Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 31, 2026

Ontario Health

OVERVIEW

The Vaughan Community Health Centre (VCHC) continues to dedicate significant staff and leadership time to focus on the quality improvement program.

As part of the 2025/26 QIP, the Committee began to work on identifying clients living with type 2 diabetes, who were not up to date with blood glucose screening. Through QI efforts, our primary care team obtained visibility on the number of clients that were not up to date and recalled them to complete their bloodwork. By the end of Q3 we reduced the number of people that had their last blood test in 2024 from 222 to 25 and increased the number of people who had completed a more recent blood work screening.

In 2026/2027 fiscal year, the VCHC's Quality Improvement Plan will focus on efficient, timely and safety quality dimensions, including a) client attachment, b) perception of timely access to primary care, c) clients being up to date with blood sugar screening, d) clients being up to date with pap tests and e) reducing faxing.

ACCESS AND FLOW

Through our QIP, we established a system to accommodate clients with semi-acute reasons for visits in a timely manner. A total of 683 same day visits for semi-urgent issues were requested by clients. 658 visits were successfully scheduled. 25 visits were not scheduled due to provider's or client's availability, which is 4% of all total requests for same day visits. We were able to adjust the same day's access availability based on higher demand days, i.e. Mondays. Our primary care providers also implemented a backup system for same day access, whereby if a provider that was scheduled to provide same day access is not available that day, another primary care provider took over the same day access time to be able to see clients that day.

Ensuring that clients have timely access to a primary care provider not only supports our clients, but the overall system by ensuring that clients are not visiting the emergency department for issues that can be addressed by a primary care provider.

While we are satisfied with our performance in accommodating semi-urgent appointment requests on the same day or next day, in the 2026-2027 fiscal year, we will be focusing on strategies to improve overall access for issues that are not semi-urgent in nature.

EQUITY AND INDIGENOUS HEALTH

As part of VCHC's Health Equity plan, in 2025-2026, we focused on understanding the experiences of the African, Caribbean and Black (ACB) community in accessing regular diabetes screening and primary health care services. We connected with local community partners, service providers and community members to provide blood glucose screenings and shared information about the availability of primary care, chronic disease prevention and management and system navigation services at the VCHC.

For 2026/27, we are continuing to plan additional staff training. Particularly, we will be providing staff with Indigenous Cultural Safety in Mental Health and the Sickle Cell Disease Education Program for Healthcare Professionals.

We are in the process of creating an Equity, Diversity and Inclusion Committee.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Clients provide feedback on services through client experience surveys across programs and service areas. The feedback is reviewed and discussed at team meetings and efforts are made to integrate clients' feedback into future or existing programs or services. Between April 1, 2025-December 31, 2025, 277 responses were received to the survey question "the last time you were sick or were concerned you had a health problem, did you get an appointment on the date you wanted?". We asked a follow up question on the survey to better understand the reason why a client was not able to obtain an appointment on the day they wanted. Out of 106 respondents who answered "no" we received 129 (122%) responses for the reason as to why the client may not

have obtained an appointment on the day they wanted. Top responses indicate that the clients wished to see their own primary care provider and they were not available that day and the time provided for the appointment did not align with their availability. As a result, in 2026/ 27, our Quality Improvement Committee will be looking at access from a broader lens, including access for follow up visits, expanding beyond semi-urgent same day access.

In the 2025/26 fiscal year, we conducted a pilot of automating client experience survey distribution by email with a small sample of health care providers. Clients received an email with the survey after attending the visit. We noted an increase in the number of surveys we were able to collect and reduced the amount of administrative time spent by medical secretaries asking clients to complete a survey.

In the 2026/27 fiscal year we will be expanding survey automation to more providers.

PROVIDER EXPERIENCE

In 2025/26, VCHC received the Primary Care Action Plan (PCAP) funding to expand access to ongoing primary care. As part of the expansion, VCHC has been able to recruit most positions for the expansion. Recruitment of a chiropodist continues to be a challenge due to the salary we can offer in comparison to the private sector.

To maintain staff wellbeing and reduce burnout, we continue to offer hybrid work or 4-day work schedule for most staff positions. That is, staff have a flexible schedule to work onsite and offsite during the week. In addition, we assess staff’s overall wellbeing by conducting an annual staff wellbeing survey, reviewing the feedback, and implementing the changes where feasible.

