

Let's Make Healthy
Change Happen.



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



3/29/2018

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.

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Overview

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Anishnawbe Health Toronto (AHT) is an accredited Community Health Centre that places culture and tradition at its core. As an agency we offer multiple interdisciplinary services to meet the health needs of our population across the lifespan. . Anishnawbe Health Toronto utilizes community engagement at every level, when setting priorities in service planning, to meet the needs of the community. Our strategic planning incorporates equity and prioritizes the shifting needs of the clients and community. Anishnawbe Health Toronto provides our urban Aboriginal population with access to health care services for prevention, screening, early detection, intensive treatment and disease management in a shared model of care, where Traditional practices and Western practices acknowledging and respecting health and healing contributions from both Indigenous healing practices and biomedical best practices and approaches. Services and programs address physical health, emotional health, behavioural issues, developmental health, mental health, spiritual balance, cultural Identity, family and community wellbeing. The community we serve is culturally diverse and vulnerable. We serve our First Nations, Inuit, Metis and non- status Aboriginal populations who are residing in the GTA. Anishnawbe Health Toronto honours and respects the freedom to make self-determined health care decisions and choices.

Anishnawbe Health Toronto CHC Quality Improvement Plan is in alignment with our organization mission, vision, strategic plan, operational plan, Multi- Sector Service Accountability Agreement (M-SAA),with the Toronto Central Local Health Integration Network (TC LIHN). Our strategic plan aligns with the TC LHIN performance indicators and the Mid-West Toronto Health Links priorities.

In partnership with the membership of the Toronto Indigenous Health Advisory Circle, Public Health Toronto and the TC LHIN, Anishnawbe Health Toronto is committed to supporting the implementation of the Toronto Indigenous Health Strategy, using a population health approach to:

- Address the social determinants of Urban Indigenous health through actions to influence the health, justice, education, housing and food systems
- Reduce health inequities-differences in health that are avoidable, unfair and unjust-through programs and services that are culturally secure, accessible and address historic and current wrongs. (Toronto's First Indigenous Health Strategy 2016-2021, TIHAC report).

Aboriginal people experience higher rates of physical, emotional and mental illnesses, equity and access issues as compared to other populations, living in the GTA. There is an increasing disparity in both our health status and the impact of the social determinants of health on our health and wellbeing. . Our Health Counts Toronto report,(2016) " Aboriginal people with low income, less than high school education or were unemployed had higher percentages of being diagnosed with chronic conditions, mental health-14% of Indigenous mental health patients in hospitals reported being homeless in comparison to 8% of patients from general population; Poverty- 91% of our Aboriginal population living in Toronto are living below the poverty level, Homelessness-16 % of the homeless population identified as Aboriginal and two thirds of Aboriginal people in Toronto say that they have been affected by residential, either personally or through a family member. (Our Health Counts Toronto report, 2016)

Our Aboriginal population is younger than the non- Aboriginal population. Almost half (48%) of the Aboriginal population consists of children and youth ages 28 years and under, compared to 31 percent of the non-Aboriginal population.

The disparities in health status and the social determinants of health facing our population living in our urban setting has not improved for our children youth and families.

Our adult, children, youth and elder populations are experiencing significant higher mental health problems/illnesses. Our children and youth have proportionately higher rates of addictions and suicide.

Our intra-disciplinary teams of Western and Traditional practitioners work collaboratively to ensure the delivery of a cultural holistic client centered care.

Walking through the broader health care system can be challenging for our population who experience cultural barriers and navigation challenges that can result in poor outcomes and poor engagement, in the broader system services. This has been a challenge for our population and program staff and practitioners and teams, as we do not have navigator resource staff to step outside of AHT to walk with the clients to ensure access their care providers throughout the broader health care system. Additional navigation resources for both in our mental health programs and our primary health teams would close the gap and reduce barriers affecting our populations' access to the health care that they require beyond the services of AHT.

Our clients and their families/supports are central, in the process of creating their pathway of care. There is no wait time to access our Primary Health care and/or other programs and services at Anishnawbe Health Toronto. New clients and registered clients can access the care they need through scheduled visits and/or same day appointment access.

Our Board of Directors, Management and Direct Service providers are committed to addressing and managing quality improvements, to ensure equitable access, clients and family centred integration of care, partnerships with external organizations and systems, placing the client and their family central to their care and decision making. Our operational plan is linked to our program-specific work plans and performance indicators. Improving service delivery through evidencing, effective, patient centred, efficiency, safe, timely and equitable performance is key indicators of success.

