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

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

This narrative report has provided an opportunity for the South Riverdale Community Health Centre (SRCHC) team to review how we responded to the pandemic. In this document, we highlight how the organization's vision, values and quality improvement framework informed operational priorities over the last two years. Throughout the document we have included quotes from clients to demonstrate our operational impact. The reader will also find hyperlinks connecting to more details about frameworks that guided our work, as well as reports that highlight the impact our collective and collaborative effort has had on population health.

SRCHC provides high quality primary health care services, harm reduction supports and community programs to residents living within our catchment area within East Toronto. We serve over 10,000 clients across five locations. We use an interdisciplinary team approach so that our clients have access to coordinated services from a variety of providers under one roof. That includes doctors, nurse practitioners, midwives, chiropodists, respiratory therapists, physiotherapists, social service workers, community outreach workers and health promoters. The team also works closely with partner agencies in the East Toronto Health Partners Ontario Health team (OHT) to ensure seamless transition to other health care and social services.

Guiding SRCHCs values and strategic directions were reviewed through a process led by our board in partnership with staff, clients, partners, clients and community. The biggest changes that we made to our strategic plan was the definitions and articulation of our values. Our vision of "empowered, healthy, thriving communities where everyone belongs", can only be realized if the centre's work is guided by:

- **Commitment to Reconciliation & Relationship**, as an organization we recognize that healthcare systems have harmed Indigenous people and Indigenous communities. As part of the healthcare system, we are committed to Indigenous self-determination, actioning reconciliation, building relationships, and learning from Indigenous people/communities/organizations.
- **Health Equity & Social Justice**, recognizing that differences in health outcomes are avoidable and unfair and are shaped by the social determinants of health and systems, and that our role is to advocate for health equity and justice
- **Meaningful Engagement** acknowledges that we have a responsibility to shift the power structures that value certain voices or experiences in decision-making. That power is not distributed equally in society and mainstream systems. In response, we choose to use an equity approach when engaging stakeholders so that privilege and position does not dictate who contributes when planning, implementing, and evaluating our services.
- **Holistic Approach** considers and honours the whole person. We recognize that attending to a holistic sense of health requires an understanding of the diversity of human experiences, the systems and environments that shape health and wellbeing and the importance of the individual's right to autonomy and choice.
- **Evidence & Values-Informed Practice** acknowledges that that care can be best informed by what we learn and what we believe. We acknowledge the limitations and historic harms of evidence-based practice that have not been responsive to community experience, knowledge and emergent evidence. Given that, as an organization, we will champion approaches that inform practice, leadership, and transformative change that align with our values and the lived experiences of communities,

SRCHC's Quality Improvement Framework

At SRCHC, services are designed to meet the needs of priority populations. We work with newcomer communities, individuals living in poverty, clients with chronic illnesses and individuals who use substances and/or have serious mental health challenges.. The organization has three service delivery teams focusing on population health issues: Substance Use and Mental Health, Integrated Primary Care and Community Health and Chronic Disease.

SRCHC's quality improvement framework has been developed to align with the organizational mission, values and our strategic priorities of leading systems transformation and building a strong, sustainable future. The framework informs organizational quality improvement priorities and guides the implementation of services and operations.

Partnership

- We work with East Toronto Health Partners, the East Toronto CHC Network and other community partners 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.

Commitment to Reconciliation

- We work with East Toronto Health Partners, the East Toronto CHC Network and other community partners to ensure that Indigenous health care is planned, designed, developed, delivered and evaluated by Indigenous governed organizations.

Population Health and Anti-Racism Framework

- We work with East Toronto Health Partners, the East Toronto CHC Network and other community partners to ensure COVID recovery and ongoing planning/ service delivery address healthy equity, anti-Black racism and anti-Indigenous racism.

Team Based Care

- Apply a health equity/anti-racism framework in providing access to high-quality, team-based, client-centred healthcare.

Access

- We expand access to client-centered 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.

Co-Design

- We develop structures, systems and innovative approaches to engage service users in evaluating and co-designing how services/programs are delivered.

Demonstrate Outcomes

- We strive toward demonstrable, equitable health outcomes for priority populations.

Data Informed

- We ensure information management tools are able to provide timely access to data that supports quality improvement (QI) activities and accountability.

Reflections since your last QIP submission

Pandemic Plan and Priority Response

This last two years have been challenging for the clients, communities and staff of SRCHC. In the last year, the hope of leaving the pandemic behind was replaced by ongoing waves and continued adaptation and adjustment to implement a sustained response to COVID, while maintaining high quality, accessible services.

