Let's Make Healthy Change Happen.

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

Thames Valley
Family Health Team

Thames Valley FHT is the lead organization for:

HealthLink
London Middlesex
Let's make healthy change happen

4/2/2019

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 Thames Valley Family Health Team is one of the largest Family Health Teams in Ontario. With more than 115 physicians across 19 sites within London/Middlesex, Oxford and Elgin counties, we are committed to providing team-based primary health care to over 158,000 patients.
Our team of health professionals including (but not limited to) physicians, nurse practitioners, registered nurses, social workers, dietitians, pharmacists, occupational therapists, respiratory therapists and psychologists, all working together to deliver the very best patient care via one-on-one patient care, services, programs, community partnerships and more.

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

The Thames Valley Family Health Team (TVFHT) continues its strong focus on improving the delivery of services to our diverse patient population. in late 2018/early 2019 TVFHT simplified our organizational strategic directions in order to prioritize focus in a number of specific areas. This process was done collaboratively with input from staff, physician partners, external partners, etc. Some examples of our achievements from 2018-2019 include:

- Mobilizing resources to support several pilots and partnership programs that assist with continuity of care for patients at time of discharge and onward. This work includes a pilot project in partnership with St. Thomas Elgin General Hospital (STEGH) that supports effective care transitions of CHF/COPD patients from hospital to primary care in conjunction with home care and other community partners.

- TVFHT has an identified "access point" within the organization to assist community partners in connecting with our organization for the purposes of improved patient care, effective/efficient care pathways, and continuity of care. This access point is intended to assist all community partners in making linkages to our organization, and currently the "access point" is working as the contact for Strathroy Middlesex General Hospital (SMGH) to ensure participation from a TVFHT provider in care coordination of complex patients at time of discharge.

- TVFHT has also focused significant resources in fiscal 2018/2019 to the further implementation and expansion of Coordinated Care Planning, in partnership with Health Links. During this fiscal year more than half of our staff has received coordinated care planning training and we have introduced new technology at 5 sites to assist with patient screening and identification. TVFHT will continue to prioritize this work in 2019/2020.

- The Launch of the Quality Champion role occurred in 2018/2019 which now actively shares QI initiatives FHT wide and assists in maintaining team focus on the idea of quality care and delivery. Most recent work by members in this role has revolved around coordinated care planning.

- TVFHT moved from a manual program registration model to an online registration model which has significantly improved patient access to our programs and services. This models has assisted with increasing patient awareness of the services offered by TVFHT and has enabled patients who would have otherwise been unable to access certain programming/services, to do so. In fiscal 2019/2020 we will continue to refine this model to ensure ease of use and optimized patient access.

- Building Foundations Group is a program that targets patients with a past history of trauma. We have offered this program in conjunction with a hospital partner trauma program, as a bridging resources until patients are accepted into the hospital program. In fiscal 2018-2019 we identified a gap in this care model as it was limited to London residents. As such, we have since provided training to 14

additional social workers to enable us to offer the Building Foundations Group to patients in all 3 of the counties TVFHT operates.

- Opioid prescribing has been an area of focus in many ways for TVFHT. TVFHT continues to have multiple sites running Chronic Pain programs aimed at teaching patients self-management techniques for improved pain management. The program looks at both the physical and mental challenges faced by these patients and over the course of the 6 week program, helps patients better understand and manage the physical and mental factors associated with chronic pain.
TVFHT has implemented multiple EMR tools including stamps, templates and toolbars, to assist with identifying and better managing patients with opioid use disorder.

- TVFHT and the London Health Sciences Centre (LHSC) are working to re-establish a pilot project to explore ways to improve transitions from hospital to primary care. The initial focus will be on exploring ways to impact the "follow-up with a primary care provider within 7 days of discharge from hospital" metric and to identify if there are other impacts that improved follow-up may have (for example, 30-day re-admission rates).