We continue to offer staff the chance to use onsite gym equipment, when not in use by clients. We redesigned a space to provide staff with a comfortable, safe space to use for their individual needs such as debrief, mental health break, religious practices and more.

Lastly, VCHC was able to provide all staff with a compensation increase in 2025/26 fiscal year.
We will continue to collect staff feedback and make changes as needed and where feasible.

SAFETY

To ensure VCHC promotes a safe environment for clients and staff, when there is an incident, an incident report is created, and staff involved takes the appropriate measures to work with the clients in addressing the issue. The incident is discussed at Joint Occupational Health & Safety Committee and team meetings, without identifying client information, to evaluate the situation, and identify strategies to prevent future recurrence and make plans to implement those strategies.

We continue to utilize e-fax for communicating with specialists and pharmacies. All primary healthcare providers have access to and utilize eReferral, eConsult, Ontario Laboratory Information System (OLIS), Hospital Record Management (HRM), electronic prescribing, secure e-mail communication and availability of online appointment bookings.

In 2026/27 VCHC will be looking at strategies for reducing fax volumes (i.e. e-fax and fax).

PALLIATIVE CARE

Depending on the client's needs, VCHC's Family Doctors and Nurse Practitioners:

1. Provide home visits to clients that are homebound.
2. Identify the needs of the client and refer them to appropriate supports using the Palliative Care Common Referral form through Ontario Health at Home.
3. Provide support to the family members during their client's being in palliative care and afterwards. For example, referring family members to grieving services, interpretation services.

In 2025/26, VCHC's primary care team obtained training from a Palliative Care Coach provided by our OHT (Western York Region OHT). Our team participated in 3 presentations focusing on the 1) Introduction to the Palliative Care Program, Referrals and Early Identification Tools; 2) Palliative care referral map and 3) Medical assistance in dying. In addition, our team also completed a training course on "serious illness conversation" which focused on equipping health care professionals with the tools and knowledge needed to have compassionate and effective conversations with patients and their families dealing with serious illnesses.

As next steps, our team is working on incorporating the use of respective referral forms into their practice, incorporating learnings from Canadian Serios Illness Conversation training in their care and considering utilizing early ID tools in EMR / for screening.

POPULATION HEALTH MANAGEMENT

In the 2025/26 fiscal year, VCHC continued to implement the Locally Driven Population Health Management (LDPHM) strategy. Our goal is to increase health literacy of priority populations within FSAs of focus, regarding prevention, management, and impacts of type 2 diabetes on their health and wellbeing. While our primary focus was reaching members of the African, Caribbean, Black (ACB) community, the results of our outreach efforts capture the outreach conducted with the broader community in Vaughan. To reach more of the ACB community, we expanded beyond Maple and Concord.

Through the work of Community Ambassadors, we established connections with local community organizations and places of worship serving the ACB community, as well as our local hospital, the Welcome Centre, food banks, and local businesses. The connection evolved from community partner meetings, to tabling at local events supporting the ACB community with resources, provision of blood glucose screenings by VCHC's Diabetes Education Team, and referrals to VCHC.

In 2026/27 fiscal year, we will work on connecting individuals to system navigation and case management. We will continue to collaborate with community partners to co-design programs and services to meet the needs of ACB community for diabetes care and chronic disease management.

CONTACT INFORMATION/DESIGNATED LEAD

Anaïd Khatchatourian (she/her)
Director, Community Health Services
Vaughan Community Health Centre|9401 Jane Street, Suite 206|
Vaughan, Ontario L6A 4H7
905-303-8490 Ext. 2629 |akhatchatourian@vaughanchc.com

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 31, 2026**

CarinBinder

Carin Binder, Board Chair

Ana Khatchatourian

Ana Khatchatourian, Quality Committee Chair or delegate

LoAn Ta-Young

LoAn Ta-Young, Executive Director/Administrative Lead

Other leadership as appropriate

2026/27 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

Vaughan CHC Corporation 206-9401 Jane Street, , Vaughan , ON, L6A4H7

AIM		Measure						Change				
Issue	Quality dimension	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods (HOW AND BY WHOM)	Process measures	Target for process measure	Comments/ Types of Reports

