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

Taddle Creek

Family Health Team

3/21/2016

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.

Ontario

Overview

Taddle Creek Family Health Team (TC FHT) has two sites in downtown Toronto: Bay/College & Bloor/Christie. TC FHT, as of Mar, 2016, has 19,253 enrolled patients. Our medical 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 F16-17, will work on all HQO priority indicators and a few others.

Within the effective quality dimension, TC FHT will work to improve our cancer screening rates, improve our rate of HbA1C testing for patients living with diabetes and maintain our hospital readmission rate. More specifically TC FHT will,

- improve the % of patients aged 50-74 who had a fecal occult blood test within the past 2 years, sigmoidoscopy or barium enema within 5 years, or a colonoscopy within the past 10 years. Target: 65% Current eMR performance: 59%
- improve the % of women aged 21-69 who had a papanicolaou smear with the past 3 years. Target: Maintain 65% Current eMR performance: 63%.
- improve our HbA1C testing rate for patients living with diabetes, more specifically the % of patients aged 40 or over, with 2 or more HbA1C tests within the past 12 months. Target: 52% Current eMR performance: 48%
- maintain hospital readmission rate for our primary care population, more specifically the % of acute hospital inpatients discharged with selected conditions that are readmitted to any inpatient hospital within 30 days of the indexed admission. Target: 13% Current performance: 13% (as per ON MOHLTC Health Data Branch FY2014-15) (Note: Target not increased b/c TC FHT is the #1 performer in Toronto Central Local Health Integration Network)

Our change ideas include: initiating an internal campaign to promote Cancer Care Ontario's 'My Cancer IQ' website, continue with our turning 50 Colorectal Cancer Screening birthday card initiative, ensure accurate indexing of incoming reports, chart reminders to clinicians to order/perform intervention, list preparation for primary care providers of patients requiring intervention and sending of delayed messages to contact patients for check-ins.

Within the efficient quality dimension, TC FHT will work to maintain the rate of emergency department visits for conditions best managed elsewhere (BME). More specifically, TC FHT will,

- maintain our % of patients who visit the emergency department for conditions BME. Target: .45% Current performance: .45% (as per ON MOHLTC Health Data Branch FY2014-15) (Note: Target not increased b/c TC FHT is the #1 performer in Toronto Central Local Health Integration Network)

Our change ideas include: Finalizing our After Hour Clinics Booking Protocols to improve clarity and flexibility and to write two more Taddler Newsletter articles Re: Why Visiting ED for Conditions BME May Not Be Recommended and How to Manage at Home until Your TC FHT Appointment.

Within the equitable quality dimension, TC FHT will work to provide equitable care to internal/external complex and vulnerable patients. More specifically TC FHT will,

- explore the collection of Health Equity Demographic Data to understand the utility of collecting this data and understand how others use the data to provide equitable care

- improve access for complex, external patients and their community physicians, to inter-professional teams via our Telemedicine Impact Plus (TIP) clinics
- participate in the Referral from Emergency Departments (RED) project
Note: TIP/RED part of Mid West Toronto Health Link

Within the patient experience quality dimension, TC FHT will work to maintain our rate of patients who responded positively, on our 2015 Patient Care Survey, to the following questions:
- when you see your doctor or nurse partitioner, how often do they or someone else in the office give you an opportunity to ask questions about recommended treatment? Target: Maintain 97% 2015 Patient Survey Care performance: 97%
- when you see your doctor or nurse practitioner, they or someone else in the office always or often involve you as much as you want to be in the decisions about your care or treatment? Target: Maintain 96% 2015 Patient Care Survey performance: 96%
- when you see your doctor or nurse practitioner, how often do they or someone else in the office spend enough time with you? Target: Maintain 93% 2015 Patient Care Survey performance: 93%
Our change ideas include: Promote the use of our patient portal 'HealthMyself' for secure e-messaging, educate care providers about coordinated care plans/advanced care planning and implement a Patient Engagement Panel (PEP).
Note: 2015 Patient Care Survey sample >10% of patient population

