Let's Make Healthy Change Happen.

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

Great Northern Family Health Team

3/28/2016

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 with our improvement initiatives. Our goals for 2016/17 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

We participated in Cohort I of Improving and Driving Excellence Across Sectors (IDEAS) with a focus on Falls Prevention in Primary Care. This Project is being used as the Case Study within the IDEAS 2-day Introductory Program delivered through the Northern Ontario School of Medicine. Phase II of this project has led us and our partners to "Falls Prevention in Primary Care - Assessment to Intervention" and winning a $25,000 Alumni Achievement Award to apply toward project sustainability. One of the specific initiatives we are undertaking is to pilot the use of Telus PS and patient use of tablets through Ocean subscription to complete falls risk assessment and interventions to prevent falls and increase patient's capacity to live independently. The pilot is being held across 6 FHTs in the North East (Great Northern, Temagami, Timmins East End, Powasson, Espanola and Sudbury). We are working in collaboration with the North East LHIN and the Timiskaming Health Unit on this initiative. We are presenting the results of our pilot at the "Watch Your Step 2016 National Falls Prevention Conference" in Calgary, Alberta in May, 2016. We will be sharing how we approached our work on falls prevention and independent living. We will also be presenting the results of our project sustainability at the 2016 IDEAS Alumni Event.

Five of the Great Northern Family Health Team staff have participated in the IDEAS program. We have applied the use of quality improvement methodology within our team through the use of process maps, Pareto principle, cause and effect diagrams and PDSAs. The tools have also been used across organizations dealing with falls prevention, as well as enhancing use of community respite adult day program.

Representatives of our Community Advisory Council were asked to present our Council's experience at a Health Quality Ontario webinar as detailed under Patient/Resident/Client Engagement below.

With our current migration to Telus PS, we will no longer manually collect data which provides for efficient use of time. We are taking a program planning and evaluation approach specifically to the "Falls Prevention - Assessment to Intervention" initiative. We are incorporating workflows that deal with Chronic Obstructive Pulmonary Disease and Coordinated Care Planning work flow.

Integration & Continuity of Care

We participate in both the Timiskaming Collaborative as well as the Timiskaming Health Link Partnership.

In terms of the approach to move forward with the Collaborative, we are working on items such as:
- Northeast Specialized Geriatric Services (NESGS) Nurse Assessor: role was advocated for and is housed out of the Great Northern Family Health Team. Dr. Donald Davies, physician with the GNFHT, works closely with the RN assessor and is linked to the Sudbury NESGS team. We will be having a program update and discussion on how we can enhance the service.
- Timiskaming was approached to take part in a Chronic Obstructive Pulmonary Disease Value Demonstration Initiative. We will be having a program update and discussion on what we can improve as 4 of the FHTs initially signed up to participate stepped back from this project. We have provided feedback to the Research team and discussions are underway on how we may work together.
- Palliative Care approach to services in our district;
- Transportation proposal;
- Temagami, Bear Island and Service Providers Collaborative update;
- Englehart Health Hub update; and
- Local and regional Stay On Your Feet initiative.

In terms of the approach to move forward with the Timiskaming Health Link Partnership, and after consultation with Health Quality Ontario and a planning meeting at the NE LHIN, we have completed a Letter of Cooperation that identifies with program outcomes and are advancing as follows:
- Conducting a current state analysis and evaluation of lessons learned to-date;
- To explore results of current state analysis and determine appropriate CCP target for 2016/17;
- We initially used the LACE tool to identify patients through community hospitals. We are going to look at additional ways, including a brochure for patients to self-identify if they would benefit from a coordinated care plan;
- Leveraging the learning and coaching from Health Quality Ontario;
- Developed procedure to define financial and reporting structure of the partnership;
- Development of qualitative and quantitative measures, ie. LHIN prepared dashboard, patient experience survey and specific items to be tracked by Health Link Partnership;
- Learning from Georgian Bay Family Health Team's approach to development of Coordinated Care Plan tool within Telus PS EMR to adapt and create efficiencies for clinicians in completion of plans (4 of 5 FHTs in our district use Telus PS EMR);
- To determine high risk patients without access to primary care and what steps can be taken to improve access and continuity of care; and
- We have adapted a consensus model approach to decision-making at the Health Link Partnership table.