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)

Issue	Quality dimension	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods (HOW AND BY WHOM)	Process measures	Target for process measure	Comments/ Types of Reports
Access and Flow	Efficient	Number of new patients/clients/enrolments	Number / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	215	2971	We are including the the total number of clients VCHC is funded to attach as the target. However, the clients served by our organization are medically and socially complex and thus require more time with our providers. While we are utilizing various efforts to boost attachment, including working to full scope of practice within the interprofessional team model, attachment is slower due to the complexity of client needs. It should be noted that with the recent expansion of the primary care team, primary care providers are at different stages of attachment.	CHANGE IDEA: Use panel size targets to determine the number of new client attachments per month.	Medical Secretaries contact individuals due to drop off from panel size monthly and schedule a visit with their primary care provider. The Data Decision Support Specialist (DDSS) provides the net number of new patient attachments, that is # of clients newly attached, # of clients who left VCHC's primary care services. Recruit the full primary care team and adjust monthly targets for attachment.	# of clients due to drop off from panel size scheduled with a primary care provider. # of clients newly attached per provider, # of clients who left VCHC's primary care services.	100% of clients due to drop off from panel size are contacted (i.e. succesfully reached, scheduled, left messageX3, email, etc.) 80% of target achieved.	
								CHANGE IDEA: Better understand the needs and complexity of new clients attached.	Primary care team develops complexity of care ratings for newly attached clients. Work with DDSS to draw out data from EMR and analyze results.	Complexity of care factors and ratings identified by primary care providers and score is given.	We are able to assign a complexity care scale to 90% of newly clients.	
								CHANGE IDEA: Optimize interprofessional providers scope of practice to increase the number of cients attached.	Keswick Site Manager and Chronic Disease Program Manager to lead the process of updating our internal referral process. Then Data Decision Support Specialist (DDSS) to track the the number of referrals from the primary care providers to allied health, chronic disease prevention and management professionals, system navigators and community group programs. Interprofessional providers are invited to clinical team meetings for discussions on emerging client needs, to identify opportunities to leverage their scope of practice to support MDs and NPs with emerging client needs and new client attachment. Assess the role of Registered Practical Nurses (RPNs) to support physicians and NPs in client attachment efforts, i.e.# of visits with MD/NP, # of visits with inter-professional providers, and reasons for visits.	# of interprofessional provider meetings per quarter # of new clients seen by RPN	at least 1 interprofessional meeting per quarter held. Tbd % of new clients triaged by RPN.	
								CHANGE IDEA: Increase referrals to System Navigator for social needs/ support in navigating the medical and social systems for all clients.	Non insured clients scheduled with System Navigator after the first visit. The # of visits will be provided by the DDSS. System Navigator's scope of practice defined and shared with primary care providers. Clients with social/system navigation needs are referred to System Navigator.	# of visits with System Navigator for non insured clients # of referrals to System Navigator from PCPs and reasons for referral.	100% of new non-insured clients are scheduled with System Navigator. 100% of clients are referred to System Navigator for social / system navigation needs.	
								CHANGE IDEA: Reduce administrative time in documentation for MDs, NPs, RPNs.	AI Scribe software is procured and rolled out to primary care providers. Documentation time is tracked before and after the implementation of AI scribe.	# of providers who use the AI scribe # of time spent on documentation (pre and post survey).	100% of providers are onboarded to AI scribe by May 31, 2026 Time spent on documentaiton is reduced - time is tbd	
		Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring	% / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	67%	70%	Through QI efforts, in Q1, the last HbA1C test in 2025 was 41.36%. In Q3, the last HbA1C test in 2025 increased to 91.49%. Our team caught up with recalling all clients who were past due for their HBA1C. We will continue recalling clients who are due for their HBA1C.	CHANGE IDEA: Continue to remind clients who are not up to date with their HbA1c blood glucose monitoring	Data Decision Support Specialist provides list of clients due for HBA1C screening and clients are contacted to schedule visit with their PCP.	# of clients due for HBA1C contacted by MDs/NPs. % of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring	100% of clients due, attempted to contact (i.e. succesfully reached, left messageX3, email, etc.) 70% of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring based on when they are due.	List of clients due for their test and a note about contact from MD/NP Next quarter, same list of clients pulled from previous quarter with a comparrison on if there was an updated HBA1C date logged in.
	Timely	Patient/client perception of timely access to care: percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	62%	70%	Through our QIP, we established a well-working system to accomodate patients with semi-acute reasons for visits in a timely manner. We were able to schedule 96% of same day/next day visit requests (not accomodated =25 out of 658 requests). While we are satisfied with our performance in accommodating semi-urgent appointment requests on the same day or next day from the time of the request, the results from responses from the client experience survey indicated a drop from the previous fiscal year by 1%. Thus we will be maintaining the target of 70% for this fiscal year and focusing on strategies to improve overall access.	CHANGE IDEA : Continue survey collection.	Use of client experience survey question: The last time you were sick or were concerned you had a health problem... a. Did you get an appointment on the date you wanted Yes No b. How many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone else in their centre? Same day Next day 2-19 days (enter # of days: _____) 20 or more days Not applicable (don't know/ refused	# of surveys collected % of respondents indicate they obtained an appointment on the date they wanted.	a. 10% of annual visits b. 70% of respondents answer "Yes" to the survey question asking if they obtained an appointment on the date they wanted.	
								CHANGE IDEA: Triage clients' needs and offer same day/next day's appointment for same day/next day issues.	Medical Secretaries schedule clients for same day/next day appointment in accordance to triage guidelines.	% of same day visits available are utilized.	a. 95% of same day appointments available are booked weekly for same day issues.	
									Identify if clients are scheduling repeat visits with own provider after same day visit.	# of visits scheduled after same day visit for same issue.	tbd.	
								CHANGE IDEA: Measure and balance supply of visits with client demand by measuring supply and demand, reviewing panel size and number of visits required for a provider.	Measure third next available (measuring the length of time patients are waiting for an appointment. First and second available appointments are not used, as they could be the result of a recent cancellation)	track the baseline for # of days for TNAA per provider.	tracking is conducted for all providers	
									Increase the supply of visits to reduce TNAA	# of visits added to provider's schedules to achieve TNAA of '0'	TNAA of 0 is reached.	