Throughout the pandemic we provided on-site services with priority given to: consumption and treatment services, distribution of harm reduction supplies and in-person clinical services. In response to community needs, we also pivoted to build a food security program, working closely with our East Toronto Health Partners (ETHP) Ontario Health Team to support and deliver a range of population health programs. We were able to quickly respond to community needs because of our strong community relationships, collaborations and, above all, the passion and creativity of our staff.

In-Person Services

COVID-19 has had a detrimental impact on existing health inequities for racialized and vulnerable populations. Intentional and integrated planning has been critical to the SRCHC pandemic response. Across the healthcare system delays in care have resulted in missed routine preventative care, postponed surgeries, and poor management of complex and chronic diseases.

During the first wave of the pandemic, the organization revamped the delivery of group-based programs to virtual platforms. However, given the nature of SRCHC's priority populations it was necessary to recognize that accessing virtual programming was a barrier for many. We worked with a number of partners to distribute over 180 phones with data plans to clients, ensuring access to services was not interrupted. Meanwhile, throughout the pandemic SRCHC continued to provide on-site care. In East Toronto approximately 12% of primary care visits were in person. At SRCHC 47% of our clinical encounters were in person. As of January 2022, all staff are providing services on site, but clients are given the choice of accessing one-to-one services either virtually or in person. We have aligned our primary care work with regional priorities for primary care: access to timely in-person services and focusing on preventative care. As a result we have not seen a decrease in cancer screening rates.For example, 80% of eligible clients have had a pap test within the last three years. We have also worked with our ETCHC partners to look at screening rates for individuals who are at risk of diabetes and found that 80% of clients who were eligible based on a range of risk factors were screened. (For more details see, Building Back Better: Leveraging Socio-Demographic Data to Address Health Equity By Identifying Individuals at Risk of Diabetes)

Food Programming During Pandemic

"During the COVID-19 pandemic, I got a food card and I got to come and get food… this was definitely helpful. I shared some of the food with my brother, who isn't a client because he lives a bit further away, but it was helpful to both of us."

A total of 40% of Toronto's food bank programs were shuttered at the onset of the pandemic and many drop-in programs that provided meals were also closed. This all happened when food-insecure individuals and households needed this support. As a result, programmatic priority for SRCHC was to expand food programming to support clients and community. The organization designed a cross-organizational inter-disciplinary team to plan programming and respond to community needs. The Food Security Work Group secured funding, created new processes and developed a variety of strategies and interventions to meet a range of needs.

During FY 21/22:
- over 47,000 encounters/ visits with clients addressed food security issues;
- 49,000 meals and snacks were served at SRCHC sites and via street outreach activities; and,
- 670 internal referrals were processed by our food security team, who helped link clients to community resources, distributed food cards, provided access to supplementary groceries and for those isolating because of COVID, the team arranged food deliveries.

East Toronto Health Partners: Population Health Projects
When the pandemic began ETHP OHT partners quickly began to work together to address gaps and implement new programs and services that responded to the crisis at a population level. SRCHC built on its previous relationship with Michael Garron Hospital (MGH) and developed a team who supported outbreak management for shelters in East Toronto. This early work became a foundation that grew to encompass infection, prevention and control efforts in this and other congregate settings. It included site visits, weekly calls, surveillance and outbreak testing. SRCHC also partnered with Anishnawbe Health to support mobile COVID-19 testing to Toronto's Indigenous community, including the provision of harm reduction outreach.

COVID Case Management Project
"I like that you guys are following up. How nice you are when you talk. I was not feeling very well on the first day – under pressure, away from my family … Getting the call from you was helpful, you following up. I like the way you are thinking of how you can support us – through groceries, financial, medications, and how you try to see how you can help in any way. I like it. Very appreciated"

In partnership with other East Toronto CHCs and MGH, SRCHC also helped to develop and anchor a COVID case management project throughout the second and third waves of the pandemic. The purpose of this equity-focused project was to provide clinical and social support to community members living in high priority neighborhoods who faced challenges related to self-isolation (e.g., food security, income security, health literacy, social isolation, etc.). The team applied a quality improvement lens to inform program design and delivery as well as evaluation. Daily huddles supported communication and the clinical team were able to access timely consluts with MGH's infectious disease specialists. Weekly Project Development meetings with the MGH team and community partners helped with the refinement of referral pathways and identified program improvements.For example, the project team worked to ensure that clinical providers had access to shared records to manage referrals and support timely transitions in care. In terms of programming, CHC-based nurses provided symptom management/support, addressed specific barriers to self-isolation (including delivery of fresh groceries or personal protective equipment), made referrals and advocated with other health/social services at an individual and systems level. Between November 2020 and October 2021:
- 1,134 individuals were referred to the program and 4,197 received support overall (including family members of those referred);
- 64% of individuals who accessed the program were referred to social worker/counsellors or health promoters for support with issues related to the social determinants of health, such as: immigration, mental health, child custody, grief and loss and housing; and,
- 40% of clients were referred to either SRCHC or community partners' food access programs.

