SRCHC QIP Narrative FY 25/26

1. Overview

Client-Centered Integrated Primary Care

SRCHC provides high-quality primary health care, harm reduction supports, and community programs to over 12,000 clients in East Toronto across five locations. Our integrated service delivery model addresses social determinants of health, focusing on inclusive and accessible services for those facing barriers to care.

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 physicians, nurse practitioners, registered nurses, midwives, chiropodists, respiratory therapy, physiotherapy, social workers and 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) and Downtown East OHT to plan and coordinate services and ensure seamless transition to other health care and social services.

Quality Improvement Framework

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 with a focus on program design, collective impact, and system transformation. SRCHC Quality Improvement Principles 2025/26)

Commitment to Health Equity

At SRCHC we are particularly proud of our efforts in addressing health equity. By applying an equity lens to all our quality improvement activities, we ensure that our services meet the diverse needs of our community.

This year, we have dedicated our quality improvement resources to improving the collection of demographic information from our clients and service users. At the end of last fiscal year, we had demographic data on 73% of our clients, and at the end of Q3 for this fiscal year, we have demographic data on 84% of our clients. This data is uploaded to a patient's chart, and we have used it in several projects. For example, nurse practitioners and family doctors are provided with cancer screening lists that are stratified by income and race. This year, we have reduced inequities in cancer screening rates from 4% of the population to 2%.

2. Access and Flow

(In this section, describe improvement work that support patients, clients, and residents in accessing the right care in the right place at the right time.)

Program Design

At SRCHC, clinical programs are structured to support our clients and avoid unnecessary emergency department visits. We are open three evenings a week plus Saturdays; offer same-day appointments and have a daily drop-in clinic for urgent healthcare needs. We also provide after-hours on-call support for urgent issues. In addition, 30% of our clients access services via a variety of low-barrier drop-in programs offered in local shelters and schools as well as home visits.

Client Complexity

The results of the most recent CHC practice profile indicate that South Riverdale Community Health Centre's population has complex healthcare needs. Over 30% of patients have 10 plus co-occurring complex conditions. Despite this complexity, we have a very low rate of emergency department usage for conditions best managed elsewhere. The provincial average in this community Health Center is 11%, whereas South Riverdale has an emergency department usage rate of 4%.

Challenges: Recruitment and Retention

At this point in time, one of the key challenges we face with addressing access and flow for patients is the recruitment and retention of staff. In a recent survey of community health organizations, 94% of respondents identified compensation as the single most significant challenge for recruitment and retention. There is a widening wage gap between community health workers and workers in other areas and health sectors with an average salary increase of only 1.53% in 2023 compared to the 11% increase awarded to hospital nurses.

3. Equity and Indigenous Health

(Please share your organization's plans for quality improvement initiatives to improve equity and foster Indigenous health and cultural safety)

Framework

SRCHC applies a health equity/anti-racism framework in providing access to high-quality, team-based, client-centered healthcare. We work to develop structures, systems and innovative approaches to engage service users in evaluating and co-designing how services/programs are delivered. In addition, we continue to work with East Toronto Health Partners, the East Toronto

CHC Network, and other community partners to ensure that Indigenous healthcare is planned, designed, developed, delivered, and evaluated by Indigenous-governed organizations. At an organizational level, SRCHC has an equity and diversity committee that is focusing on several areas including training and policy

Programming

In terms of programming, we continue to work with Indigenous partners and service users to design programs. For example, we are currently running a moccasin-making group. The program provides a safe and welcoming space for 2-Spirit and Indigenous women who use drugs or are sex workers to connect with culture while learning a traditional craft. Indigenous harm reduction programs are guided by Elders and Knowledge Keepers, this is essential to maintaining the authenticity of and showing respect for cultural teachings. This is just one example of SRCHC's commitment to supporting our Indigenous clients with respectful, inclusive and culturally-relevant programming

Primary Care CONNECT

SRCHC, along with lead agency Parkdale Queen West CHC and the Centre for Addictions, received primary care expansion funding to enhance and support a complex patient population, many of whom are underhoused and require mental health and/or substance use care. The Primary CONNECT initiative links primary care with specialist services at CAMH, ensuring streamlined pathways between CAMH and the IPCT. Primary CONNECT clients will also be able to access Shkaabe Makwa Clinical Services at CAMH. Shkaabe Makwa will provide critical bridging and expedited referrals to individual and group-based supports grounded in traditional Indigenous healing practices. The goal of this program is to help increase the attachment of Indigenous clients by connecting them with Shkaabe Makwa cultural care practitioners and enhancing the team's ability to make connections with this population.

