Collaborative quality improvement plan (cQIP)

Narrative for Ontario Health Teams

March 28, 2025

QUALITY IMPROVEMENT ACHIEVEMENTS IN THE PAST YEAR

Hospital to Home (H2H)
Within the broader context of integrated planning in supporting transitions from hospital to home, in 2024 St. Mary's General Hospital launched a program to help adults who no longer require hospital care to continue their recovery, healing and rehabilitation in the comfort of their own homes. The program is modelled after the St. Joseph's Home Care, Hospital to Home Program. The program helps bridge patients as they are discharged from the hospital, providing care for them in their homes while other longer-term community-based services are arranged.

The program is developed and operated in partnership with Ontario Health atHome (OH atHome) and KW4 OHT Members. The KW4 OHT has biweekly surge calls with hospitals, Community Support Services (CSS), and Mental Health and Addictions partners to support discharges into the community. CSS involvement at ALC rounds was introduced to support the identification of potential patients for discharge.

The program has successfully allowed patients to return home as quickly and safely as possible after they receive the acute care that they need. This new partnership is one of the new and innovative ways KW4 Members are working together to meet the growing needs in our communities for home-based care. The program helps to bridge healthcare services for patients transitioning from hospital to home, providing patient-centered care while also helping to ease pressures on the over-burdened acute care system.

Many successes have already been realized.

- Approximately 175 patients have been enrolled in this program as of Q3 2024/25.
- There has been a 100% acceptance rate of referrals from the Service Provider Organization (SPO) with 0.8 days to service initiation.
- Two streams have been implemented in this program:
  - A 21-day bridging program, that allows for more fulsome longer term care planning
  - An up to 16-week stream that targets the frail seniors population, providing restorative services to help retore independence.
- More than 50% of patients in both program streams have been discharged without ongoing services.
- There has been a re-admission/ED visit rate in this program of less than 10%, below the provincial benchmark of approximately 12%.
- There has also been a notable reduction of Alternate Level of Care (ALC) Length of Stay (LOS) for patients enrolled in this program, with almost a 50% reduction for those ALC patients going into H2H versus all other medicine ALC patients.

Community Support Service Navigation Team
The Community Support Services Navigation Team works alongside non-team based primary care providers to streamline patient access to essential community-based services, addressing social determinants of health and reducing unnecessary strain on the healthcare system. This team contributes to patients accessing the right care in the right place at the right time. Embedded in the same physical location as several FHO primary care clinics, this team educates patients about their options, co-designs appropriate solutions with them, and connects them with the appropriate community services tailored to their unique needs and situations. The person-centered approach aims to address health disparities across our region.

This pilot program has been so well received by patients and providers alike that we are exploring possible expansion. Some pilot program highlights include:

- Provided access to team-based care and allied health services for 43 non-FHT primary care providers.
- Over 96% of patients referred were connected to services.
- Providers report an average reduction in administrative burden of 2 hours per month
- Providers also report a reduction in unnecessary repeat clinic visits and a reduction in appointment time for socially complex patients.
- One provider reported that they were able to roster an additional 50 patients due to the support of the CSS Navigation Team.

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

KW4 OHT considers the development of a cQIP as an integral part of our workplan and therefore has considered the cQIP areas of focus in the development of our strategic plan, approved in the spring of 2024, and our annual business plans.

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. KW4

OHT had 1,441 engagement points in the development of our Strategic Plan.

Based on the new KW4 OHT Strategic plan and the evolution of our governance model, the OHT evolved its Community Council Design Committee (CAC) to be more reflective of the broader community that we serve and to support community engagement. The new CAC operates as a “network of networks” and members act as KW4 OHT ambassadors, engaging with different communities and priority populations to ensure an equity-based approach.
Most recently CAC has:
· Evolved the governance, mandate, and composition of the existing CAC
· Developed a new Terms of Reference
· Created profiles for Members, and the Chair and Vice-Chair based on the 6 competencies listed in the "Creating Engagement Capable Environments in Ontario Health Teams: A Framework for Action".
· Onboarded 15 new members and chosen a Chair and Vice-Chair
· Created Code of Conduct, Conflict of Interest, and Confidentiality Acknowledgment and Consent documents

The CAC Chair has been added to the KW4 OHT Steering Committee, and recruitment is underway for 5 new members using a member approved skills matrix.

