Let's Make Healthy Change Happen.

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

Owen Sound
your health, your plan, your team
OSFHT FAMILY HEALTH TEAM

3/31/2016

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 Owen Sound Family Health Team (OSFHT) is an interdisciplinary group of physicians, health professionals and support staff. We are passionate about patient care and we are committed to putting our patients first. The vision of our organization is to be an effective, integrated, cohesive team that leads the way in primary healthcare. This is based on the values of respect, accountability, community and teamwork. With this in mind, the OSFHT is committed to helping our patients make healthier choices and help prevent disease and illness. To achieve this everyone at OSFHT, from doctors to custodial staff, strives every day to ensure our services can provide: (i)timely access to primary care; (ii) continuity of care that is integrated and coordinated;(iii) multidisciplinary team-based care; and (iv) a meaningful care experience that engages our patients in what matters most to them.

QI Achievements from the Past Year

Over the past year the OSFHT has undergone significant change as an organization. We recognize that change, while not easy, is the foundation of continuously improving the quality of services that we provide. Of special note, this year, some of our staff have chosen to unionize under OPSEU. This is a new experience for many of us at the FHT. The OSFHT recognizes that there will always be ways to improve the workplace and that continuing to maintain focus in providing exceptional healthcare is a credit to all members of the team. Continuously improving the culture of the workplace and maintaining its patient-focus remains a strength of our organization. In that regard, this past year we have continued to ensure timely access to:

1. Treatment of more than 36,000 people with acute illnesses, both physical and emotional;
2. Ongoing care and surveillance for people with chronic illnesses with special programs set up for specific illnesses such as diabetes and chronic obstructive lung disease;
3. Preventive care measures to ensure that people are provided appropriate screening to prevent illnesses;
4. Service co-ordination in regional retirement and nursing homes;
5. Integrated and coordinated services for complex patients with our hospital, CCAC and multiple community partners in our Health Links Leadership role.

We are committed to achieving our quality improvement targets that we set for our organization. With the engagement of our physician leaders and Board of Directors, we have developed a strong governance model that supports accountability for quality across the organization. We have strengthened our data reporting capacity and utilization of our EMR to support quality improvement measurement, monitoring and evaluation. As the co-lead for the North Grey Bruce Health Link, we know that health care quality improvement extends beyond the doors of our organization. With our Health Link collaborators and partner, Grey Bruce Health Services, we have implemented coordinated care planning processes that improve linkages in care coordination for high needs patients in our community. A total of 76 providers from across the region participated in our engagement education session on Health Links. We have continued to provide leadership in community based research initiatives such as the Expanding Paramedic Use in the Community (EPIC) Project. The OSFHT received recognition by Health Quality Ontario for its collaboration with the Canadian Foundation for Healthcare Improvement (CFHI) in Patient Engagement. We believe this type of evidence based care is a corner stone of quality primary care services.

At the service level, our diabetes program, have evolved from offering set diabetes clinic and education focus days, to providing patients with the flexibility of attending educational group that are of interest to them. In collaboration with the Active Lifestyles Centre Grey Bruce, we took an innovative approach to patient engagement, travelling to various retirement and seniors facilities to promote bone health and prevent falls.

The OSFHT recognizes that there is always room for improvement. It will be guided by its core values, its strategic plan and its unwavering commitment to its patients and its employees in advancing exceptional primary healthcare in Owen Sound and the broader Grey Bruce region.

Integration & Continuity of Care

The OSFHT is the lead primary care organization in the implementation of North Grey Bruce Health Links with our partner organization Grey Bruce Health Services. We work closely with the LHIN and our community providers to connect services in such a way that improves access, coordination and integration of care closer to home for those patients who have complex and multiple health concerns.

The OSFHT will continue to host the Regional Fracture Screening Coordinator as part of the Ontario Osteoporosis Strategy. This role functions across the healthcare system working with regional hospitals and Osteoporosis Ontario to avoid hip fractures in seniors at risk, thus reducing the burden of care on the health care system.

Supporting community paramedicine services, throughout Grey-Bruce, the OSFHT physicians and nurse practitioners work closely with EMS to ensure timely access to home based care. This program, is an effective strategy aimed at reducing 911 calls, Emergency Department visits as well as admission to hospital. Patients receiving these services often have advanced chronic conditions or require end of life support.

Engagement of Leadership, Clinicians and Staff

The Ministry of Health and Long Term Care (MOHLTC) has identified the Owen Sound Family Health Team as a Centre of Excellence in Diabetes Prevention. The OSFHT is one of 6 Family Health Teams in Ontario to continue to receive special funding for the Diabetes Prevention Program aimed at patients who are at risk of developing Type 2 diabetes. We partner and Diabetes Grey Bruce in the management of patient referrals to appropriate service levels as well as in the provision of program services to ensure access to and continuity of care between our primary care providers, community and hospital services.

Reviewing and improving our governance practices has been a key activity for the OSFHT Board of Directors. This has included educating, coaching and mentoring clinicians on their fiduciary responsibilities related to Board oversight. The Board has developed a comprehensive plan to develop new physician leaders, ensure leadership succession planning, and create capacity for organizational continuity and sustainability in advance of future primary care realignment at the LHIN and regional level. In addition the Board has streamlined the scope of its work to Quality and Risk management activities for the upcoming year.