Within the timely quality dimension, TC FHT will work to improve our 7 day post hospital discharge follow-up rate for selected conditions and improve timely access to primary care when needed. More specifically TC FHT will,
- improve the % of patients who see their primary care provider within 7 days after discharge from hospital for selected conditions. Target: 23% Current performance: 21% (as per ON MOHLTC Health Data Branch FY2014-15)
- maintain our rate of respondents who responded positively, on our Patient Care Survey, to the following question: The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually saw him/her or someone else in the office? Target: Maintain 82% 2015 Patient Care Survey performance: 82%
Our change ideas include: Continue with our internal process to search for discharge summaries and sending messages to both primary care providers and medical secretaries that patient needs to be seen and schedule medication reviews. We will also continue to collect third next available and discuss at our Board Meetings and hope to increase the number of physicians using e-booking.

The ON MOHLTC's Patient First: Action Plan for Health Care Propoal focuses on, 'ways to improve access to consistent, accountable and integrated primary care' and TC FHT's Board believes our QIP and Strategic Plan also focuses on access, accountability and integration. 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. preparing coordinate care plans, create patient engagement panel, allow on line booking, better integration with hospitals/discharge planning coordination) strategic goals/QIP objectives aligning with the ON MOHLTC's Patient First: Action Plan.

QI Achievements From the Past Year

WHAT WE ACHIEVED

A) TC FHT is most proud of the indicators in the patient centred quality dimension.
Our 2015 Patient Care Survey results are as follows:

1) 97% of patients responded positively to the question, 'When you see your doctor or nurse practitioner, how often do they or someone else in the office give you an opportunity to ask questions about recommended treatment' Target: 96% (and F14-15, 96%)
2) 96% of patients stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) involve them as much as they want to be in decisions about their care and treatment Target: 95% (and F14-15 result)
3) 93% of patients stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) spend enough time with them Target: 92% (and F14-15 results)

We are most proud of these results because they come directly from our patient population. We didn't believe we could improve on our F14-15 results and thus our F15-16 target was to maintain our past performance. What a surprise to see we exceeded all our targets. Although we performed well in F14-15, we still developed change ideas for F15-16; to explore e-booking and to create an internal strategic planning group to work on creating a Patient Advisory Committee. Both of these change ideas will come to fruition in F16-17. These change ideas have the potential for great impact to both our patients and TC FHT.

B) TC FHT is proud of the indicators in the integration quality dimension.
TC FHT is the Lead Organization for the Mid West Toronto Health Link (MWTHL) and thus has formed a range of partnerships to integrate into our healthcare community (see next section for list). TC FHT, for the past 3 years, has been stewarding the process to build partnerships among health care agencies to achieve the following initiatives:
- Ensure complex patients are attached to a family physician
- Ensure complex patients have a CCP in place for care coordination
- To reduce the number of avoidable ED visits for patients with conditions best managed elsewhere
- To ensure complex pts are seen by a family physician within 7 days of a hospital discharge

More specific examples include,
1) TC FHT partnered with University Health Network's Emergency Department on the Referral from Emergency Department (RED) project. The RED project, for CTAS 2 patients (more complex/vulnerable), when they indicate they do not have a primary care provider at ED registration, this results in an email notification to the ED's Social Worker (SW). The SW then asks if the patient is interested in primary care attachment and if yes, contacts TC FHT (or other partners also part of RED) for an appointment. The patient is given the date/time for their appointment right away. For the F15-16 QIP, we set a target of accepting 12 RED and by the end of the 3rd quarter had accepted 7. The MWTHL only initiated the project Jan 18, 2016 and thus based on our 3rd quarter result, we are confident we will achieve the target of 12. This is a great achievement, especially because only one TC FHT physicians is accepting patients but all 15 agreed to accept RED patients.
2) As a member of the MWTHL, we along with our partners set goals for the development of Coordinated Care Plans (CCPs) for complex patients. CCPs are an important tool to help complex patients manage their care, both for themselves and between providers. F15-16 target was 50 and as of the 3rd Q we had completed 48 CCPs. We are confident in the 4th Q we will do at least 2 more CCPs thus meeting our target. This is a significant achievement given that CCPs are time consuming and the community is still waiting for a provincial eMR enabled solution to allow coordination/sharing of CCPs.
3) TC FHT is also very proud that we are the top FHT performer in the Toronto Central Local Health Integration Network (TC LHIN) for having only 13% of our acute hospital inpatients discharges, within selected CMGs, readmitted to any acute inpatient hospital within 30 days of the discharge (as per the ON MOHLTC's Health