4. Client Experience

Share how your organization plans to incorporate information from experience surveys; or other feedback received about care experiences into improvement activities.

Client Engagement Approaches

SRCHC uses several approaches to engage clients and service users to improve our services. In addition to the numerous program client and patient advisory committees that exist to inform programming and services, SRCHC invests in meaningful and wide engagement of service users in our annual client experience surveys, including supported engagement via in-person interviews as well as self-directed surveys.

Survey Feedback and Insights

This year's client survey, we received feedback from 618 clients and spent over 130 hours (about 11 days) supporting clients to complete the surveys and reflect on their client experience of access to service and impact. We heard from clients that they value reminder calls for appointments. However, they want us to look at using technology to communicate with providers directly. There is also a need for improved communication regarding the basket of services and programs available at SRCHC.

Planned Improvements

To this end, two key projects that we will initiate this year are upgrading our website to improve service navigation and introducing secure patient messaging.

5. Safety

(Describe a quality improvement project or initiative that is part of your organization's efforts to create and sustain a culture of safety.)

Approach

SRCHC addresses the safety needs of newcomers, the non-insured, and people who use drugs by ensuring equitable access to services and security, particularly for those whose health conditions and status are subject to criminalization and systemic exclusion. Our organization offers unique approaches such as women-only groups, low-threshold access with high levels of engagement and support. Services are co-designed with clients to ensure that their safety and culturally appropriate needs are incorporated into program planning and service delivery.

Consumption and Treatment Services

One significant operational barrier SRCHC faces in addressing client safety is the upcoming closure of our safe consumption and treatment program, KeepSix, at the end of March. This closure presents multiple challenges related to transitioning clients to other services. CTS programs provide essential overdose response services in communities where drug use occurs. The lack of CTSs in Toronto is expected to result in preventable overdose deaths following these closures. SRCHC will strive to connect CTS clients to existing health, treatment, and community services for people who use drugs. However, the closure of CTS will have repercussions across all services provided by SRCHC, increasing demand on primary care services, AIDS Bureau and Hep C funded services, and social work care.

Systems Impact

The impact of this closure will also affect remaining CTSs and emergency services in the city. SRCHC anticipates a substantial increase in overdoses and drug poisonings in the community when services close. A recent study estimated that each month, 636 unique individuals (47% of all CTS service users) will lose access after the closures.

KeepSix Wind Down Plan

During the wind-down period, SRCHC will focus on emergency preparedness measures, building the capacity of service users, partner organizations, and community members to recognize and respond to overdoses. SRCHC will continue to provide Naloxone and Naloxone training to community members from its main location and refer harm reduction clients seeking supervised consumption to existing sites in other parts of the city.

6. Palliative Care

(Describe how your organization has delivered (or plans to deliver) high-quality palliative care.)

Focus and Capacity

Palliative care is not a primary focus for SRCHC, partly due to limited staffing capacity. However, we do provide home-based care for older adults, conducting, on average, 400 visits per year to clients living at home.

Medical and Social Support

Family doctors, registered nurses, and social workers offer comprehensive medical and social support, empowering family caregivers. Our team collaborates with patients and their family caregivers to create detailed care plans specific to identified issues.

Specialized Referrals

We ensure appropriate and timely referrals to specialized care, including wound care specialists. This is an integral part of our approach to providing holistic care for our patients.

Bereavement Support

Upon bereavement, our team connects the families of our patients to relevant bereavement support services if necessary, including funeral services. This final step ensures that families receive the support they need during difficult times.

7. Population Health Management

Share how your organization is partnering with other health service organizations to care for the unique needs of people in the community.

Program Design

At SRCHC, we have designed programming and service delivery with three teams that focus on population health issues: Substance Use and Mental Health, Community Health and Chronic Disease, and Integrated Primary Care. SRCHC utilizes multiple population-level sources of information to support access to health care and other services/programs. At a strategic level, a key enabler of leading systems transformation is demonstrating equitable health outcomes for priority communities. The organization measures progress at a population health level, access to services, team-based care, preventative care, harm reduction services, and health promotion and well-being.

