35,000 needles per month on average and serves over 3,000 clients who use drugs each year. COUNTERfit also runs one of the few community-based mobile harm reduction delivery services in Toronto and supports community members to provide harm reduction services in their homes (the 'Satellite' program). COUNTERfit also provides overdose training and distributes

naloxone kits to clients and community partners and local agencies. In the first half of this year the COUNTERfit team distributed over 3,000 naloxone kits (April-September 2017). COUNTERfit also has one of the few harm reduction programs with services designed specifically for women and SRCHC's Hepatitis C treatment program is one of the few places in Toronto where people who use drugs can receive Hepatitis C treatment and support.

In June of 2017, SRCHC, Queen West CHC and Toronto Public Health's the Works received approval for the federal exemption application to allow the organizations to operate safe consumption services. This expansion of SRCHC services has allowed us to provide another support that helps address the current overdose epidemic. SRCHC supervised consumption service (known as 'keepSIX') is small scale and discretely located within the agency's existing harm reduction program space. It has a separate intake/waiting area, four injection booths and a post-injection observation room. The service will operate during our current health centre hours and will be staffed by a nurse, a health promoter and harm reduction workers.

At a systems level, SRCHC is active in working to develop provincial and regional level strategies to respond to the overdose crisis. Staff are involved both with the Ministry of Health's Provincial Task Force and SRCHC is the PQW lead for the Toronto Central LHIN.

Managing Chronic Pain

As the HQO practice standard document recommends, a multi-modal combination of non-opioid therapies delivered through a multi-disciplinary team can often be effective in managing chronic pain. SRCHC has a number of supports that assist with the management of chronic pain, in particular physio-therapy and social workers. Twenty five percent of referrals to SRCHC's physiotherapist are for help with managing chronic pain.

In addition, the Choose Health Program runs a 6-week long chronic pain self-management program that was developed at Stanford. Between April and December 2017, we offered 9 chronic pain management programs that served 113 people living with chronic pain. Four of these programs took place in organizations that offer a range of social services and the rest took place in primary care settings. Increasing popularity of this particular service has prompted us to engage in strategic conversations with leads of system-level initiatives such as the Toronto Academic Pain Management Institute, physiotherapy network, etc.

Workplace Violence Prevention

Prevention

The safety and security of SRCHC staff, clients, volunteers and visitors are of utmost importance. The Agency's workplace safety program includes risk assessment processes, safety guidelines/protocols, policy and procedures (aligned with Ontario - Bill 168), reporting and investigation processes, evaluation and implementation of corrective action, communication process and follow-up instruction/ skill development for staff and volunteers.

SRCHC has a Joint Occupational Health and Safety (JOHS) Committee as required under the Occupational Health and Safety Act. The committee conducts monthly inspections to identify risks or issues, conducts safety inspections and conducts staff training to ensure that staff are aware and take the necessary precautions in the workplace. Under the direction of JOHS, SRCHC has developed a robust program of training to prevent workplace violence including de-escalation training and crisis response for staff.

Incident Reporting and Safety Audits

SRCHC has invested in a variety of audits and made improvements to the organizations physical set-up. Panic buttons are located in all individual counselling and clinical spaces and some common spaces. In addition, we have systems in place for off-site, home visit, after hours and weekend programs to ensure the safety of our staff.

Staff are also trained and encouraged to report any risks. We have a reporting and monitoring system that enables staff to self-report incidents of workplace harassment, violence and health and safety. These reports are reviewed by management and leadership teams on a weekly basis, as well as JOHS with a view to mitigating existing issues, as well as preventing and reducing incidents in future. A summary of incidents and trends is reviewed by the Board of Directors twice a year and is integrated with the balanced scorecard monitoring report.

Contact Information

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