Collaborative quality improvement plan (cQIP)

Narrative for Ontario Health Teams

March 22, 2024

KW4 ONTARIO HEALTH TEAM

Ontario Health

QUALITY IMPROVEMENT ACHIEVEMENTS IN THE PAST YEAR

KW4 OHT Integrated Care Team/Complex Care Program (ICT/CCP)

The ICT/CCP program is a collaboration between health and social service providers to support older adults living with complex and chronic conditions through advanced care planning, system navigation, and case management.

The program:
- Provides a wrap-around interprofessional team in primary care
- Reduces patient and care partner burden of attending multiple appointments
- Expedites referral to community service programs
- Provides ongoing case management
- Reduces primary care visits, and
- Optimizes geriatric specialist time through shared care

The program aims to identify patients early in their frailty journey and support their health and social care needs, avoiding urgent specialist intervention and/or institutionalization.

The program started as a pilot and has received sustainability funding through the OH West ALC Strategy. The program has recorded many successes in the management of older adults living with complex and chronic conditions. In 5 months:
- 231 patients were assessed
- 62% of patients were followed up for ongoing care and case management
- There were 60 case consults by geriatrician and/or geriatric psychiatrist

• 9 patients were seen in primary care by a geriatric psychiatrist

82% of patients said the program made them more confident in managing their health and 100% of patients, ICT members, and primary care providers who responded were very satisfied or satisfied with their experience in the program.

This program's work continues to be recognized nationally. KW4 OHT is looking to expand the program to other providers to support upstream prevention of older adults living with complex and chronic conditions.

PATIENT, FAMILY, CARE PARTNER, AND COMMUNITY ENGAGEMENT AND PARTNERING

KW4 OHT approaches the cQIP as part of our work rather than something separate and therefore have considered the cQIP areas of focus in the development of our inaugural strategic plan, which will be approved in the spring of 2024.

When designing our strategic planning process, Steering Committee approved some guiding principles one of which was a commitment to a robust and informed process, one that included engaging with a range of patients, families, care partners, health and wellness service providers, partners and members of our community.

As of March 2024, we have had 1,441 engagement points. We have:
• Heard from 329 people through surveys available in 8 different languages
• Had conversation with 773 people at various community events
• Obtained feedback from 149 people at 23 different focus groups
• Received valuable input from 190 participants at our three planning sessions

KW4 OHT's Community Council Design Committee (CCDC) has also provided input. They have a mandate of strengthening and expanding effective and representative community engagement and participation in the planning, design, delivery and evaluation of OHT implementation activities. This continuously evolving group collectively brings the intersectionality of lived experiences evident across our community.

KW4 OHT recognizes that strong relationships with Indigenous leadership and communities, founded on respect, reciprocity, and open communication are critical in ensuring that we address the needs of Indigenous peoples. We will be focusing on establishing and strengthening meaningful relationships with Indigenous communities in the region through trust-building initiatives and co-designing qualitative engagement methods and long-term strategies.

SUPPORTING UNATTACHED PATIENTS

Rapid Access Primary Care Clinic (RAP Clinic)
In February 2024, KW4 OHT launched a RAP Clinic proof of concept. The clinic is a collaboration between primary care, hospitals, settlement and community agencies, Public Health, and the School of Pharmacy. The goal is to create continuity of care for patients who have no primary care provider and frequently visit the Emergency Department for routine care.

The Clinic operates three days per week. Referrals target unattached patients from priority neighbourhoods with chronic

conditions who have had a recent emergency department visit for less urgent or non-urgent conditions (CTAS score of 4 and 5).

Patients referred to this clinic have access to Nurse Practitioners, pharmacy services, translation and interpretation services, and dedicated post-appointment follow up services.

The Clinic will measure:
- # of clients
- # of unattached clients
- # of clients from priority neighbourhoods
- % of clients diverted from the ED
- Patient experience

Refugee Health Integrated Care Team
KW4 OHT piloted a Refugee Health Integrated Care Team (RH ICT) program. The program uses an integrated care team approach to support non-team based primary care providers (PCPs) in accepting existing refugees into their practice, thereby opening spots at the Refugee Health Clinic to serve new incoming refugee families.

To-date, 621 medically stable refugees have successfully transitioned. Access to virtual interpretation service was provided. The program also supports PCPs by directly delivering, and linking patients to additional care and services, including mental health and community-based services.

Based on the success of the pilot, KW4 OHT continues to support the program until sustainable funding can be obtained.

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 22, 2024**

Brenda Vollmer, cQIP lead

Other leadership as appropriate

Other leadership as appropriate