Data Branch data for FY2014-15). Although we are the top FHT performer in the TC LHIN, we still did not meet our 10% target for F15/16. Many of the same challenges, as noted in the 'What We Learned' section below for the 7 days post discharge, are the same challenges for not meeting this target.

C) TC FHT is proud of the indicators in the access quality dimension. TC FHT set a F15-16 target of 1000 home visits done by any clinician. As of the end of our 3rd Q, we are 73% over our target (1728 home visits) well surpassing our target. We are also proud that we are the top FHT performer in the TC LHIN for having the lowest % of patients visit the ED for conditions best managed elsewhere (as per the ON MOHLTC's Health Data Branch data for FY2014-15) and also met the F15/16 target of .45%. Our 2015 Patient Care Survey result to the question, 'The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioners to when you actually saw him/her or someone else in their office?' showed 82% of patients responded positively.

WHAT WE LEARNED

A) We learned that it is difficult to see patients within 7 days post discharge (for selected conditions). We are concerned about our ability to meet the F16-17 target set for this indicator (23%) as we did not meet our F15-16 target of 25%. The ON MOHLTC Health Data Branch data indicates 21% of TC FHT patients were seen with 7 days post discharge in F14-15. We face many challenges as follows:

1) We learned that clinicians do not feel this indicator is 'fair' (desire for indicator to be revised to be % of patients who were in contact with a provider within 10 days after discharge) and that it is too difficult to achieve, especially when only 67% of discharge summaries are being received within 7 days (so they do not pay attention to it and/or give up)
2) TC FHT is not attached to one hospital and is dependent on OntarioMD's Hospital Report Manager (HRM) to expedite electronic transmission of admission/discharge information to our eMR (not all hospitals report to HRM)
3) Some patients prefer to visit physician when they are feeling better (which is not usually within 7 days of discharge)
4) From the physician's perspective, many prefer to deal with patients presenting today and are reluctant to create work if the patient is not calling with a problem
5) For other patients, physicians believe they know the patient and know they are well supported, so unless they indicate they need to be seen, they will not initiate
6) Once the discharge summary is received, how to fit the patient into the physicians schedule without cancelling other patients appointments (the timing is often short and there is lack of space)
7) Many patients have had f/u by our team pharmacist or RN and this is not factored in

B) We learned that understanding the source of your data is important. For example, to determine the % of patients up-to-date in screening for colorectal cancer screening (CRCS) and to set targets, we have been utilizing our eMR's Preventative Care Summary Report (PCSR). We have since learned this is not the best source as this report is used to estimate preventative care bonuses. We have since created an eMR search, based on Cancer Care Ontario search criteria, and the results are quite different. For F14-15, our CRCS rate from the PCSR was 36% and for F15-16, by the end of the 3rd Q, our eMR search indicates 59%. Our F13-14 HQO Practice Profile Report has us at 71%. Understanding the multiple data repository sources (i.e. ON MOHLTC Health Data Branch, HQO's Practice Profile Report) and using these or confirmed eMR searches can save a lot of time, energy and result in

more accurate targets. You will note on our QIP we have indicated the current performance source and noted our history along with the various data sources.

C) We learned that reducing influenza rates for patients over age 65 is difficult to track. Our F15-16 target was 57% and as of the 3rd Q we have achieved only 49%. Many patients receive their flu shot now outside of primary care (i.e. pharmacies or their place of work) and although we had a change idea to promote the use of the tracking billing code (when patient receives outside of the FHT) this was often not recorded when the patient was asked if they had the flu shot. In addition, many patients choose not to receive flu shots at all.