Vaccine Strategy
As vaccines became available, SRCHC supported the ETHP's and City's vaccine strategy by rapidly delivering first and second doses to 12 shelters and 21 group homes or supportive housing providers. In addition, SRCHC delivered over 3,000 doses of vaccine at 68 unique outreach locations with over 150 visits that included encampments, Consumption & Treatment Services, and home visits. SRCHC also held 21 low-barrier vaccine clinics on-site at the health centre for its clients and other high priority community members.

Lessons Learnt
SRCHC's response to the pandemic offers lessons for recovery and our work as an OHT ongoing including models of care and collaboration that have the potential to be transferable and transformational. Some key lessons include:

- the harmonization of social and clinical supports through interprofessional teams who have access to shared client records;
- project structures that allowed for reflection and information sharing; and,
- distributed leadership models that support collaborative decision making and innovation.

Overdose Crisis
Toronto has the highest rate of people who use illicit drugs in Ontario. Both fatal and non-fatal overdoses have been at crisis levels for many years. There were an estimated 2,819 opioid-related deaths in Ontario in 2021, up 15% from the year before (2,687), which was a 70% jump from 2019, the year before the pandemic. Over the past 5 years, nearly 10,000 people have lost their lives from the overdose crisis, with the rate of opioid-related deaths doubling over this time (from 9.1 to 18.8 per 100,000)[1]. In the first nine months of 2021, the number of overdose deaths in Toronto was already 358. Prior to the pandemic, the average number of fatal and non-fatal calls attended by paramedics in Toronto for suspected opioid overdoses per month was 65. From December 2021 to March 2022, they attended an average of 105[2]. These deaths are being driven by the unregulated toxic drug supply. In addition, the criminalization of drug use, together with historical and ongoing structural oppression, subsequent stigma and overall neglect of people who use drugs by our health and social service system creates multiple barriers to health and well-being for this group. Pandemic restrictions further disrupted the illicit drug supply (making it more toxic) and increased social isolation (which increases overdose risk) and reduced health care access more broadly. The loss of community programming and reduced capacity in shelters, drop-ins and detoxes also increased the vulnerability of people who use drugs to poor health outcomes.

Consumption and Treatment Services
Throughout the pandemic, SRCHC continued to offer in-person services to people who use drugs and expanded programming. SRCHC operates two Consumption & Treatment Services (CTS) on Queen Street E and in Moss Park. In 2021, the Queen St CTS had an average of 675 visits per month and staff reversed 400 overdoses. At our Moss Park location, there were an average of 981 visits per month and staff reversed 836 overdoses. In addition to overdose reversal, teams at each site continued to ensure service users had access to a range of services/supports including: first aid and basic primary care, take-home naloxone and overdose response training, peer-to-peer support, wound

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[1] Source: Office of Chief Coroner (OCC) -Data effective Apr 18, 2022. Accessed via correspondence with Dr. Tara Gomes, April 29, 2022.
[2] Toronto Public Health. Toronto Overdose Information System. February 2022. https://www.toronto.ca/wp-content/uploads/2020/12/859b-CallsforSuspectedOpioidOverdoses_GeographicInformation.pdf

care, hygiene supplies and nutrition (take away meals), COVID-19 vaccinations, Hep C treatment, mental health support and referrals to substance use treatment services.

In partnership with researchers and lab clinicians at St Michael's Hospital, SRCHC began a drug-checking project in late 2019 which continued to operate throughout the pandemic to ensure access to timely and detailed information about the unregulated drug supply for service users, harm reduction workers, and clinicians. In early 2020, SRCHC expanded its mobile harm reduction efforts in East Toronto to include dedicated Community Health Workers/street outreach in underserved and high needs neighbourhoods. We also partnered with other East Toronto Health Partners OHT members to create a new harm reduction and health 'Hub'.

Expansion of Safe Supply Programming

In July 2020, SRCHC officially launched its safer supply program. Safer supply programs are an established, evidence-based harm reduction option for people who use opioids. Through these programs, people who are currently reliant on an illicit and toxic opioid supply have access to pharmaceutical-grade opioids, as well as access to support staff and comprehensive health and social services. Recent evaluation findings demonstrate that people who use such programs report better health outcomes, improved quality of life, increased stability and feelings of social inclusion, decreased criminalization, fewer overdose events, and reduced emergency hospital visits. Since it began, SRCHC's safer supply program has provided support to 536 individuals with 7,373 prescriptions written and 331 referrals made to other health and social service providers.