		Percentage of screen-eligible people who are up to date with cervical screening	% / PC organization population eligible for screening	EMR/Chart Review / Q2 2025 (covering 42 months of participation for cytology (Pap) testing, and 66 months of participation for HPV testing up to September 2025)	84%	87%	We will be working on reaching 87% in alignment with the target set out in our Multi-Sectoral Accountability Agreement (MSAA)	CHANGE IDEA: Re-stablish a patient reminder system for individuals due for their pap tests	Data Decision Support Specialist provides list of clients due for preventative cancer screening. RPN contacts clients and offers visit with their primary care provider.	# of clients contacted who are due for their preventative cancer screening. Out of the clients who were offered an appointment, the # of clients who actually scheduled a visit for their preventative cancer screening. # of clients up to date with their preventative cancer screening.	100% of clients contacted (i.e. succesfully reached, left messageX3, email, etc.) 90% of clients who were offered an appointment, scheduled an appt (# of people who the RPN actually spoke with and scheduled an appointment) # of clients contacted by RPN who completed their preventative cancer screening.	List of clients due for their test and a note about contact from RPN. Next quarter, same list of clients pulled from previous quarter with a comparrison on if there was an updated pap test date logged in.
Safety	**Safe**	Number of faxes sent per 1,000 rostered patients	Number of faxes / PC patients/clients	Other / Most recent quarter of data available (consecutive 3-month period)	778	tbd	Over the last 3 months, we sent a total number of 3,926 efaxes for a total roseter of 5,026 patients.	CHANGE IDEA: Collection of baseline data on fax volume (both physical and eFax).	Use EMR to track efax volumes. Use fax machine to track faxes.	# of e-faxes sent by the primary health care organization in the last quarter (3 months)	100% of fax volumes are accounted for.	
								CHANGE IDEA: Identify forms that could be replaced with Ocean eReferral	Diagnostic imaging referral forms are replaced with Ocean eReferral forms	diagnostic imaging forms are sent to hospital through Ocean.	tbd.	Utilize OCEAN to fax diagnostic imaging referral to Mackenzie Health Hospital.