Integration & Continuity of Care

Although still a proposal, the ON MOHLTC's 'Patients First - A Proposal to Strengthen Patient-Centred Health Care in Ontario' December 27, 2015 discussion paper, positions TC FHT to work closely with the TC LHIN [or our Sub-LHIN and/or our Patient Care Group (PCG)] on primary care planning and performance management. More specifically, we hope to work with the TC LHIN to plan services, to facilitate health human resource planning, to improve access to inter-professional teams for those who need it most and to link patients with primary care services. TC FHT envisions this partnership supporting our QI initiatives and the gaps/issues noted in the proposal align nicely with our F16-17 QIP.

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 3 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)
- -123 Solo Community Physicians in the SCOPE (Seamless Care Optimizing the Patient Experience) Project

These are agencies/organizations TC FHT has been working with to improve integration and continuity of care. In addition to bringing these HSP together, TC Lead Physician (and Executive Director) plan for multiple meetings/working groups for various initiatives. For example, the Lead Physician and ED attend quarterly MWTHL Council Meetings, bi-monthly Complex Vulnerable Working Group Meetings and chair the Toronto Health Link Regional Steering Committee looking at how to improve

hospital/primary care 7 day f/u post discharge initiative. Being the lead organization for the MWTHL has been key to integrating with other HSPs in our catchment area and to promote continuity of patient care.

Engagement of Leadership, Clinicians and Staff

TC FHT has a Quality Improvement Committee (QIC) that meets monthly with representation from physicians, IHPs and administration from both sites and 6 suites. Our QIDSS (Quality Improvement Decision Support Specialist), in conjunction with the Executive Director, lead the QIC. Planning and progress on our QI initiatives is reviewed at each QIC meeting. It is also the QIC that develops the QIP and discusses/implements change ideas.

The Executive Director reports the QIP progress to the Board quarterly. TC FHT engages all staff through monthly Clinical Meetings & bi-weekly Team Meetings. The QIP is presented in the Spring at a Clinical Meeting and at least 2 more times throughout the year.

This year change ideas will be assigned and lead by a QIC member and then reported back to the QIC.

Patient/Resident/Client Engagement

TC FHT does not have a Patient Advisory Council (PAC) at this time. A planned F15-16 QIP improvement was to create a PAC but first to learn more about PACs. We learned quite a bit in F15-16 and now feel knowledgeable enough to proceed in F16-17. Although we do not have an official PAC yet, TC FHT adopted the MWTHL's Seniors Advisory Volunteer Initiatives (SAVI) Group in F15-16. The SAVI group was mainly made up of TC FHT patients thus in an excellent position to advise a second Strategic Planning Sub Group looking at Enhanced Care for Seniors. The group has provided feedback on different ideas and has volunteered to co-ordinate 3 lecture series for TC FHT seniors in F16-17.

In January 2015, TC FHT had a Strategic Planning Day and one strategic initiative was to develop a PAC. A Strategic Planning Sub Group was formed and they decided first to learn PAC best practices and about different PAC models. The sub group invited the Change Foundation to a meeting to learn more and following this meeting the sub group felt that a Patient Engagement Panel (PEP) was better suited to our needs. A PEP would allow us to draw on patient volunteers for specific tasks thus ensuring the patient volunteer has the right knowledge, skills, time and an interest in the work. There would not be a set committee but rather a large pool of patient volunteers who would review PEP opportunities (i.e. reviewing the QIP, reviewing our Patient Care Survey) then assess their own knowledge/skills and interest before volunteering. The PEP Strategic Planning Sub Group is now in the process of developing the PEP Terms of Reference and plan to use our patient portal, HealthMyself, as our recruitment/communication tool.

We also engage patients via the Patient Care Survey and through ongoing evaluations of our groups.

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. Jessica Yu
Quality Committee Chair or delegate Sherry Kennedy
Executive Director / Administrative Lead Sherry Kennedy
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)