The CAC and KW4 OHT are currently reviewing the Engagement Capable Framework to determine key areas of focus for the upcoming year.

Some examples of recent engagement include:
· Engaging with leaders from St. Joseph’s Health Care to inform the future direction of St. Mary’s General Hospital building in Waterloo Region.
· Meeting with and providing advice to the new Co-hospital transition on important facts to consider for the new, integrated hospital.
· Reaching out to members of the rural community and the Region of Waterloo to ensure an equitable approach to engagement.

SUPPORTING UNATTACHED PATIENTS

KW4 OHT Expanding and Enhancing Interprofessional Primary Care Team Implementation Plans
KW4 OHT is supporting the two successful “KW4 OHT Expanding and Enhancing Interprofessional Primary Care Team Implementation” initiatives to create pathways and improve primary care access and attachment to an interprofessional team for the unattached in our community. The following are some highlights.

Woolwich Community Health Centre (CHC) Primary Care Access Clinic
• An Open Access clinic was established for individuals from the three townships (Wilmot, Wellesley and Woolwich) who did not have a primary care provider, including patients without OHIP
o Clinics are offered three times per week at two different locations. Services offered include medical care, follow-up for routine care, connection to counselling services, medication reviews with a pharmacist, community and navigation support, and assistance with finding a primary care provider
• High-level success from April 1 – October 31, 2024 include:
o exceeded the new incremental attachment target having

attached 1,044 patients
  - o exceeded the new incremental access targets having provided access to 3,024 patients

Waterloo Regional Nurse Practitioner-Led Clinic (NPLC)

- NPLC provided barrier-free access to breast, colon, and cervical cancer screening across the region at Community Cancer Screening Clinics. Anyone in the community, whether they had a healthcare provider or not, was able to book online with an RPN at any of the NPLC three sites. This program will continue through 2025.
- NPLC collaborated with Community Healthcaring KW and the Seamless Care Optimizing the Patient Experience (SCOPE) program to improve access to primary care for unattached individuals visiting local Emergency Departments for conditions that could be managed elsewhere. Patients referred received timely follow-up and, when needed, were rostered for ongoing primary care.
- NPLC also offered several group programs to NPLC patients and to the broader community, including Strategies for Better Sleep (CBTi), Heart Health, Mindfulness, Walk and Talk, and Smoking Cessation. These will continue to expand in 2025.
- High-level success from June to November 2024 include:
  - o successfully attaching 1,360 patients to primary care
  - o providing access to an additional 130 individuals

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 clinic provides access to episodic primary care for unattached patients who frequently use the Emergency Department as their first point of access. 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. This clinic facilitates connections to specialist care, pharmacy, and attachment to the Waterloo Regional Nurse Practitioner Led Clinic. The RAP clinic has recently partnered with the PREVENT clinic at St. Mary's General Hospital, enhancing the support for patients with high or increased risk of developing cardiovascular disease.

High-level success includes:

- 48% of clients seen diverted from the ED.
- 46% of patients seen at the clinic reside in priority neighbourhoods.
- 100% of clients presented with 2 or more medically complex conditions and a minimum of 2 social complexities.

Refugee Health Integrated Care Team (RH ICT)

KW4 OHT's RH ICT program provides primary care attachment for medically stable refugee patients. The RH ICT also provides support to Primary Care Providers by directly delivering, and linking refugee clients to, additional care and services, including mental health and community-based services. 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.

High-level success includes:

- 373 patient interactions prior to transition.
- 117 patient interactions post-transition.
- 210 patients attached to primary care.

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 28, 2025

Brenda Vollmer, cQIP lead

Other leadership as appropriate

Other leadership as appropriate