With this in mind, as the organization settles into the implementation of its new collective agreement with OPSEU, we are committed to making significant investment in all staff to provide them with the knowledge and tools for engaging leadership, clinicians and patients. Specifically, OSFHT will engage the Union through joint participation in building skills to improve labour relations and dispute resolution. To date we have provided Workplace Violence and Harassment training, educated 6 staff to lead the Joint Occupational Health and Safety Committee, and provided a comprehensive workshop on privacy legislation as well as de-escalation training to manage conflict. We believe investing in our staff to improve job satisfaction, is a quality improvement strategy that translates to a better care experience for our patients.

At the program service level we will continue to strengthen our allied health team in developing their knowledge and understanding of primary care quality improvement methods, measurement and reporting. Over the past year we have developed report cards for each program and service to provide a more meaningful way to review and interpret program performance. This work is predicated on developing standard data collection tools that are embedded into our EMR for more efficient searching and collation of data. Program leads have worked diligently to define program indicators and metrics to track their progress in delivering quality based services. To promote transparency, all OSFHT staff were engaged in a joint AFHTO-MOLHTC education session for the Executive Director and the Board to discuss annual business planning, program development and MOHLTC accountability reporting.

Patient/Resident/Client Engagement

According to the Institute for Patient-and Family-Centred Care "Without sustained patient / family participation in all aspects of policy, program development and evaluation, the care system will fail to respond to the real needs and concerns of those it is intended to serve." The OSFHT has been engaged in developing expertise in regards to patient engagement strategies. While working with the Centre for Healthcare Improvement, the OSFHT successfully completed a project that enhanced its understanding of quality methods to better engage patients in their care of diabetes. Patient satisfaction with Diabetes Group Education Sessions was nearly 97% as compared to regular diabetes visits. Patient Interviews and Process Mapping highlighted areas for improvement. Quality improvement and health literacy workshops improved provider capacity. Leveraging existing self-management workshops increased patient engagement in their own care. A major theme across all of our programs for the upcoming year will be improving health literacy and self-management in support of building a more sustainable and equitable health care system.

Coordinated, patient-centred care for complex patients and seniors is front and centre of the North Grey Bruce Health Links initiative. Health Links brings the full care team together in one meeting to develop a Coordinated Care Plan (CCP) based on the individual's goals. After a brief project start up period, to date we have identified 177 high needs patient and developed over 37 Coordinated Care Plans. Over the next year we will build our repertoire of patient stories to identify sustainability gaps and improve the quality of primary care healthcare 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 : Dr. Elyse Savaria Executive Director: Caroline Rafferty

2016/17 Quality Improvement Plan for Ontario
Primary Care Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	**Improve rate of cancer screening.**	Percentage of patients aged 50-74 who had a fecal occult blood test within past two	% / PC organization population eligible for screening	See Tech Specs / Annually	91572*	45.4	50.00	We are basing our target on an improvement of 10% as we strive to reach the	1)Improve utilization of cancer screening activity reports (SAR) from CCO	Educate nursing staff on the access, interpretation and patient follow up using SAR	100% nurses educated in use of SAR reports	Call all eligible screening patients within 6 months of start of initiative	
		Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the	% / PC organization population eligible for screening	See Tech Specs / Annually	91572*	75.6	75.60	Since our rate is already above the average for Family Health Teams in	1)See above	See above	See above	See above	HFHT
	Improve rate of HbA1C testing for diabetics	Percentage of patients with diabetes, aged 40 or over, with two or more glycated	% / All patients with diabetes	Ontario Diabetes Database, OHIP / Annually	91572*	84.8	84.80	Since this is a new metric this year and we are unsure what the average value	1)Increase focus on access to testing for patients with 2 or less HbA1c tests in 12 months	Implement Point of care testing (PoCT) for HbA1c	PoCT implemented in 2 FHO physician practice	End of Q3 2016/2017	
Patient Experience	**Improve Patient Experience: Opportunity to ask questions**	Percent of respondents who responded positively to the question: "When you see your	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91572*	88.91	90.00	We are pleased with our high patient experience performance	1)Modify survey to assess patient experience across different service points and time of day	Distribute survey at time of registration	Providers will be surveyed equally each month	All service points have been surveyed equally	
	Improve Patient Experience: Patient involvement in decisions about care	Percent of patients who stated that when they see the doctor or nurse practitioner, they or	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91572*	89.87	92.00	We are pleased with our high patient experience performance	1)see above	see above	see above	see above	
	Improve Patient Experience: Primary care providers spending enough time with patients	Percent of patients who responded positively to the question: "When you see your doctor or	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	91572*	84.63	90.00	We are pleased with our high patient experience performance	1)see above	see above	see above	see above	
Timely	**Improve 7 day post hospital discharge follow-up rate for selected conditions**	Percent of patients/clients who see their primary care provider within 7 days after	% / PC org population discharged from hospital	DAD, CIHI / April 2014 – March 2015	91572*	33.6	33.60	We are setting a target of maintenance since this metric definition has	1)continue to work with hospital IT in obtaining discharge data	report is accessible to FHT staff through hospital intranet	report is available on a daily basis	Program staff able to access report by q2	
	Improve timely access to primary care when needed	Percent of patients/clients who responded positively to the question: "The last time you were	% / PC organization population (surveyed sample)	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period available)	91572*	25.05	30.00	This performance does not please or surprise us given the	1)Using Advanced Access principles and EMR scheduling data, continue to monitor third next available appointment	monitor weekly TNA data for all primary care physicians and nurse practitioners using EMR scheduler data. Review TNA data at monthly QI team meetings	Percentage of primary care physicians and nurse practitioner who have TNA between 0 and 3 days 100% of staff provided ongoing training with advanced access principles.	75% of all primary care physicians and nurse practitioners will have TNA between	