For 2016/17, The Executive Director of the Great Northern Family Health Team will co-chair the Collaborative with the Executive Director of the Canadian Mental Health Association, and co-chair the Health Link Partnership with the Chief Nurse & Health Professions Officer/Director of Operations at Temiskaming Hospital.

Engagement of Leadership, Clinicians and Staff

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.

Patient/Resident/Client Engagement

A Community Advisory Council was established in 2014/15 and we have been working with this Council to educate members to have them help communicate the programs, services and strategies of the Great Northern Family Health Team. This Council has shared in the development of the 2016/17 Quality Improvement Plan and will continue to inform us on improvement opportunities to enhance patient centered care. The Community Advisory Council is co-chaired by a physician and the Executive Director.

Of note, representatives from our Community Advisory Council were invited by Health Quality Ontario to share our Council's work to-date at a webinar on February 18, 2016. Over 100 teams participated in the call where we shared our story, which included: our reason for starting the Council, when and how we began the council, who participates, what we have talked about, how we have progressed and how our patient advisors feel. Initially, we adapted our Terms of Reference, with permission, from London Health Sciences Center in August, 2013. Information shared with the council includes:

- Great Northern Family Health Team members, programs and services;
- Canadian Index of Wellbeing video clip;
- Measuring What Matters document (Ontario Trillium Foundation);
- Let's Start a Conversation Video (developed by Health Unit);
- Essential Ingredients for Change document;
- AFHTO indicators;
- Shared links to AFHTO website, HQO website and Patients First - Action Plan for Healthcare document; and
- We also talked about quality improvement methodology and use of project charters.

At the same webinar, Health Quality Ontario provided additional information and documentation on how to commence a Council. The Health Quality Ontario documentation on developing a Council was shared with the members of our Council, who agreed that we had established ourselves appropriately. Specific HQO documentation shared included: Creating an Effective Terms of Reference, Recruiting for Diversity and Choosing Meaningful Projects.

Our Community Advisory Council will meet quarterly to review pertinent information such as Quality Improvement Plan measures, Operating Plan, website development and building update.

Our patient members are engaged and prepared to continue to learn about healthcare transformation and their role in it as we move forward.

Other

We undertook a strategic planning process in Jan/Feb 2015 with the high level priorities and 2015/16 updates as follows:

1. Patient Accessibility: Our physicians are in the clinic 2 1/2 to 4 days per week as they also cover at the hospital caring for inpatients, covering Emergency Room shifts, deliveries and assisting in the Operating Room. For the days they are in, we asked each office to track the number of patients that requested a same day/next day appointment and the number of patients that were given a same day / next day appointment. For the month of February, the actual performance was: for two physician practices, their same day/next day was 100%, a third physician practice was at 50%, and for the NP and RN the same day/next day was 35%. In 2016/17, with the relocation of our team to a new clinic site, and the addition of three physicians to our team, we will roster additional patients and re-study this measure.

2. Team Approach - Internal: We are evaluating roles, maximizing scope of practice, meeting regularly with establishment of regular front office meetings and clinical lunch and learn sessions. We are also using quality improvement methodologies as we learn how best to deal with issues. We will continue with our regular Family Health Team meetings, Full Team meetings and ad-hoc meetings to address specific initiatives or concerns.

3. EMR Standardization/Consistency: We are migrating from P & P to Telus PS in April, 2016. The team will learn together and determine how best to standardize entry and clinical workflow so that we can maximize the features of the EMR to benefit improved data collection to enhance patient care, Ministry data collection and population based information relative to our Family Health Team.

4. Building - Relocation: Our team is relocating to a new clinic site in December 2016 or January 2017. This will support patient accessibility, internal team approach and workflow improvements that will be supported through our new EMR.

5. Team Approach - External: With our team's involvement in Timiskaming Collaborative, Timiskaming Health Link Partnership and the Local and Regional Stay On Your Feet initiative, we are engaged in working with external representative and agencies to enhance provision of local services.

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, Physician Lead, Co-Chair - Quality Council Dr. Glenn Corneil	Executive Director, Co-Chair – Quality Council Shirley Watchorn