Let's Make Healthy Change Happen.

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

Great Northern
Family Health Team

3/22/2017

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.

Overview

The Great Northern Family Health Team strives to enhance primary health care, improve patient access and integrate a collaborative approach model to improve the health of our patients.

The Great Northern Family Health Team's Quality Improvement Plan serves as a functional document which identifies our main improvement initiatives. Our goals for 2017/18 originate from our strategic focus and commitment to quality patient care. Our work in quality will continually emerge under a health system with a culture that is safe, effective, patient-centred, efficient, timely, equitable, appropriately resourced and focused on the health of our population.

QI Achievements From the Past Year

Our new EMR (Telus Practice Solutions) has been instrumental in helping our team become focused on measuring our programs' performance and successes. We have finally been able to incorporate standard performance measures so that we can compare ourselves regionally and provincially. We have made considerable strides in EMR data quality with a focus on use of diagnostic codes (ICD-9), recording of flu vaccinations, patient smoking status and use of OLIS to import legacy reports into patient charts to ensure we have the most updated information. Our docs also gained access to their SARs and reconciliation work is underway. One of our physicians is a lead for a new EMR Data Working Group along with the NP, QIDSS and ED.

Our Quality Council continues to meet monthly with two physician members.

An exciting QI project "Towards Reducing ED Visits for CTAS 4 & 5 - Role of Primary Care" had tremendous results. Our FHT, as well as Haileybury & Temagami FHTs, the CHC, our QIDSS and the Temiskaming Hospital partnered to identify strategies to inspire primary care patients to contact their primary care team first before going to the ER for non-urgent issues. Our AIM statement was to 'Reduce the number of ED visits for CTAS 4 & 5 by 5% by March 31, 2017'. For this QIP, we analyzed available data (Q1 through Q3).
Compared with 2015/16, our CTAS 4 & 5 visits are 22% lower for 2016/17. Our initial baseline data showed UTIs had been one of the top diagnoses for CTAS 4 & 5 visits so we targeted that condition for patient education to ensure our patients knew they do not require an appointment for testing/treatment. Our UTIs are down 11% compared with the same time period last year. We also found the percentage of rostered patients is 12.6% compared with 26% last year. Visits in Q3 of this FY are 17% lower than in Q1.

We have established an EMR Data Working Group and have sought input from all staff to prioritize our standardization efforts. Through team discussion at both our Quality Council and with frontline staff, we have identified these as our top three EMR standardization priorities: update address book, categorize documentation and update patient handouts available within EMR. Specialized training has also taken place to customize forms as well as work flow tools within the EMR. This allows for real time updating and customization that supports our clinicians work flow and efficiency.

Our team has received an award from AFHTO for Collaboration Across Interprofessional Teams to Foster Improvement in Falls Prevention. We have also won an IDEAS Alumni Achievement Award in relationship to Falls Prevention in Primary Care. This Falls Prevention work has been spreading across the Northeast LHIN with many partners contributing to its success.

Population Health

From Public Health data we know smoking prevalence is 33% in our district, compared with 14% for Ontario (2013/14). Our team asks all patients over aged 12 their smoking status and ensures the EMR record has smoking status recorded. We offer both the Ottawa Model Smoking Cessation Program and the STOP smoking cessation program. Our Social Worker, RN and Respiratory Therapist (RT) are trained as counselors.

With the average age of our patients 45 years and with high smoke prevalence it comes as no surprise that we have a high number of patients with COPD. So we were excited to become a pilot site for a provincial COPD Value Demonstrating Initiative (offered through the ON Lung Assoc). Patients with severe COPD are being identified and regularly followed to help them manage their symptoms and improve quality of life. Our RT is the project lead.

Other project initiatives in the past year, dealing with population health, that we have undertaken include:

- Falls Prevention Risk Assessment & Intervention (very important as 25% of our patients are 65 years & over);
- Diabetes Focused Visits (From our EMR we know that 11% of our patients have diabetes diagnosis; and
- Hypertension Management Program through the Cardiac Care Network (From our EMR we know that 25% of our patients have hypertension.

Equity

In applying an equity lens to our patients, we know that 25% of our patients are 65 years of age and older; and that 38.7% of our patients are in the lowest two income quintiles.

We have worked collaboratively at a local level to offer group classes in Tai Chi, From Soup to Tomatoes which is an exercise class viewed on the internet, but locally is hosted in a community room with a volunteer which has had great success in attendance. These classes are offered free of charge.

In January, 2017, we initiated a "Health Matters" monthly column in our local newspaper to provide educational information to anyone who reads them. Topics to date included Choosing Wisely and Prescription Renewals.

We have also participating in regional collaborative meetings with the objective of improving transportation.

