Let's Make Healthy Change Happen.

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

MARATHON FAMILY HEALTH TEAM

4/13/2015

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

Marathon Family Health Team (MFHT) Quality Improvement activities are well aligned with the organizational mission, vision statements and strategic plan. The MFHT mission statement indicates we are committed to sustainable, comprehensive, high quality primary care for our communities. The MFHT vision statement indicates that MFHT, through its work and through collaboration with community partners, will work to achieve optimal health and wellness for the people of our communities. The MFHT QIP also strives to align with Ontario's Action Plan for Health Care and the goals and objectives of the proposed Thunder Bay District IDN Health Link.

MFHT applies quality improvement methodologies such as Continuous Quality Improvement (CQI) and Plan Do Study Act (PDSA). By applying such methodologies, MFHT continues to collect data about their existing programs and services to benchmark performance, track and validate criteria that affect outcomes and recognize problems in the processes of care and practice.

The following QI objectives are planned for 2015-2016:

ACCESS:

1. Review same day appointment availability and use to determine need by day of week and seasonally adjust the number of same day appointments accordingly.
2. Continue recruitment efforts to hire a new nurse practitioner which will improve the availability of same day appointments.
3. Work with the local hospital to determine for what conditions patients are visiting the ED and develop plans to reduce these visits.
4. Continue to develop the Respiratory Health Program and increase uptake for COPD and Asthma education within the Marathon Family Health Team to improve control of respiratory conditions.
5. Provide comprehensive CHF care.
6. Continue to provide comprehensive DM care and improve upon DM outcome measures.

INTEGRATION/COLLABORATION:

1. Improve current performance measures of % of patients who saw a primary care provider within 7 days of discharge from the hospital for selected conditions, by contacting other FHTs in the the LHIN to determine if there is anything they do that we can implement here.
2. Contact Thunder Bay Regional Health Science Center discharge planning to explore ways to increase communication regarding discharge of local patients and booking of post discharge appointments.
3. Develop method to track or to inform patients going for surgeries and procedures that will require post discharge follow-up appointment bookings.
4. Collaborate with local community hospitals to identify and review patients readmitted within 30 days for selected case mix groups to identify the factors that contribute to readmission and possible ways to address these issues.

In addition, the MFHT 2014 - 2017 Strategic Plan, has identified five strategic operational directions with stated objectives, some of which will further Provincial priorities in the areas of ACCESS and INTEGRATION/COLLABORATION, for example:

Strategic Direction - ACCESS

1. Develop strategy for monitoring access to providers

2. Develop strategy for addressing inadequate access or access in-balance between providers:
3. Optimize supply and demand for same day appointments:
4. Determine population need:
5. Optimize appropriate use of providers:
6. Provide patient access to selected sections of the EMR

Strategic Direction - Addictions & Chronic Pain - INTEGRATION/COLLABORATION Quality Improvement Targets:

The goals of the Addictions & Chronic Pain committee are to optimize addiction and chronic pain management, optimize opiate prescribing patterns, improve patient education, improve collaboration and develop research initiatives.

As goals and objectives are met, the MFHT Addictions and Chronic Pain committee will engage and make contact with local stakeholders such as North of Superior Programs, First Nation communities of Pic River and Pic Mobert, etc., identify how continuous collaboration while moving forward with other health agencies will be structured, such as scheduled meetings, etc., create collaborative initiatives such as day programs for addictions, etc., and include the services of a physiotherapist and other stakeholders such as the NW CCAC for engagement of strategies for self management of chronic pain.

Strategic Direction - Health Promotion:

1. Receive feedback from community members regarding health promotion needs and use MFHT to lobby for improved health promotion opportunities within the community (ie. High school and indoor walking program).
2. Link to community-wide health promotion committee.
3. Link to Healthy kids steering committee, for consideration of joint initiatives.

Integration & Continuity of Care

The Marathon Family Health Team identified several objectives for integration and continuity of care across sectors as follows:

1. Timely access to primary care appointments post-discharge through coordination with hospital(s).

In fiscal 2014-2015, an effective system for communication between the local Wilson Memorial General Hospital and MFHT was implemented to enable the booking of appointments within 7 days post discharge with the most responsible provider. An initial assessment of the effectiveness of this communication indicates that 86.4% patients were booked for an appointment within 7 days of discharge.