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

The past year, Anishnawbe Health Toronto has strengthened interdisciplinary integration of care through collaborative shared care. Our Diabetic Education Team, Primary Health Team, Traditional Team, Mental Health Teams and outreach teams collectively created a circle of care, for clients experiencing complex health and social challenges. Families and caregivers and supports were invited into the circle of care, with the client central to their care and direction. The strategy improved coordination of services and resources to address and prevent social and health complications that are the result of many influences beyond the client control. Empowering the client to trust that the circle is in place and will effectively and efficiently advocate and intercede to detect and prevent barriers that impact on the health and wellbeing of the client, their families and the community.

As a participating member of the Mid West Toronto Health Link and as a member of the Mid West Toronto Health Council, we have contributed to inform and collectively

address the challenges and barriers for our vulnerable populations to preventative and early intervention upstream health care access.

The Indigenous Palliative Care Committee (IPCC) was an ad hoc committee with a mandate from the Board of Directors to design a palliative /hospice service design model that harmonizes western and traditional approaches to end of life or threatening illnesses. The IPCC met for 9 consecutive monthly meetings. The committee membership included AHT Board members, Clients, community members, Traditional Healers, Palliative Care Physicians, Primary Care Nurse Practitioners, Traditional Coordinator, Management and 2 Spirit community members. The committee develop a palliative/hospice service design model that harmonizes western and traditional approaches to end of life or life threatening illnesses.

The IPC report detailed gaps in the current palliative care biomedical delivery design and benefits of a harmonized western and traditional delivery model of care.

The Indigenous Palliative Care model is founded on traditional teachings to support the Palliative Care clients and their families/caregivers and community, through the journey. The Indigenous Palliative Care delivery design is grounded in Indigenous values, beliefs and the unique diversity of Indigenous peoples. The service scope and practices focus on the end of life experience, as a part of the journey of life, every day circle of living, family and the ceremonies are reflected in the model design.

In partnership with the TC LHIN, Anishnawbe Health Toronto is invited Aboriginal community partners, Palliative care delivery hospital, hospice, home care, homeless initiatives and local and regional Indigenous and main stream cancer care organizations and resources to participate in a Community Engagement session with our Indigenous Palliative Care Committee. Our Indigenous Palliative Care Committee shared our Harmonized Western and Traditional Palliative Service Design and Model with the stakeholders.. Cultural gaps in the current palliative care delivery were explored with the participants through visuals and analysis of the biomedical palliative care delivery model of care.

Anishnawbe Health Toronto submitted a proposal to the TC LHIN. The Indigenous Palliative Care program was approved and is in the process of implementation. The implementation of the Traditional Palliative Care delivery model of care will support current Western palliative care delivery services, through a harmonized western and traditional blend of practices. The intended outcome is to better meet the cultural needs of Indigenous patients and their families in end of life and/or those who are experiencing life threatening illnesses.

Resident, Patient, Client Engagement

Anishnawbe Health Toronto engages clients, families and communities to have an influential voice, as members of the Board of Directors, ADHOC and standing committees and working groups, client satisfaction surveys, program evaluations, program developments, community initiatives, Toronto Mid-West Health Links, Toronto Mid-West Health Council and other organizational, community, local and provincial tables.

Other

Anishnawbe Health Toronto strives to respond to the direct service and program needs of our diverse populations, across the lifespan. The Board of Directors, management and direct service staff work collectively to ensure that service delivery and service coordination is tailored to the individual and family, group and community unique needs and that access is seamless and timely.

Collaboration and Integration

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Engagement of Clinicians, Leadership & Staff

In January, 2017, Anishnawbe Health Toronto Board of Directors mandated that an ADHOC Indigenous Palliative Care Committee (IPCC) be established. The IPCC was established February 2017. The committee met for 8 consecutive sessions on a monthly basis. The IPCC goal was to develop a palliative/hospice service delivery model, to harmonize western and traditional approaches and practices. The IPCC collectively were engaged in a journey to assess cultural gaps in the current delivery of palliative care services and to strategically analyze strategies, operational planning to implement a harmonized western and traditional palliative care delivery model. The IPC committee membership included Traditional Healers, palliative care experts and specialist, board representation, community and client representation, management and Primary Health Team member representation.