Integration and Continuity of Care

We participate in both the Timiskaming Collaborative as well as the Timiskaming Health Link Partnership. Our Executive Director co-chairs the Collaborative with the Executive Director of the Canadian Mental Health Association. Our Executive Director co-chairs the Health Link Partnership with the Chief Nurse and Health Professions Officer and Director of Operations from the Temiskaming Hospital. Funding for Health Link is flowed through the Kirkland Lake Hospital.

We were successful through the collaborative partnership in acquiring a Nurse Assessor for the District of Timiskaming that is aligned with the Northeast Specialized Geriatric Centre. This individual practices out of the Great Northern Family Health Team and works closely with one of our doctors who is a primary care

geriatric physician. At this point, a joint application has been made for funding to hire an Occupational Therapist to work alongside the nurse assessor and to support our falls prevention work in primary care.

Through a collaborative approach with partners in the COPD VDI, we have been able to customize Telus PS to support the work of the project and the respiratory therapists. We continue to work together to enhance the outcome of this project.

Through our Health Link Partnership, we revised our Business Plan and focus resulting in meeting our care plan target for 2016/17. We will be revising our Business Plan as we look forward to possible multi-year funding and sustainable frontline resources to be able to implement meaningful systems and workflows. Achieving a streamlined system that is properly resourced will support keeping patients comfortably in their home, decrease admissions and readmissions to hospital, and decrease emergency room visits.

Access to the Right Level of Care - Addressing ALC Issues

Alternate Level of Care (ALC) refers to patients who no longer need treatment in a hospital, but who continue to occupy hospital beds as they wait to be discharged or transferred to another care environment. The Great Northern FHT, together with our partners are active participants in the Timiskaming Health Collaborative and Health Links. This includes (but is not limited to) working together to develop coordinated care plans for complex patients and putting programs and supports in place for patients so that they can be supported in the community and in their home. Over the 2017/18 year, we hope to continue this work and continue to strengthen our partnerships so that we can provide the right care at the right time for patients to allow for them to continue to be supported in the home, preventing decompensations and in turn decreasing the burden on the hospital and other care environments. We also look forward to investigating with our partners further opportunities there may be for us to work together to address ALC issues.

Engagement of Clinicians, Leadership & Staff

We conducted a strategic planning session that takes us from 2015 - 2020 with our entire team and the priorities that emerged are:

1. Patient Experience/Accessibility
2. Building Relocation
3. EMR Standardization
4. Team Approach - Internal & External

We are moving forward with our priorities and will be using tablet technology and CognisantMD Ocean subscription to enhance patient survey processes; accessibility is measured in our survey as well as tracking same day, next day appointments within the EMR.

Our team is relocating to 240 Shepherdson Road the last week of March, 2017 and will be reopening our clinic to the public on April 3, 2017.

EMR standardization is underway with more to be done and we really have not looked back since we migrated to Telus PS in April, 2016. Standardization is supported as meaningful quality improvement work.

We use quality improvement tools and methodologies to support a culture of quality. A number of staff have been trained in IDEAS and are alumni of the program. Leadership, clinicians and staff are engaged in the development and performance of

this plan. Through the Quality Council, comprised of frontline staff, administrative and physician membership, performance will be tracked against measures. The Quality Council is co-chaired by the Physician Lead and Executive Director.

Resident, Patient, Client Engagement

A Community Advisory Council was established in 2014/15 and remains in place. This Council will be reviewing our Quality Improvement Plan looking for change ideas that would enhance patient centered care. The Community Advisory Council is co-chaired by a physician and the Executive Director.

With our move to a new clinic, we will be in a position to better engage with our community members. We plan to hold open forums where we will invite patients to come and learn more about what our team offers on an individual basis as well as programs and services. Within the proper environment, and centralized approach we will now have as a team working together, we will be able to focus more on health promotion and what we can do to help patients self-manage more readily. Our Community Advisory Council members will have a role to play as we move this forward.

Staff Safety & Workplace Violence

We have policies in place that support workplace safety and dealing with workplace violence. Our new building incorporates appropriate security measures and we do not work alone when patients are being seen in clinic. We have reporting mechanisms in place and will be using an in and out board.

With a view to wellness and a vibrant team culture, our new clinic has a kitchen where we will join as a team for health breaks. We will be able to move the waiting room chairs to enable us to hold exercise classes after regularly scheduled clinics are done. We expect to hold free classes for the public once a month, aged 55+ and over, as well as offering exercise classes to our staff.

Contact Information

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Other

Thank you to the Ministry of Health and Long-Term Care, Family Health Team Branch, for their continued support of our Family Health Team. After 5 years of working on a project to relocate our clinic, we are finally able to say this is taking place. With our move, we have two physicians joining immediately, and we already have four other physicians who are inquiring about practice with our team. We look forward to continued growth, applying quality improvement philosophy to our approach and helping our community residents with their health goals.

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
Quality Committee Chair or delegate
Executive Director / Administrative Lead
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)