Partnerships and Community Care

We continue to work with East Toronto Health Partners, Downtown East OHT, the East Toronto CHC Network, Toronto Opioid Overdose Action Network (TO2AN), and other community partners and networks 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.

Early Pregnancy Clinic

This year SRCHC's midwifery team worked with Michael Garron Hospital on the development of the Early Pregnancy Clinic. This clinic provides care to people experiencing cramping, bleeding, pain, or other complications in the beginning of pregnancy for up to 20 weeks. The clinic is staffed and led by midwives from the MATCH program. Midwives assess patients and may provide blood work, ultrasound, and counseling as needed. Midwives may also consult obstetrics and gynecology staff on an as-needed basis, such as for ectopic or molar pregnancies or other cases that may require surgical follow-up.

Downtown East Lower Limb Preservation Project

The Downtown East OHT Lower Limb Preservation project team carried out a detailed current state analysis throughout the early months of 2023. Findings highlighted inconsistencies in foot screening across settings, variable escalation of care pathways, and significant gaps in equitable access to foot care. The team established 2 working groups: The Screening & Prevention Working Group and the Escalation of Care Working Group.

The screening work group focused on improving consistency of foot screening, with an initial focus on primary care settings. Based on best-practice guidelines, the initial target population for screening included people living with diabetes, and expanded to include people with peripheral artery disease and neuropathy with or without diabetes. The group identified opportunities to flag at risk populations for screening across different care access points, including pro-active identification of people at risk within a CHC primary care team leveraging

health equity and clinical EMR data, clients/patients living with diabetes attending diabetes follow up appointments with primary care providers, and interactions with ICHA providers in select shelter settings.

It was of utmost importance to ensure that people who were screened at moderate to high risk and with active complications could access the right care at the right time. The Escalation of Care Working Group aligned with the Screening Work Group to map risk-level categories from screening to the appropriate referral destinations. Given significant gaps in equitable access to foot care, the project team established community chiropody clinics to ensure people at moderate-high risk could access care regardless of their ability to pay or access to insurance.

As part of the evaluation framework, partner sites are asked to report on # of clients/patients screened and the # of clients/patients with active complications being referred through the escalation pathway. At SRCHC, significant support from the IT/IM team has enabled the capture of this data connected to use of the simplified screening tool. Between Oct 3, 2023 - Jan 31, 2025: 339 unique clients received foot screening, 86 clients were identified at moderate-high risk and referred through the chiropody pathway, and 4 clients were found to have active wounds. Leveraging health equity data, we saw that the clients screened had high healthcare utilization with SRCHC, were more likely to be racialized, low income and have low self-reported physical and mental health.

8. Administrative Burden

(To help support the primary care initiative of "patients before paperwork," share how your organization is supporting clinicians and the interprofessional team in being able to spend more time on direct patient care by streamlining clinical and administrative work.)

Current Clinical Structure

At SRCHC, the administrative burden is managed by scheduling longer appointment times and allocating specific administrative time. This allows providers to handle referrals, complete necessary forms, and coordinate care with other healthcare providers. We also have standardized encountering tools, assessment tools and client education materials integrated into the EMR. Additionally, team care is optimized by employing a small team of Registered Nurses (RNs) who provide clinical case management support, particularly given the complexity of SRCHC clinical clients.

Funding for Secure Messaging and AI Scribe

SRCHC staff have access to several provincial assets that support streamlining clinical care. All clinicians have access to Connecting Ontario, OLIS, eReferral and eConsult. SRCHC was one of

the first community agencies to accept e-referrals for the Toronto Diabetes Care Connect program. We are now looking to expand our e-referral program to include more of our services and are waiting for Ontario Health to complete the procurement process to select a referral management system for the Toronto Region.

Implementation Barriers

A significant barrier to implementing secure messaging, online booking, and AI scribe tools is the prohibitive costs associated with monthly subscriptions. To roll these tools out across our clinical, administrative, and allied health teams, we need to budget over $200,000. If we can overcome these financial barriers, we can integrate these tools into clinical workflows and improve clinical efficiency.