Quality Improvement Priorities for FY 22/23

East Toronto Health Partners and Collaborative Quality Improvement

As the health sector works towards COVID recovery, we are working with our ETHP and the East Toronto CHC Network (ETCHCN) to align collaborative quality improvement activities. We have worked with our OHT partners to create shared quality goals and align quality improvement efforts across OHT partners. East Toronto working groups have been established with patients, caregivers and care providers to identify barriers and opportunities for improvement related to cancer screening, alternate level of care (ALC), mental health and substance use.

East Toronto CHC Network QI Collaborative

South Riverdale CHC is the anchor partner at the East Toronto Health Partner and represents four community health centres (Access Alliance, East End Community Health Centre and Flemingdon Community Health Centre) who provide services in the east end of Toronto. Community Health Centers in East Toronto have a long history of working together in an integrated and collaborative manner. We have worked on a range of local healthcare initiatives with a focus on health equity, health promotion, community governance, and team-based care for socially vulnerable and medically complex residents.

Over the upcoming year, SRCHC will work with our ETCHC Network partners to align with Ontario Health's priorities of reducing health inequities, transforming care, and promoting service excellence. Our work will focus on increasing cancer screening rates, sharing data to support a quality improvement culture and improving how we collect point-of-care socio-demographic data from clients and service users. This work will help the ETCHC Network identify health inequities and work to implement and evaluate solutions to reduce those inequities. It will also help inform planning and advocacy at a systems level.

Client Partnering and Relations

At SRCHC we are continually working with clients and service-users to improve programming, address community needs and inform systems-level advocacy. During the pandemic we continued with our client experience surveys to evaluate our programs and services. We used a variety of approaches to engage clients, including in-person interviews, phone interviews and an on-line survey format, spending over 70 hours interviewing 200 clients. In particular, we were interested in getting feedback about virtual care. During virtual visits, clients reported that staff were ableto talk to and ask questions. As one client noted, "*Even though the appointment is over the phone, I still feel like I am being listened to…… I still get the same care over the phone. They treat me as well over the phone as they do in person. They listen to my needs and give me time to talk. Sometimes I even feel a bit more comfortable talking over the phone.*"

We also continued to operate a range of advisory committees, for example both the Moss Park and Queen St CTS held regular community advisory meetings with service users to inform the work of each site. Finally, we also engaged clients and service users in the design and development of our new Strategic Plan informing our revised values and focus on maximizing community impact through collective action. Over the next two years, SRCHC will invest in grass roots groups as well as foster community ownership to support action.

Staff Experience

The last two years have been challenging SRCHC staff. Despite challenges and losses, staff has come forward like never before. We continued to work together to provide access and fill gaps where our system has failed our most vulnerable. hey We worked with partners and community members to amplify policies and practices that result in health equity and improve health outcomes.

In the early days of the pandemic SRCHC supported staff in a number of ways:

- implementing additional COVID-19 sick days so staff would be supported when having to isolate due to the pandemic;
- holding staff appreciation events, and during the first wave, when local businesses were closed, providing snacks and meals to staff who were working on-site;
- providing a flexible and supportive work environment and work-from-home options when appropriate; and,
- implementing rigorous health and safety policies and processes.

As we entered the second year of the pandemic, a number of pressures affected staff wellness. We continued to expand our programming and approximately 20% of our staff were on-boarded during the last 12 months. Workloads during the pandemic continued to increase, yet staff faced multiple personal and professional challenges, especially as they worked at the intersection of two health crises. (The overdose crisis being the other public health emergency that was never formally acknowledged or resourced appropriately.)

Working within this context, SRCHC continues to be committed to building a strong and sustainable future through the development and implementation of strategies that ensure staff wellness and organizational health. Therefore, in 2021, in response to feedback from staff, a cross organizational Wellness Work group was set up to address structural and environmental issues that impact staff wellness. The following priorities were identified:

- build a diverse, comprehensive and readily accessible menu of evidence-based resources to support staff;
- continue to consult with staff and teams to identify and bring forward pressing issues and concerns related to staff wellness;
- develop centre-wide policies, practices and protocols that use trauma- informed, anti-oppressive frameworks to prevent negative workplace events, and reduce critical incidents;
- inform staff learning and training needs to build staff capacity, competency and support; and,
- promote a work culture that balances individual and collective responsibilities to build and sustain a healthy and safe work environment.

Contact Information

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)