In fiscal 2015-2016, efforts will be made to develop a similar communication strategy with Thunder Bay Regional Health Sciences Center Hospital discharge planning for local patients being discharged from Thunder Bay and requiring post discharge appointements. A method will also be developed to track and/or inform patients going for surgeries and procedures that will require post-discharge appointment booking so that these appointments can be booked in a timely fashion.

2. Reduce Unnecessary Hospital Readmissions. MFHT will continue to identify the percent of patients/clients who are readmitted to any acute inpatient hospital for

non-elective patient care within 30 days of discharge after they have been discharged with a selected condition (based on CMGs). In collaboration with Wilson Memorial General Hospital, MFHT will identify and review patients who are readmitted within 30 days for selected case mix groups to identify factors contributing to readmission and possible ways to address these issues. We currently have some of the lowest rates in the Province, so there might be little room to improve on this issue as we are not sure how much lower we can go.

3. With the hire of a new full-time Nurse Practitioner in 2015, MFHT will re-establish the on-site Pic River and Pic Mobert First Nations well woman and pap clinics for First Nation women.

4. With the development of a new data sharing agreement with other health agencies, MFHT will implement shared EMR access for messaging, booking, chart information and referrals for post-discharge appointments.

5. The MFHT recently partnered with the Northwest CCAC to pilot the Telehomecare project for patients with COPD or CHF. This project enables patients to stay in their own homes and become an active partner in making healthy lifestyle choices with the goal to help patients to avoid unnecessary trips to the hospital and to catch problems before they turn into emergencies.

The Marathon Family Health Team has a number of existing integration and collaboration programs in place to provide continuity of care as follows:

1. The MFHT collaborates with the Marathon Diabetes Clinic (MDC) at Wilson Memorial General Hospital to offer regular and intensive DM follow-up to patients to achieve better DM control via their joint Diabetes Management Program. A number of processes have been developed to ensure this occurs as follows:

a. The MDC has access to the MFHT electronic medical record (EMR).
b. A MDC clinician and MFHT DM provider is identified in the patient EMR.
c. A draft MFHT flow sheet has been created jointly by the MDC and MFHT. We have tried unsuccessfully to find an IT specialist who can create the final form in electronic format to the EMR. The current flowsheet is still being utilized until this new form can be created electronically, although it is not optimal.

Planned quality improvements for the DM program are outlined in the workplan.

2. MFHT has an established process for the routine scanning of ER reports from the local Wilson Memorial General Hospital to the MFHT EMR.

3. The MFHT Wound Care Management Program has been expanded from Simple Wound Care Management to Complex Wound Care Management. The two full-time Registered Nurses will finish their Complex Wound Care Management best practices training in early March 2015, and MFHT expects the nursing staff to conduct on-site Complex Wound Care treatment and management as well as home visits.

4. Collaboration with local hospital Wilson Memorial General Hospital for referrals of colonscopy, x-rays, lab-work, ultrasounds and outpatient procedures. The MFHT social worker also has hospital privileges and sees in-patient residents of the hospital for brief social work intervention. The MFHT social worker also provides a shared-care psychiatry program with psychiatry consults for patients through the hospital Ontario Telemedicine site.

5. Collaboration with Marathon Seniors Center and MDC for community blood pressure and blood sugar level screening clinics.

6. Integration of a Physician Assistant High School program between MFHT and the local Marathon & District High School. The program provides for a weekly walk-in/drop-in High School clinic for all students.

7. Integration of the MFHT Registered Dietitian with the Northern Ontario Dietetic Internship Program to provide research project/research advisory advice for dietetic interns. This is a collaborative project with Thunder Bay Public Health Unit, Northern Ontario Dietetic Internship Program and the MFHT.

8. Collaboration with the North West LHIN for the proposed Thunder Bay District IDN Health Link to help develop the Health Link strategy and align the proposed Thunder Bay District IDN Health Link goals with the MFHT goals identified within the QI Plan.

9. In fiscal 2014-2015, MFHT launched a new community-wide health promotion committee for MFHT and other agencies to work together on the strategic direction for Health Promotion. In 2015-2016 through the use of grant funding to hire a student of health promotion, a community health promotion co-ordinator role will be implemented to assist the health promotion committee with the assessment, planning, development, implementation and evaluation planning of community health education and health promotion programs through MFHT. In addition, engage in opportunities that will present to collaborate across other sectors such as education and public health in order to develop the health promotion plan.

