Let's Make Healthy Change Happen.

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

1/16/2018

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.

Overview

The Superior Family Health Team (SFHT) provides timely access to quality integrated and coordinated primary health care to meet the needs of our patient population. We provide patient-centred chronic disease management, disease prevention, and health promotion services. We work with our physicians and health system partners to strengthen health outcomes in preventative care and disease management to meet the needs of our community.

SFHT continues to set targets to improve performance. The team will focus on understanding measurements be accessing and reviewing data from various sources including the SFHTs electronic medical record (EMR), hospital data, Ministry of Health and Long Term Care (MOHLTC), Cancer Care Ontario (CCO), Association of Family Health Teams of Ontario (AFHTO), etc. By increasing the awareness and understanding of the data, SFHT will be better positioned to identify new areas for improvement in the future.

We have used the experience and learning opportunities gained in our previous submissions of our Quality Improvement Plans (QIP) to prepare for the 2018-19 QIP. This year's QIP top priorities continue to focus on:

- Access: ensuring availability of same day/next day appointments when needed.
- Integration: scheduling follow up appointments with medication reconciliation within 7 days of discharge from hospital

SFHTs Quality Assurance Committee is comprised of leadership, clinicians, and administrative staff. With the diversity of the committee, quality can be reviewed from different perspectives providing a robust plan for improvement or change. Once the QIP is completed a staff meeting is scheduled to review our goals and receive feedback going forward. The QIP is also publicly available via our website.

In recognizing significant gains this year in the outcomes of our quality improvement initiatives, SFHT is committed to maintaining this momentum within our team and to expanding efforts where impact on patient health care equity can be demonstrated.

We will continue to build upon our successes and enhance the programs and service that benefit those that we impact. We are committed to Quality Improvement, leveraging our EMR technology, and to working in collaboration with healthcare and social organizations in our region.

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

Superior Family Health Team has successfully implemented a new method of tracking patient statistics. With the help of our newly acquired Quality Information Decision Support Specialist (QIDSS), an Encounter Assistant (EA) was created in December 2017 and tailored to the needs of our Family Health Team. This EA will not only provide more valuable data but will help to identify patients that may not be receiving the proper access to services provided by our FHT.

The implementation of our Discharge Program has increased the patients seen within 7 days of discharge and every discharge patient is contacted upon discharge.

As of March 2017, SFHTs rates of less urgent hospital emergency visit measured as CTAS level 4-5 was 83.8 per 1000, significantly lower than the provincial average of 140.3 per 1000. This is a direct indicator that our processes are working.

Increased the patients accessing the Ontario Health Network (OTN) expanding capacity for referral services, reducing patient wait and travel times and costs associated with travel/accommodations and lose of wage.

The walk in clinic that we established in 2014 at the Neighbourhood Resource Centre (NRC) to provide primary care to orphan patients who have difficulty accessing care continues to be successful. This year we provided care to 326 patients (954 visits), many of which have no primary care provider or health card. The collaboration between social and health organizations to meet the health and social needs of this segment of the population at the NRC has been regionally recognized as a model that improves outcomes in health equity.

Patient satisfaction continues to remain stable with same day/next day availability at 100% and 93.5% of patient's state that they are involved as they want to be in decisions about their care and treatment. The number of surveys completed continues to increase every year better capturing the patient's viewpoint.

In December 2017, Lifelabs started coming to the clinic on Tuesdays from 8:30-4 and Thursdays from 8:30-12 to provide in house point of care for INRs and regular lab services. This has improved patient care and allowed patients to have their appointments and blood draws done at the same time. Patient feedback has been extremely positive about the available service. We are currently looking at bringing Lifelabs to the NRC during the time we are there to allow more access to services without the need for transportation which can be a barrier to the patients we see there.

Resident, Patient, Client Engagement

A Patient Advisory Council (PAC) was established in October 2017. This council will be providing input into our QIP looking for change ideas that would enhance patient centred care. The PAC is currently being chaired by the Executive Director but the goal is for the PAC to be co chaired by a community member. We are currently deciding on a QI project to pursue. This committee although new has provided valuable insight into the continued commitment to quality improvement.

Patient feedback continues to be collected through patient satisfaction surveys. The number of patient surveys has increased over the past year through the efforts of the clerical and nursing staff. The survey is available in paper form or on our website. There is a poster posted in the waiting room encouraging patients to complete the survey as well as quarterly blitzes when we are actively seeking feedback.

Currently, we are collecting feedback from patients on group sessions that they would be interested in attending. Patients are asked to complete a short survey with the option of leaving their name and phone number to be contacted.

Collaboration and Integration

SFHT, including physicians, nurse practitioners, registered practical nurses, registered dietitian, registered pharmacist, social worker, chiropodist and clerical staff, work together to optimize integration and continuity of care.

Working in collaboration with the MOHLTC, Health Quality Ontario, the North East LHIN, AFHTO and other Family Health Teams with the goal of sharing experiences related to Quality Improvement and learning from one another is another method that we intend to employ to ensure that Quality Improvement continues to move forward.

SFHT was the Executive Sponsor for the Ideas Project-Addressing the social determinants of health by improving access to primary healthcare services to disadvantaged people through expansion of the Neighbourhood Resource Centre Model. The project was part of Cohort 12 and was done in collaboration with Algoma Public Health.

Memory Clinic continues to be successful and partnering with the Alzheimer's Society has proved invaluable. Patients receive collaborative patient-centred care that promotes the active participation of each discipline in patient care. Through collaboration there is an inter-professional process of communication and decision making that enables the separate and shared knowledge and skills of health care providers all with the same goal.