On June 12th, the committee reported that "over the past few months, our Indigenous Palliative Care Committee has been engaged in a strategic analysis of cultural palliative care service gaps. The committee has completed their planning session and has developed an Indigenous Palliative Care Delivery Model of Care. The report highlights key cultural gaps in the current palliative care delivery model. The harmonizing of the Indigenous Palliative Care delivery model with the current biomedical Palliative Care delivery model will close the care gaps. The harmonized delivery model is founded on our understanding of life, values, beliefs and philosophy.

A harmonized Indigenous and Western Palliative care delivery model will provide equitable access for Indigenous peoples to Traditional healing practices and treatments, in collaboration with Western Palliative care direct services. The AHT Indigenous Palliative Care Team, working collectively with the Western Palliative Care teams will ensure palliative care environments that are client and family/caregiver centered. The Indigenous Palliative Care delivery design is grounded in Indigenous values, beliefs and the unique diversity of Indigenous peoples. The service scope and practices focus on the end of life experience, as a part of the journey of life, every day circle of living, family and the ceremonies are reflected in the model design. The Indigenous Palliative Care design embeds

early engagement of clients and their families in delivery of palliative care service. Statistical findings evidence that early engagement, in palliative care services and resources positively impact the client's palliative health, prolonging life and the quality of one's life experience. The grieving process and needs of the family continues after the one has passed on. The Indigenous Palliative model of care acknowledges the family and family members as needing care, as well as the one who is diagnosed as palliative.

The Indigenous Palliative model of care brings the family and the one who will be passing on, an environment of cultural care that supports them together, to share their stories and find meaning and understanding of the end of life experience. The Indigenous Palliative care model acknowledges that the palliative experience of clients, family, and caregivers is a continuum of interconnected spiritual, physical, emotional and mindfulness.

While the Indigenous holistic world view is central to the experience of individuals and families, medical palliative care approaches and interventions support the Indigenous experience but are not central to the interpretation and/or cultural experience of death or chronic illness.

The Indigenous Palliative care model acknowledges that the grieving process and needs of the family continues after the end of life experience for the one who has passed, and recognizes family members as central and in need of care, along with the palliative client.

The Indigenous Palliative Care design embeds early engagement of clients and their families in delivery of palliative care service. Statistical findings evidence that early engagement, in palliative care services and resources positively impact the client's palliative health, prolonging life and the quality of one's life experience.

The direct program, teams and units meet regularly to review the progress of Quality Improvement strategies and operational plans to highlight and celebrate successes and to develop and implement areas for improvement. Management, direct service teams and administrative supports meet monthly with our DMC to share new change ideas, within the framework and context of their program and team objectives and goals.

Population Health and Equity Considerations

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Access to the Right Level of Care - Addressing ALC

Clients access their Primary health care prevention, early intervention and chronic disease management through a collective wrap around same day appointment option. The Primary Health team, Diabetic Education team, mental health team, traditional team and other disciplines utilize a shared care delivery model of care to ensure that the clients physical, emotional, mental and spiritual care. This strategy can positively impact to reduce hospital access where primary health interventions can address the needs of the client.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

In compliance with our narcotic policy, Opioid is not generally prescribed for management of pain. In situation where physicians and/or Nurse practitioners are considering prescribing opioids, ethic review is required prior to prescribing. Ethic review require that medical practitioners, traditional healers and other allied care providers gather to discuss other options or other interventions to create a plan of care.

Workplace Violence Prevention

Anishnawbe Health Toronto is committed to providing a workplace in which all individuals are treated with respect and dignity. Workplace violence and harassment will not be tolerated from any person in the workplace. All staff are expected to uphold this policy and to work together to prevent workplace/domestic violence and harassment. This policy applies to staff, visitors, clients, delivery people and volunteers of Anishnawbe Health Toronto.

Workplace harassment means engaging in a course of vexatious comments or conduct against a worker in a workplace - a comment or conduct that is known or ought to be reasonable be known to be unwelcome. Harassment may also relate to a form of discrimination as set out in the Ontario Human Rights Code, but it does not have to.

There is a workplace violence and harassment program that implements this policy. It includes measures and procedures to protect workers from workplace violence and harassment, a means of summoning immediate assistance, and a process to report incidents or raise concerns.

Workplace violence and harassment program training includes Non-Violent Crisis Intervention, Workplace Violence Prevention Awareness and Safety & Security Orientation.

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)