Challenges, Risks & Mitigation Strategies

The Marathon Family Health Team (MFHT) continues to face a number of risks and challenges that may affect accomplishment of the QI Plan for 2015-2016.

1. In fiscal 2014-2015, MFHT reported on the many human resource challenges. There was 53% vacancy in allied health professional staff. This in-ability to maintain a full complement of providers caused resources to be stretched and there was not as much time available to work on Quality Improvement projects. Access, which continues to be a significant measure for QI plans is particularly dependent on the human resources available - less providers, less access no matter what else we try to do to address that particular issue.

As a mitigating factor, we proceeded to employ the services of an allied health professional recruiter. This person in one year, was able to help MFHT secure employment for one full-time registered nurse, one full-time registered practical nurse, and one full-time social worker. We are still recruiting for a full-time nurse practitioner, but with the assistance of the allied health professional recruiter, we continue to conduct several interviews with interested applicants and we are hopeful that we can place an individual to this position permanently in 2015. MFHT reduced the 53% vacancy down to only 18.75%, reflecting 1.5 FTE allied health professional vacancies instead of 4.0 FTE vacancies. The .5 FTE vacancy stemmed from the Registered Dietitian reducing her professional hours down to significantly less part-time hours, as she begins to engage her retirement plan over the next three years.

The challenge for fiscal 2015-2016 will be to retain all of the allied health professionals we currently have on staff. The MOHLTC has announced no increases in compensation for another year, and with salaries below provincial average for the

health and administrative positions, we will again be faced with the challenge of trying to retain a full complement of human resources, in the face of other provincial health organizations who can offer more lucrative financial employment packages that might entice them to leave their current position with the Clinic. You can design all the programs, services and QI Planning you would like for primary health care, but you will only realize success if you can sucessfully recruit and retain human resources to administer them. Primary care needs an equal playing field for remuneration of all staff working within primary health care facilities, otherwise, constant turnover and vacancy of positions will impede growth and consistency.

2. MFHT relies on non-FHT administrative staff to operationalize much of the QI Plan. These individuals have limited resources of time, they are not FHT employees therefore we have limited ability to direct their daily activities. While they have been trained in QI methodologies, their assigned daily activities leaves them with little time to fit-in large scale QI data gathering projects.

In order to mitigate this issue, in the past couple of years, the physician group has supported the hiring of additional administrative personnel, so cross-training has occurred between administrative stations. Once cross-trained, the administrative staff have assisted each other to tackle the day-to-day assignments in a highly productive fashion. This leads to some available time in the afternoon for administrative staff to handle the additional QI projects. This is not a perfect solution to the issue, as it can be affected when many staff are off work due to vacation or illness, but it has helped the QI committee to move forward with the QI targets and initiatives they wished to implement this past fiscal term.

3. Obtaining timely access to hospital data is challenging and limits the ability to accurately assess impact of initiatives to address hospital related indicators such as post discharge visits, hospital readmissions and ED visits. The data available through the Health Data Branch Web Portal is one year behind and while we are able to acquire some more timely data from our local hospital, our patients population frequently uses the Thunder Bay Regional Health Sciences Centre (TBRHSC) for more major issues. Also, in order to understand the data it is helpful to be able to look at for patterns i.e. are there certain types of conditions responsible for the readmissions? is it a small number of people readmitted several times or all different people? What contributed to the readmissions? How many of these readmissions started from TBRHSC vs WMGH? It is not possible to determine these issues based on the data provided from the Web Portal.

In order to mitigate some these issues we will be making efforts over the next year to work with medical records and other staff at our local hospital to acquire and analyse data to better understand patterns of use, or to have them provide more helpful aggregate data.

4. As we continue to identify and track more outcome measures, the tracking process becomes more time consuming for the epidemiologist. Some measures can be determined using EMR queries and some subsequent data manipulation while others require manual extraction.

Over the next year we will work with IT to develop more automated production of outcome measures through software development that will run queries, merge resulting files and determine outcomes. Efforts will continue to be made to create ways for data to be entered into the EMR in a way that is easy to retrieve e.g. through creation of more measurements and processes to ensure providers use measures currently available.

Information Management Systems

The Marathon Family Health Team (MFHT) continues to use OSCAR version 12.1 as their Electronic Medical Record (EMR). The EMR is used by physician providers and allied health providers for documenting, tracking, understanding, communicating and improving on local health care needs through:

1. Data retrieval that provides annual profiles of patient demographics such as gender, enrolment status, chronic disease registries and utilization of available appointments by patients of the numerous health care providers on staff.

