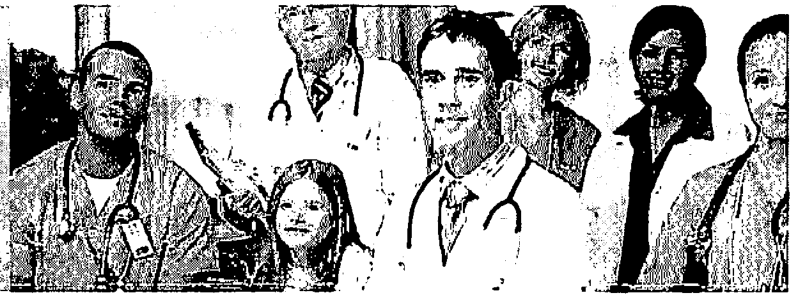

# Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

*Taddle Creek*
**Family Health Team**

**3/31/2015**

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

Taddle Creek Family Health Team (TC FHT) has two sites in downtown Toronto: Bay/College & Bloor/Christie. TC FHT, as of Jan 31, 2015, has 18,820 enrolled patients. Our team consists of 15 physicians, 3 nurse practitioners, 3 registered nurses, 3 social workers, 1 dietitian, 1 pharmacist and 1 physician assistant. We also have a dedicated Diabetes Education Program (DEP) who care for both FHT and community patients living with diabetes. DEP staffing consists of 2 registered nurses and 2 dieticians. In total there are 40+ staff working to care for this diverse population.

TC FHT, in F15-16, will work on all HQO priority indicators and a few others.

Within the access dimension, we will work to increase patient access to their primary care provider (PCP) when needed (2% increase), work to decrease emergency visits for conditions best managed elsewhere (.05% reduction) and increase PC visits for housebound patients (4% increase) by:
- Exploring e-Booking
- Having our Board review/discuss 3rd next available results quarterly
- Providing additional support/coverage for PC@Home Team
- Writing an article in our newsletter Re: Why Visiting EDs for Conditions BME may not be Recommended & How to Manage at Home (if possible) until your TC FHT appt
- Informing patients of After Hour Clinic option by distributing wallet size cards
- Performing a prospective audit of After Hour Clinic to determine % occupancy, time appts booked and reason for visit in order to develop booking protocols Re: When appts can be booked & how clinic should be used

Within the integration dimension, we will work to provide timely access to primary care appointments post hospital discharge for selected conditions (achieve 25%), work to reduce unnecessary re-admissions (achieve 10%), create coordinated care plans (CCPs) for complex patients (target 50) and participate in the RED (Referral from Emergency Department) Health Link project by:
- Having Medical Secretaries request pts inform us when discharged & make appt
- As part of internal process of searching for discharge summaries also send eMR message to PCP & Medical Secretary that pt needs to be seen
- Exec. Dir./Lead Physician participating in MWTHL Regional Steering Committee focused on addressing hospital gaps in notifying primary care provider of discharge Re: When appts can be booked & how clinic should be used
- Modifying internal process - after physician visit, physician to send x1 delayed message in eMR to RN or Pharm to f/u with pt x1 within 30 days
- Define & identify complex pts
- Educate clinicians of value of CCPs
- Pts presented at Complex Care Clinic to have a CCP (est. 10), PC@Home team to complete 10 CCPs & Physicians to complete 2 each (with help from CCAC Coordinator when appropriate)
- Participating in the RED (Referral from Emergency Department) Health Link Project

Within the patient-centred dimension, we wish to maintain the high % of pts who respond to our Patient Experience Survey that they have an opportunity to ask questions, they feel they are involved in decisions about their care and that they are able to spend enough time with their PCP by:
- Improve automation of Patient Care Experience Survey
- Create Patient Advisory Council

Within the population health dimension, we will strive to improve the percent of our population receiving the influenza vaccination (2% increase) and our colorectal cancer screening rates (4% increase) by:

- Improve tracking of pts who have already rec'd flu shots elsewhere by ensuring Q130A tracking code entered (and improve internal signage asking pts to inform clinician if pt already rec'd flu shot)
- Track and contact pts without flu shot documented in chart
- Co-ordinate/delegate access to CCO's SAR (Screening Activity Report) to assess if data can be used to monitor/create reminders in eMR
- Learn from Women's College FHT how PS reminders can be used to improve % pts who are up-to-date in screening for colorectal screening

The ON MOHLTC's three provincial priorities are: patient engagement, integration/coordination and quality & funding (as per Dec 2, 2014 ON MOHLTC 2015/16 QIP memorandum from Susan Fitzpatrick, Associate Deputy Minister & Dr. Joshua Tepper, President and CEO HQO). TC FHT's Board believes we are aligned with these priorities. In January 2015, TC FHT engaged in a comprehensive strategic planning process to articulate our FHT's goals for the coming 5 years. We were encouraged to see many (i.e. method to identify complex patients and prepare coordinate care plans, create patient advisory group, allow on line booking, better integration with hospitals/discharge planning coordination) goals aligning with the QIP.