Patient/client/resident partnering and relations

Thames Valley Family Health Team works diligently to incorporate patient feedback into our work, including quality improvement. Through the use of online patient experience surveys, patient experience surveys collected at our sites, patient town hall meetings (held in all 3 of the counties of operation in 2018/2019) and Coordinated Care Planning patient feedback provided via TVFHT specific feedback links.
The TVFHT patient experience survey collects information about the patient experience at the clinic and with their provider including; access times, perceptions about involvement in their care, types of services offered, if services met patient's needs, staff sensitivity, etc.
The TVFHT Coordinated Care Planning patient feedback form collects patient information on; perceived level of support from care team, if patient felt acknowledged during the process, patient involvement in care plan development, etc.
Patient feedback has been pivotal in driving much of our QI work including; patient discharge care continuity, expansion of ccp focus, and programs/services offered by the organization. An example of this is the transition TVFHT made from a manual program/service registration model to an online registration model. This shift was driven by the desire to provide equitable and optimal access to the services and programs we offer. By moving to an online registration model this allowed all of our patients to attend programs/services at any of our 19 sites. The online registration model was implemented late spring 2018 and since inception TVFHT has seen a significant increase in program registration and, as a result, an increase in the number of program runs offered by the organization.

Workplace violence prevention

TVFHT has an Occupational Health and Safety Best Practice Committee that, working with our Human Resources staff, is involved in maintaining current, and implementing new, health and safety policies and procedures as required. These cover topics including (but not limited to):

- Workplace Violence
- Emergency Duress
- Working Alone
- Infection Prevention, Control, and use of Personal Protective Equipment
- Home Visit Safety
- Harassment and Discrimination

The Best Practice Committee has membership from both leadership and staff, and we have designated representatives from each of our physical locations. Monthly site inspections are usual practice and are reported and reviewed regularly. Violence risk assessments from all sites and staff were completed and reviewed. All staff are required to have up-to-date WHMIS training, fit testing and fire safety.

Contact Information

TVFHT is located at:

1385 North Routledge Park, Unit 6,
London, Ontario, N6H 5N5
519-473-0530

We can be contacted through our website, http://www.thamesvalleyfht.ca, and at info@thamesvalleyfht.ca.

Other

TVFHT's ability to access the Primary Care Practice Reports continues to be welcome. The challenge, however, remains that the data in these reports is out-of-date by the time it is received. For reference, the most current data we have available to us through these practice reports is to the end of March 2018, a year out of date in planning for the 2019/2020 QIP. To effectively monitor quality improvement initiatives requires real-time metrics that are responsive to change efforts. Having data that is more than one year old does not allow true evaluation of changes in practice. Alternative ways of measuring improvements in a timely manner would rely on different data sets which may not correlate with the data sets required within the priority indicators and which may not allow comparisons between organizations. As a result, TVFHT has, and will continue to, focus on internal metrics that may better inform our quality improvement efforts.

Equitable compensation in primary care also remains a challenge to recruitment and retention efforts. Investments have been made in this area, but we still do not have a competitive compensation package, and losing staff to better compensated parts of the health sector continues to challenge us.

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 Aindrea Cramp _______________ (signature)
Quality Committee Chair or delegate Lauren Kopechanski _______________ (signature)
Executive Director/Administrative Lead Mike McMahon _______________ (signature)
Other leadership as appropriate Jill Strong _______________ (signature)

2019/20 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

HT is the lead organization for:

Thames Valley FHT 12-1385 North Routledge Park, London, ON N6H 5N5

		Measure									Change				
	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
	lls must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)														
	Efficient	Percentage of patients who have had a 7-day post hospital discharge follow up for	P	% / Discharged patients	See Tech Specs / Last consecutive 12-month period.	91498*	CB	CB	Actively pursuing community/hop sital partnerships to		1)Active work is being done to re-establish HRM discharge projec with LHSC. Additionally, hospital - FHT linkages are being made via	"1) Focused work is being done by way of IDEAS Prevent pilot project related to discharge for COPD/CHF patients to ensure continuity of care during and post discharge, using defined pathways and CCP. 2) We are in the preliminary stages of establishing an	"% of patients discharged in which a discharge summary was received within 48 hours - % of patients followed-up within 7 days of discharge by phone or in-person - % of patients deemed requiring follow-up within primary care following discharge - % of patients	All patients discharged, for which we receive notification of discharge within	Much of the focus of this work will be around coordinated care planning and
		Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification	P	% / Discharged patients	EMR/Chart Review / Last consecutive 12-month period.	91498*	CB	CB	Actively pursuing community/hop sital partnerships to		1)IHPs that review discharge summaries and or are involved in care conferences or discharge process will arrange for	Review of discharge notifications, care conference, established pilot project process/contact point, access point, etc.	Ensure action on all discharge summaries that are received within 48 hours of discharge.	All patients discharged, for which we receive notification of hospital discharge,	This will be targeted via several defined pathways.
		Percentage of patients identified as meeting Health Link criteria who are offered access to	C	% / # of patients screened	In house data collection / April 2019-March 2020	91498*	CB	5.00	Health Links data suggests approximately 5% of patients would meet		1)Expand CCP screening to all TVFHT sites (currently 5 sites are actively engaged in this work). Leverage internal resources to make	Expansion of Ocean project to additional TVFHT sites, aligning FHT clinicians with contact points at various community organizations/hospitals to support CCP appropriate patient identification at time of discharge.	"% of eligible patients who visit clinic who are screened using complex care questionnaire. % of patients who visit clinic who check in using ocean tablet % of patients who are identified by complex care questionnaire as meeting CCP criteria, who are	"50% of patients visiting site screened 80% of identified patients referred for	As of the end of fiscal 2018/2019 ocean technology has been integrated within
	Timely	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or	P	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	91498*	47.83	70.00	Based on objective measurement of access (third next available		1)Continued emphasis on the importance of access for acute/episodic care. As well as a focus on reasonable wait times for	Weekly tracking of time to appointment for physicians and nurse practitioners as well as all other providers.	Time from request/referral to appointment.	Targets are as follows: - Pharmacists: 90% of patients offered an appointment	Access is a priority for TVFHT and we use weekly tracking as a
Theme II: Service Excellence	Patient-centred	Percent of patients who stated that when they see the doctor or nurse practitioner, they or	P	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	91498*	92.73	95.00	Current performance is strong for this indicator (well above LHIN		1)Increased and continued focus on patient involvement across all sites.	Continuation of current practices and education of new employees on these best practices.	Use of methods across all sites to allow patient to provide feedback on their experience.	Quarterly review of data and reporting of outcomes to identify successes	In previous years we observed that patients were much more likely to provide
Theme III: Safe and Effective Care	Effective	Proportion of primary care patients with a progressive, life-threatening illness who have had	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	91498*	CB	50.00	Because this indicator is new for 2019/2020 we will need to determine our		1)Evaluate current state and establish internal process around early needs identification.	Through the use of the EMR and PCPR, as well as through CCP work and screening that is currently taking place.	Aggregating data from all sites to have full organizational picture to then determine best approach moving forward which may involve linkages with current in-house CCP and/or other existing project/work.	To have a full understanding of organizational baseline and defined process	Once the preliminary work is complete we will have the opportunity to
	Safe	Percentage of non-palliative patients newly dispensed an opioid within a 6-month reporting	P	% / Patients	CAPE, CIHI, OHIP, RPDB, NMS / Six months reporting period ending at the	91498*	CB	CB	This is a new indicator and only data available at this time is PCPR		1)Evaluate current state and establish internal priorities around this indicator.	Through the use of the EMR and PCPR.	Aggregating data from all sites to have full organizational picture to then determine best approach moving forward which may involve linkages with current in-house opioid project/work.	To have a full understanding oforganizational baseline.	Once the prelimary work is complete we will have the opportunity to
Equity	Equitable	Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for	C	% / screen eligible individuals	EMR/CCO-SAR / April 2019 - March 2020	91498*	31	28.00	Although current performance is above LHIN average, we will		1)Continued focus on this indicator by way of EMR data pulls throughout the year for patients overdue for screening.	As in past years, we will do EMR data mining where possible and share the findings with physicians and clinicians in order to assist in improving outcomes in this area.	Regular reporting.	All EMR eligible teams to receive reporting at least once during fiscal 2019/2020.	Although we will continue to do work on this indicator, this is not a priority
		Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least	C	% / Women 21-69	CCO-SAR, EMR / Annually / April 2019 - March 2020	91498*	66	69.00	Continued focus on this indicator should yield continued improvements		1)Continued focus on indicator. Nurse practitioners participate in week long cervical screening initiative	Nurse practitioners conduct a week long focus on cervical screening. In fiscal 2017/2018 NPs completed 156 PAPs, administered HPV vaccine 43 times and recommended the vaccine to 67 others during the screening week.	Quarterly review of data, NP led initiatives.	Participation of all NPs in week long cervical health initiative.	Although we will continue to do work on this indicator, this is not a priority