2. Data retrieval that profiles the types of appointments available, number of cancellations and no-show appointments.

3. The EMR facilitates patient safety and quality improvement through the use of a recall reminder/alert module that supports patient/client reminders around FOBT, Mammogram and Cervical screening processes. Through the use of queries, recall lists for patients requiring DM lab work can also be generated.

4. We use the EMR to track data over time for FHT-wide QI and research activities; to identify patients who are due for preventive visits and evidence-based screening; and to define which patients require outreach.

5. The team has standardized care using EMR templates and consistent data entry for some conditions.

6. Prescription management which includes organization, security and prescribing methods for initial and repeat prescriptions via auto-faxing prescription module, on and off-site, with or without patient visits, which reduce patient errors and redundancy. Through this module prescriptions are automatically faxed to the local pharmacy.

7. Management of medical records which include safe storage of patient medical information, password protected access and backup methods for storage of medical records on internal and external site servers.

8. EMR that includes all essential information necessary to provide quality patient care, e.g. cumulative patient profiles, up-to-date lists of medical problems, drug allergies and adverse drug reactions and medications, past medical histories, record of telephone conversations and clinical decision documentation.

9. Messaging between health care providers and staff.

10. Management of patient test results, medical reports and investigations.

11. Up-to-date facility website (launched in May 2014) with patient interactivity module scheduled to be released in 2015-2016.

12. Well established IT committee that has representation from the physician group (identified Lead Physician for I.T. and Associate Physician for I.T.), senior administrative management, allied health professionals, epidemiologist and I.T.

administrative staff. The I.T. committee has over the past ten years strived to create and support data entry initiatives and to standardize EMR templates, e-forms and disease registries.

Enhancements to the FOBT, cervical and mammogram surveillance and screening program in fiscal 2014-2015, allowed all health providers to review the preventive section of the EMR capabilities in order to identify a smooth and efficient way to capture patients with positive/abnormal results for tracking and timely follow-up, by alerting such providers of the need to follow-up with those identified patients.

The reminder module within the EMR was also activated in the appointment scheduler to identify those patients who had not yet booked an appointment for FOBT, cervial or mammogram screening.

The team has had the advantage of being able to consistently work with the same EMR without having the stress of moving to a different EMR software because the current one was not competent. The longer the team can work with the same EMR software, the more proficient they become at entering, collecting and retrieving relevant and meaningful data.

Engagement of Clinical Staff & Broader Leadership

The Marathon Family Health Team engages clinical staff, corporate leadership and community agencies by:

1. Engaging the entire organization through bi-monthly team meetings with all providers and staff present, periodic retreats with senior management and monthly Board of Director meetings.

2. Communicating results from annual patient surveys to all staff and providers, so they are aware of areas of strength and areas for improvement. Patients and other community agencies are also able to access these results via the MFHT website.

3. Posting of current data analysis reports such as disease registries/problem lists from the EMR, chronic disease outcome measures, reasons for visits, and data analysis from the MOHLTC to the MFHT website.

4. Development of the 2014-2017 strategic plan with input from clinical staff, partnering local and regional health care agencies or groups and community stakeholders.

5. Posting of QI target and initiative summaries for fiscal year 2014-2015, through placement in key staff locations around the Clinic (administrative office, staff room, exam rooms, main corridors and at all staff desks) so that staff are continually reminded of the current QI Plan initiatives and how those initiatives align with our strategic plan.

6. As QI Plan initiatives are achieved, information documents are routed to all staff and providers for report-back. In addition, patient report-back documents will be designed and then posted to the MFHT website for community agency and patient awareness of MFHT progress in attaining stated QI targets.

7. Review of other local health care agencies strategic plans such as Wilson Memorial General Hospital, proposed Thunder Bay District IDN Health Link and engagement with them in their planning process and alignment of the MFHT strategic plan to those identified strategic directions.

8. Participation in community health fairs and organization of community screening clinics for measurement of blood sugar and blood pressure levels.

Patient/Resident/Client Engagement

The Marathon Family Health Team (MFHT) understands that the patient voice is a critical component of effective health system design. The opportunity to provide meaningful input into the way that health care services are delivered needs to be considered and created.