## Integration & Continuity of Care

The Mid West Toronto Health Link (MWTHL) spans downtown Toronto and roughly covers the area between Lake Ontario and St. Clair Avenue on the north/south axis and between Yonge Street and Dovercourt Avenue on the east/west axis. For the past two years, TC FHT has been the lead organization for the MWTHL bringing the following Health Services Providers (HSP) together,

Primary Care
-Access Alliance
-Anishnawbe Health
-Central Toronto Community Health Centre
-Planned Parenthood
-Centre Francophone
-Mount Sinai Family Health Team
-Toronto Western Family Health Team
-Women's College Family Health Team
Community Support Services
-West Neighbourhood House
-St. Stephen's Community Services
Acute Care
-University Health Network
-Women's College Hospital
-Mount Sinai
- Emergency Medical Services
-Toronto Central CCAC
Local Government
-Toronto Central LHIN
-Toronto Community Housing (TCH)
-96 Solo Community Physicians in the SCOPE (Seamless Care Optimizing the Patient Experience) Project

In this role, we have been stewarding the process to build partnerships among health care agencies to achieve the following initiatives:

1) Ensure complex patients are attached to a family physician
- Exceeded F13-14 target & expected to exceed F14-15 target (as of Q3 488/637)
- Attach marginalized patients to right PCPs via peer-to-peer outreach initiatives (60 pts as of F14-15 Q3)

- Developed key linkages: e.g. Community Health Centers (CHCs) with Community Support Agencies, CHCs with solo GPs
- Workshops to increase comfort and competencies for community GPs to take complex patients
- Referral from Emergency Department (RED) initiative launched to attach CTAS 2 patients in ED to primary care
- Partnering with Emergency Medical Services (EMS) & Toronto Community Housing (TCH) to identify complex seniors in TCH in need of a PCP (TC FHT's PC@Home Team responding to need)

2) Ensure complex pts have a care plan in place for care coordination
- Exceeded target in 2013-2014, on track for enhanced target of 255 CCPs for 2014-2015 (as of Q3 170/255)
- Development of Telemedicine IMPACT PLUS (TIP) Clinics to coordinate muti-disciplinary care for complex patients – 4 TIP Teams/6 clinics offered monthly in our Health Link (Taddle Creek offers two clinics a month to solo family physicians)
-Convened working group to target at-risk populations – within hospital, within the TCH and assisting unaffiliated solo primary care providers to identify and begin implementing coordinated care planning
-Highlighted successful model embraced by the WCH FHT
-Helped lead an application for a 'Bundled Case Project' between Mount Sinai Health System, UHN, WCH for a 'Hospital at Home' initiative for inpatients with CHF, COPD & pneumonia

3) To ensure complex pts are seen by a family physician within seven days of a hospital discharge
- Chaired Toronto Regional HL Steering Committee to address gaps in care in achieving this goal and in July 2014 submitted recommendations to the TC LHIN
- Facilitated 2 QI projects to address gap (one with TC FHT to create process for tracking)
- Worked with CPSO/ON MOHLTC to improve and share MD contact information
- Pharmacy working group piloting project to enhance med/rec between hospital and community pharmacists

4) To reduce the number of avoidable ED visits for pts with conditions best managed elsewhere
- Linked Toronto Community Addiction Team (TCAT) to UHN ED Social Workers workflow (1st Q showed a 38% decline in ED visits)
- Introduced Advanced Access scheduling to 4 community Primary care providers
-Identified mechanisms to reduce ED visits during holiday surge and will implement in 2015/16

The MWTHL prides itself on patient, physician and partner engagement and sharing knowledge/skills as an early adopter. The following summarizes our activities in this regard:

Patient Engagement
- Seniors Advisory Volunteer Initiative (SAVI) -10 seniors championing recommendations from the Seniors' Strategy Rpt – "Living Longer, Living Well "- Dec 20, 2012 and hosted two Seniors' Health Fairs with an average of 300 participants representing diverse ethnic groups
- Patient representation on all working groups, including 5 patients serving on Health Council, two patients co-chairs of working groups
- Peer-to-peer outreach led by patients for patients in need