The partnerships that we have created through the NRC with John Howard's Society, Algoma Public Health Community Mental Health Program, Sault Ste. Marie Police Services, Canadian Mental Health Association, City of Sault Ste. Marie Social Services, Breton House, Algoma Family Services, Children's Aid Society, allows us to provide comprehensive primary care to orphan patients who would otherwise have difficulty accessing care.

The Northeastern Ontario Family Health Team Network (NEOFHT) is committed to quality improvement not only within their teams but regionally. In AFHTO's Data 2 Decision report 5.1, 17 out 27 teams participated, *making*

this region the highest number of participating teams provincially, the 4th time in a row. The network identified that teams in this region are innovate and their successes should be celebrated and shared with other health care providers.

In partnership with the QIDSS in the region, the teams started by agreeing on a common set of indicators to track performance on the nine most common programs. These indicators are meaningful, measureable and actionable. This will allow the teams to move beyond measuring and reporting to quality improvement. Through the standardization of indicators, teams will be able to focus on improving patient care. In addition, these common set of indicators will allow teams to compare results and identify areas of quality improvement, and even more importantly success stores that they can share with their peers. These common set of measures will lead to collaboration, shared learnings and scalability across the region.

To help insure that the data in the electronic medical record (EMR) supports these programs and performance indicators, the network is focusing on insuring that the data is collected efficiently, and in a standardized method. The NEOFHT have agreed to support a one-year trial using one-time funding to purchase Ocean technology from CognisnantMD. Though the use of standardized patient engagement tools no matter what team the patient is accessing care; the data is captured and measured in the same way. Taking the focus from getting the data, to doing something with the data.

This technology will not only help standardize data for measurement and quality improvement but will increase patient engagement. Through the use of Ocean tablets, patients are able to access tools such as falls prevention screening, mental health screening, smoking cessation, preventative care, and patient experience surveys. This tool will increase patient's access to programs, while insuring that the team is focusing on what matters most to the patient. The Ocean Platform will allow the North East to connect with patients in the clinic or within their homes.

The NEOFHT is excited to be working together to implement a large-scale quality improvement effort in the region.

Engagement of Clinicians, Leadership & Staff

SFHT is a teaching facility that provides learning opportunities to medical, nursing, pharmacist and dietitian learners. Continuing education is encouraged and integrated into the function of the clinic through case presentation and education sessions that all staff and learners can attend.

Our strategic plan measures are reviewed quarterly with a session planned for fall of 2018 to revise the plan with input provided by Board Members, Patient Advisory Council and staff.

Population Health and Equity Considerations

We are taking part in the Tapestry Pilot Project in collaboration with McMaster University and the Canadian Red Cross. Health Tapestry could be though of as a "Health Links prevention program." Health Tapestry aims to reach people and intervene before they are in crisis. The program aims to reach people and intervene before they are in crisis by getting an understanding of their life and health goals as well as needs and risks in order to plan care based on principles that are shown to support healthy aging (fitness, nutrition, planning ahead for end of life conversations, building social connections, etc.). While both programs work to better understand the needs and experiences of their patients, Health Tapestry involves volunteers in the process. From our Primary Care Practice Report we know that 20% of our patients are over the age of 65 and the program is geared to patients over 70 years of age.

We continue to offer a weekly walk in clinic at the Neighbourhood Resource Centre (NRC) servicing an area in our city that scores poorly on all social determinants of health. Recently, a documentary aired "Steeltown down, Overdose Crisis in the Soo" which was filmed primarily at the Neighbourhood Resource Centre and really stressed the complex needs of the population serviced through the walk in clinic. Although we were not featured

in the documentary the patients that we service are in need of many programs and services that through collaboration with other organizations such as John Howard Society, Children's Aid Society, Housing, Algoma Family Services, Canadian Mental Health we provide as well as the services and programs offered through our FHT

Access to the Right Level of Care - Addressing ALC

SFHT has a dedicated CCAC staff member that spends ½ day a week at our clinic and participates in providing more efficient navigation of services. Moving forward we are hoping to increase the time spent at SFHT. Through the discharge follow up, patient transitions from hospital to the right community services will be identified.

The lead physician for SFHT is the Medical Director and attending physician for Cedarwood Lodge Long Term Care Home.

Home visits are also provided to patients who have difficulty attending appointments ensuring that the patient's care is not compromised.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Superior Family Health Team integrated the Opioid Management Toolbar into the electronic medical record in January 2018. This resource was created by another Family Health Team in Ontario and provides staff with numerous resources such as opioid conversion calculators, opioid initiation checklists, user agreements, patient education materials and links to pain management guidelines. Our goal in the coming year is to educate prescribers on the use of the Toolbar, identify patients on greater than 90 morphine equivalents per day (MEQ) and subsequently reassess their drug regimens and refer them to a pain clinic.

Workplace Violence Prevention

Health & Safety is a top priority of SFHT. Policies are in place to ensure a safe environment for staff and patients. Definitions of key concepts are consistent with Human Rights Legislation.

SFHTs Joint Health & Safety Committee meets quarterly to review policies and procedures. We also have processes in place for workers to report incidents of workplace violence, to summon immediate assistance and how the employer will investigate and deal with incidents or complaints.

Policies are communicated to staff by semi-annual staff meetings centred on Health & Safety as well as email communiques highlighting any new legislative requirements.

As an organization we are committed to staff and patient safety.

Contact Information

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Other

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)