In fiscal 2013-2014, a clinic-wide patient survey was distributed amongst patients for a select period of time, so that MFHT could solicit information from patients for the purposes of improving quality. The annual survey was repeated again in January 2015.

A lot of the patient survey questions dealt with access and quality.

1. Patients have access to the healthcare provider they wish to see.
2. Patients are routinely able to see their usual provider.
3. Patients are involved to the extent that they want to be in decisions related to their care or treatment.
4. Patients are encouraged to ask questions about recommended treatment.
5. Patients feel their health care provider spends enough time with them.
6. I am given the opportunity to make compliments or complaints to the office about its service and quality of care.

Within the MFHT 2014-2017 strategic plan, one of the strategic directions is Governance, and one objective under that strategic direction for 2015 will look at options for Board structures and their pros and cons. Currently, MFHT is a provider-led Family Health Team, and the organization is looking at whether or not having a patient advisory committee as part of the Board structure is the right direction to implement in order to add meaningful input from patients to improve the quality of our health care programs and services. We are a small, rural, isolated community, so it is important to seek the communities input regarding this significant question.

On the MFHT fiscal 2014-2015 patient survey, patients were asked about community patient advisory groups. Of the 43 patients who aswered this item on the survey, 40 (93%) indicated that they thought it was a good idea. Eleven per cent indicated that they would be interested in being a part of a patient advisory group. These results and other factors will be considered by the board over the next few months as they decide whether to implement a patient advisory committee.

In addition to the above, in fiscal 2014-2015 the MFHT launched a new Health Promotion facebook page, and invites patients regularly to comment on the health promotion postings to this page. Patients may also provide feedback to MFHT via the MFHT website under the contact us section and by writing comments and suggestions on paper and putting in the waiting room comment box.

In fiscal 2015-2016, the development of a waiting room tool to help patients raise health promotion strategies that they would like to discuss with their provider (trialled in fiscal 2014-2015, considered for rollout 2015-2016) will be developed. Additionally, through the use of a health promotion grant student, we will host focus groups to inform MFHT as well as other local agencies regarding health

promotion needs and goals and we will work with other agencies to ensure these are supported.

Accountability Management

The Marathon Family Health Team continues to monitor and track performance of QI Plan initiatives throughout the fiscal year by:

1. Aligning the target initiatives to the MFHT strategic plan timeline, in accordance with the five (5) strategic directions stated.

2. The on-site Epidemiologist supports the Board and Administrative leadership through data extraction and analysis, report generation, on-going performance measurement and monitoring of all QI activities in alignment with the fiscal QI Plan, corporate strategic plan, Wilson Memorial General Hospital strategic plan, community strategic plan and Northern Lights IDN Health Link strategy.

3. There is a Board identified lead physician for Quality Improvement.

4. The Quality Improvement Committee, which involves the Lead Physician, Associate Lead Physician, Administrative Lead, one Registered Nurse and the Epidemiologist, continues to focus the organization on quality and continuous quality improvement and is a standard corner of discussion at monthly Board meetings and bi-monthly Family Health Team meetings with all staff and all providers.

5. The monthly Board meetings review issues brought forward from the Quality Improvement committee and provide ongoing Board review of the approved Quality Improvement Plan and its stated objectives as they align to the Corporate strategic plan.

Other

The QI Plan creation continues to be an opportunity for Marathon Family Health Team (MFHT) to revisit and review progress from the past year and lay out plans for the next fiscal year. Last year MFHT indicated that it wanted to report significant progress in other measured areas which could not be reported in the progress section of the template as MFHT could not add the indicators and measures outside of what the MOHLTC and HQO had mandated. MFHT appreciates that the progress report section of the current QIP was pre-populated with all our target measures from the previous year's QIP. We are also pleased to be able to add indicators to various sections of the current QIP workplan. To further improve the efficiency of QIP developement it would be ideal if there was an option to use the previous year's workplan as the starting point for the current workplan as a number of the measures reported on last year's QI Plan are on the current plan; it is more time-efficient to edit the previous year's information rather than starting from scratch.

In order to further improve efficiency, MFHT encourages the MOHLTC, AFHTO and HQO to continue to consider how repeat reporting can be minimized between all agencies. Any steps to reduce the time required for reporting tasks increases the time available to act on the QIP and provide quality health care to our patients.

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 Eliseo Orrantia
Clinician Lead Eliseo Orrantia
Executive Director / Administrative Lead Joanne Berube
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)