Physician Engagement

- Seamless Care Optimizing Pt Experience (SCOPE) –engaging 95 physicians in a PC integration project (not funded by HL but foundational in supporting HL)
- Volunteer Physician Advisory Group – 8 MDs who meet semi-regularly (q2 monthly to review HL initiatives – four of whom hosted a booth on Health Links for the MOHLTC at the Ontario College of Family Physicians annual Scientific Conference, November 2014).
- SPIN: (Solo physicians in need) 36 community MDs connected to CHCs for a range of psychosocial and other ancillary services for their complex patients
-Connecting GTA: instrumental in engaging local family physicians to become the first primary care cohort to trial Connecting GTA platform

Partner Health Link Support
- Working with two Health Links to launch Peer-to Peer outreach in their HLs
- Stewardship of the TIP (Telemedicine IMPACT PLUS clinics) for the 4 early adopter Health Links
- Compiled Youth Services Inventory for Central West Health Link (CWTHL)
- Member of Stewardship Group for CWTHL
- Facilitated OMA event to engage MDs for CWTHL and West Toronto Health Link

The past two years as the lead organization for the MWTHL have been key to integrating with other HSPs in our catchment area and to promote integration & to facilitate continuity of patient care.

## Challenges, Risks & Mitigation Strategies

TC FHT has many challenges/risks that make it difficult to implement quality improvements. Listed below are the indicator, our quality improvement initiative, anticipated challenges and potential strategies to mitigate.

Access Dimension

Indicator: % pts able to see physician/NP on the same or next day, when needed (Target 80%, 2% increase)
Improvement initiatives:
A. TNA - Board review/discuss quarterly
B. Explore E-booking
Challenges:
A. Board addressing physicians with TNAs >1 day
B1. Addressing common concerns about e-booking
B2. Cost to adopt technology to perform e-booking
B3. Team buy-in to adopt e-booking
Strategies to mitigate:
A. Discuss with Lead Physicians
B1. Review 2 key papers on e-booking (Exploring the Value, Benefits and Common Concerns of e-booking - Canada Health Infoway & Adoption, Use and Effects of an E-Appointment System - HEC Montreal) and synthesize into Clinical Mtg Presentation
B2. Share cost of new technology btw FHT/FHO
B3. Dispel myths and promote benefits

Indicator: # home visits done by any clinician (4% increase)
Improvement initiative:
A. Provide ++ support/coverage to PC@Home Team
Challenge:
A. Physicians agreeing to support PC@Home physician when away
Strategies to mitigate:
A1. Ensure Physician Assistant backing up PC@Home physician aware of pts with red flags and can succintly brief covering physician/NP
A2. Create an equitable rotational schedule

Indicator: % pts who visited the ED for conditions BME (Target .45%, .05 decrease)
Improvement initiatives:
A. Article Re: Why Visiting EDs for Conditions BME May Not Be Recommended & How to Manage at Home until your TC FHT Appt
B. Inform patients of After Hour Clinic option by distributing wallet size cards Re: Accessing After Hour Clinic
C. Perform a prospective After Hour Clinic audit to determine % occupancy, time appts booked and reason for visit in order to develop booking protocols Re: When appts can be booked & how clinic should be used
D. Highlight After Hour Clinics & THAS (Telephone Health Advisory Service) numbers when new TC FHT website is launched
Challenges:
A1. Recruiting author to write said article and getting approval from all clinicians
A2. Ensuring message reaches intended audience (pts who use Emergency Departments for conditions BME)
C1. Time to design/perform audit
Strategies to mitigate:
A. Ensuring 'Work Time' provided to write article
A2. Initiate easy method to collect email for later entry in eMR then use eMR, to export email & Wellx to distribute
C. Share work: Exec. Dir/QIDSS design/Admin. support conduct

Integration Dimension

Indicator: % pts who saw their PCP w/i 7 days after d/c from hospital for selected conditions (Target 35%)
Improvement Initiatives:
A. Medical Secretaries to request pts to inform us when discharged & make appt to see PCP
B. As part of internal process of searching for discharge summaries also send eMR message to PCP & Medical Secretary that pt needs to be seen
C. Exec. Dir./Lead Physician to participate in MWTHL Regional Steering Committee focused on addressing hospital gaps in notifying primary care provider of discharge
Challenges
A. Pts recall post discharge to contact us
B. Additional administrative step
C. Integrating with multiple downtown acute hospitals to improve discharge planning for selected conditions (often we do not get notification of either admission or discharge)
Strategies to mitigate:
A. Provide Medical Secretaries with selected conditions and estimated length of stay (LOS) and request they put in an eMR reminder to call pt to book appt
B. Streamline process as much as possible
C. Exec. Dir./Lead Physician to continue to be a member of the Regional Steering Committee (supported by MWTHL) to understand complexities and offer Primary Care input

Indicator: % pts readmitted to hospital (w/i 30 days) after d/c from hospital with selected condition (Target 10%)
Improvement initiatives:
A. Modify internal process - after physician visit, physician to send x1 delayed message in eMR to RN or Pharm to f/u with pt x1 within 30 days
Challenges:
A1. Physicians need to be educated on how to send delayed messages
A2. Physicians forget to send delayed messages
Strategies to mitigate:

A1. Prepare document to educate and offer a Lunch and Learn
A2. Audit and report back

Indicator: Increase co-ordinated care plans (CCP) for complex pts
Improvement initiatives:
A. Define & identify complex pts
B. Educate clinicians of value of CCPs
C. Pts presented at Complex Care Clinic to have a CCP (est. 10), PC@Home team to complete (est. 10 CCPs) & Physicians to complete 2 each (est. 30)
Challenges:
A1. Multiple definitions and approaches to identifying complex pts
A2. Quality of data in eMR (if definition based on multiple chronic conditions + multiple medications these are not kept up to date)
B. Currently no technological solutions for sharing amongst all members of circle of care and pts thus clinicians question value for co-ordinated care
C. Team to use CCP template
Strategies to mitigate:
A1. Be open to multiple approaches to defining (use either MWTHL definition and/or physician 'gut' instinct pt complex)
A2. Create multiple methods to search for complex pts and have physicians confirm
B. Advise technological solution not within our control and highlight internal co-ordinated care benefits (i.e. during after hour clinics) & encourage them to seek internal CCAC Coordinator support when appropriate
C. Demonstrate ease of use during Clinical Meeting

Indicator: # of RED (Referrals from Emergency Department) Accepted
Improvement initiatives: 6 physicians participate in the RED Health Link Project accepting 12 referrals
Challenges:
A. RED project not yet well defined
B. Ensuring 6 TC FHT physicians will participate in the RED HL Project and accept 12 RED Referrals
C. Ensuring referral forms scanned into eMR in order to search/report
Strategies to mitigate:
A. Learn more
B. Education
C. Lead Physician to continue to be involved in RED HL Project and inform TC FHT what referral looks like and then ensure eMR set up to consistently find

Patient Centred Dimension

Indicator:
% pts always/often have the opportunity to ask questions
% pts always/often feel they are involved in decisions about their care
% pts always/often spend enough time with their PCP
Improvement initiatives:
A. Improve automation of Patient Care Experience Survey
B. Create Patient Advisory Council
Challenges:
A. Team feels that annual survey is excessive and do not want administrative staff to distribute or to use IPADs
B1. Lack of experience in managing Patient Advisory Council
B2. Time commitment - Executive Director already supporting Board and 3 working committees
B3. Getting pts to volunteer to be on Council
Strategies to mitigate:
A. QIDSS to investigate automated methods to distribute (Wellx, email, etc)

B1. Review 2014 AFHTO Conference presentations on how other FHTs have created Patient Advisory Councils

Contact FHTs who have done this and request to observe one in action

Learn from MWTHL successes in incorporating pts on their Council and Working Groups (used International Association of Public Participation as guide)

B2. No strategy to date

B3. Consider adopting MWTHL SAVI Group as our starting point for our Patient Advisory Council (all members are TC FHT pts)

Population Health Dimension

Indicator: % pt population >65 that received influenza immunization (Target 57% - 2% increase)

Improvement initiatives:

A. Improve tracking of pts who have already rec'd flu shots elsewhere by ensuring Q130A tracking code entered

B. Track and contact pts without flu shots

Challenges:

A. Pts are receiving flu shots in the community, conditioning clinicians to ask the question and if done outside FHT entering Q130A code is burdensome

B. Administrative burden: perform searches/chart review to see if they indicated rec'd elsewhere then add Q130 code; and if not, contact pts to come in and get flu shot

Strategies to mitigate:

A1. Internal patient signage: Advise clinician if you have already rec'd flu shot

A2. Ensure all clinicians know how to input Q130A code if flu shot rec'd outside of FHT

B. Share the burden amongst administrative/medical secretaries/nurses

Indicator: % eligible pts who are up-to-date in screening for colorectal cancer

Improvement initiatives:

A. Co-ordinate/delegate access to CCO's SAR (Screening Activity Report) to assess if data can be used to monitor/create reminders in eMR and learn from Women's College FHT how PS reminders can be used to improve % pts who are up-to-date in screening for colorectal screening

Challenges:

A. CCO SAR data may not prove to be useful in improving % pts who are up-to-date in screening for colorectal screening

Strategies to mitigate:

A. Design efficient and effective process to ensure CA screening is addressed

Here are some overarching mitigating strategies we use to thwart challenges/risks:

1. Monthly presentations (during Clinical Meetings) about QIP and progress to team & solicit members to participate/become invested
2. Utilize Quality Improvement Decision Support Specialist (QIDSS) to develop monitoring mechanisms and implement initiatives
3. Utilize Quality Improvement Committee (QIC) for consultation and to review QIP progress
4. Report quarterly to Board on QIP progress and illustrate link with 2015 Strategic Planning process
5. Include QI questions in interviews to gauge appreciation for QI/Incorporate QI goals in performance reviews
6. Find alignment opportunities between MWTHL and FHT QI initiatives

## Information Management Systems

TC FHT uses its information management system (Practice Solutions eMR) to better understand the needs of our patients, to inform quality improvement and for target setting. For the 2015/16 QIP, the eMR will be used for the following indicators:

Access Dimension

1) Indicator: % pts able to see physician/NP on the same or next day, when needed (Target 80%, 2% increase)
   eMR used to determine TNA
2) Indicator: # home visits done by any clinician (4% increase)
   eMR used to track # home visits

Integration Dimension

1) Indicator: % pts who saw their PCP w/i 7 days after d/c from hospital for selected conditions (Target 35%):
   eMR used to track receipt/notice of discharge summary and whether pt was seen w/i 7 days
2) Indicator: % pts readmitted to hospital (w/i 30 days) after d/c from hospital with selected condition (Target 10%)
   eMR used to track whether pt f/u w/i 30 days and whether re-admitted (if we receive another discharge summary/notice w/i 30 days)
3) Indicator: Increase co-ordinated care plans (CCP) for complex pts (F14-15 - 65)
   eMR used to create CCP custom form, identify complex pts and to track # CCP custom forms completed

Patient Centred Dimension

1) Indicator: % pts always/often have the opportunity to ask questions
2) Indicator: % pts always/often feel they are involved in decisions about their care
3) Indicator: % pts always/often spend enough time with their PCP
   eMR used to collect email eventually to be used to send survey electronically & identify pts willing to participate on Patient Advisory Council

Population Health Dimension

1) Indicator: % pt population >65 that received influenza immunization (Target 57% - 2% increase)
   eMR used to track pts who have already rec'd flu shots or rec'd elsewhere by ensuring Q130A tracking code entered and to contact pts who have not rec'd
2) Indicator: % eligible pts who are up-to-date in screening for colorectal cancer
   eMR used to track pts who are up to date in screening for colorectal cancer

## Engagement of Clinical Staff & Broader Leadership

TC FHT has a Quality Improvement Committee (QIC) that meets monthly with representation from physicians, IHPs and administration from both sites and 6 suites. Progress on our QI initiatives is reviewed at each QIC meeting. It is also the QIC that develops the QIP and discusses process improvement plans. The Executive Director reports the QIP's progress to the Board quarterly. TC FHT engages all staff through monthly Clinical Meetings & bi-weekly Team Meetings. The QIP is presented early in the Spring at a Clinical Meeting and at least 2 more times throughout the year.

Note: As of February 2014, TC FHT has had a QIDSS (Quality Improvement Decision Support Specialist) position (1.0 FTE between 6 FHTs). Other partner FHTs: Women's, Sunnybrook, Village, South East Toronto, Mount Sinai.

## Patient/Resident/Client Engagement

This is an area TC FHT could improve. TC FHT does not have a Patient Advisory Council (see Patient-centred initiative to create a PAC in F15-16). We engage patients via the Patient Experience Survey and through ongoing evaluations of our groups. We also hear the voice of our patients on the MWTHL council and working groups (see Integration & Continuity of Care section).

## Accountability Management

TC FHT leadership will be held accountable for achieving the targets set out in our QIP. The Board of Directors (BOD), as a stipulation to receiving FHT funding, must establish and maintain a governance structure and address specific matters, one of which is management of the FHT (Section 2.2 ON MOHLTC FHT Funding Agreement). Our BOD is accountable for the overall performance of the corporation (as per Governance Policies & Procedures) and delegates this function to its Executive Director (ED). The ED is then held accountable to the BOD for overall management and performance of the organization. The BOD reviews the ED's performance annually and progress toward the QIP initiatives is one measure of success.

## 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
Clinician Lead
Executive Director / Administrative Lead
CEO/Executive Director/Admin. Lead ____________________ (signature)
Other leadership as appropriate ____________________ (signature)