Let's Make Healthy Change Happen.

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

Taddle Creek
Family Health Team

3/27/2019

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

Taddle Creek Family Health Team (TC FHT) has two sites in downtown Toronto, Ontario: Bay/College & Bloor/Christie. TC FHT has 18862 enrolled patients (and about 1200 active, non rostered patients). Our clinical team consists of 16 physicians, 3 nurse practitioners, 3 registered nurses, 4 social workers, 1 dietitian, 1 pharmacist and 1 physician assistant. We also have a Diabetes Education Program (DEP) who cares for both TC FHT and community patients living with diabetes. DEP staffing consists of 2 registered nurses and 2 dieticians. In total there are 50+ staff working to care for this population.

TC FHT has a Quality Improvement Committee (QIC) that meets quarterly with physician, interdisciplinary health providers and administration; there is representation from both sites. Our QIDSS (Quality Improvement Decision Support Specialist), in conjunction with the Executive Director, chair the QIC. The QIC is responsible to develop the QIP, implement change ideas and monitor progress. In the drafting the F19/20 QIP, QIC considered Health Quality Ontario's (HQO) priority indicators & Practice Reports, the ON MOHLTC's Health Data Branch statistics, TC FHT's F18/19 QIP (including Patient Care Survey results) and TC FHT's 2015 Strategic Plan. The QIC also considered the aim of the ON MOHLTC's Patient First Act and Toronto Central Local Health Integration Network's (TC LHIN) 2015-2018 strategic plan. Once the QIP is drafted, the Executive Director discusses it with TC FHT's Board in March, seeks approval and then reports on progress to the Board throughout the year. Once approved, the QIP is then presented at a spring Clinical Meeting (where most staff are present) and then again at a fall Clinical Meeting (to present on progress).

Below is an overview of TC FHT's F19/20 Quality Improvement Plan (QIP). For each measure, the following is provided: current performance/target, quality dimension, rationale and our change ideas.

1) Measure: % of hospital discharges (any conditions), where timely notification (within 48 hours) was received, for which f/u was done (any mode, any clinician) within 7 days of discharge
Current Performance: Creating Baseline Target: 65%

Dimension: Efficient
Rationale: Patients with complex conditions require ongoing support from primary care, home care, hospitals and specialists. This is especially true when a patient is discharged from the hospital with selected condition(s) (i.e. stroke, COPD, pneumonia, congestive heart failure, gastrointestinal conditions and diabetes). When we receive notice from hospitals that one of our patients has been discharged, we need to contact the patient, ideally within 7 days of their discharge. We want to to discuss discharge instructions, discharge medications, homecare needs, f/u with specialist appts, in-home supports and their need to come in for an appointment. By following up with these patients', to ensure their conditions have stabilized and their care is coordinated, we help ensure an effective transition from hospital to home and potentially avoid readmissions.

Change Ideas: For many years TC FHT has collected data for this measure but only for the selected conditions mentioned above. For many reasons, we have decided to now collect data for any condition. This will reduce the burden on Administrative Staff who have had difficulty deciphering from hospital discharges if the discharge is for a selected condition. This change necessitates we update our internal processes, documentation and outcome calculation methods. For example, we will be updating our process map, revising our eMR documentation tool ['7-Day Follow-up Encounter Assistant (EA)] and creating new searches to calculate outcomes. We plan

to educate and audit clinicians in order to ensure a single method to document f/u is being used (the 7-Day Follow-up EA). We will also continue to monitor our rate of 30-day re-admissions as a measure of effectiveness.

2) Measures:
% of patients able to see a doctor or nurse practitioner (NP) on the same or next day, when needed
Current Performance: 77% Target: 80%
% of patients who stated that when they see the doctor or NP, 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
Current Performance: 96% Target: 96%

Quality Dimensions: Timely/Patient-Centred
Rationale: In May 2015, the Institute of Medicine defined patient-centered care as: "Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. Being patient-centred means listening to, informing and involving patients in their care." Since 2013 TC FHT has been surveying our patients because we want to hear what our patients are saying about access, about the care and treatment they are receiving and how they think we can improve. We will continue to survey our patients, support a patient advisory committee (PAC) and act on what we hear to the best of our ability.

Change Ideas: We will continue to pose the following questions on our Patient Care Survey: The last time you were sick or were concerned you had a health problem, now many days did it take from when you first tired to see your doctor or NP to when you actually saw him/her or someone else in the office? When you see your doctor or NP or someone else, how often do they involve you as much as you want to be in decision about your care and treatment? We also want to use our online patient portal (HealthMyself) to administer the survey (as opposed to email) to be more efficient. We will continue to collect, once a month, for all physicians/NPs, the number of days to their third next available (TNA) appointment and present to our Board the '% of months with a TNA <=1 day.' Our last change idea for this measure is to increase access by expanding the use of e-booking.

3) Measure: % of patients with medication reconciliations in the past year
Current Performance: 21% Target: 25%

Quality Dimension: Effective
Rationale: The Institute for Safe Medication Practices (Canada) states, 'Medication errors do not just cause injury to patients; they are also costly to the healthcare system. US data suggests an estimate of about 2 percent of hospitalized patients experience a preventable adverse drug event, and an estimate of 700 deaths per year result from medication errors.' A recent Canadian adverse events study indicates that the most common types of adverse events include drug-related events (Baker, Norton, Flintoft, Blais, Brown, Cox, Etchells, Ghali, Hébert, Majumdar, O'Beirne, Palacios-Derflingher, Reid, Sheps and Tamblyn, JAMC, 2004). The study found that 3.1% of 3745 charts reviewed retrospectively had documented an adverse drug reaction. However, this is likely underestimated as unplanned hospital admissions or readmissions due to medication non-adherence may not be captured.

Change Ideas: Our change idea is to improve our documentation in order to calculate this outcome. Our Quality Improvement Decision Support Specialist (QIDSS) will convert our MedRec stamp to a custom form that links to our 7-day

Encounter Assistant. Our pharmacist will educate the team on MedRec documentation tools and how to do a MedRec.

4) Measure: % of non-palliative patients newly dispensed an opioid within a 6-month reporting period prescribed by any provider in the healthcare system within a 6-month reporting period.
Current Performance: 5% Target: 5%

Quality Dimension: Safe
Rationale: Opioids are natural or synthetic substances used to reduce pain in clinical settings, but are also produced and consumed non-medically. Common opioids include oxycodone, hydromorphone and fentanyl. While they can be an effective part of pain management for some medically supervised patients, opioid-related harms such as addiction and overdose present a significant challenge for public health. Toronto Public Health, from Apr 2016 until Jun 2018 reported 185 ED visits and 23 hospitalizations due to opioid poisoning and for 2017, reported 308 deaths from opioid toxicity causes. Canada is facing a national opioid crisis (Health Canada).

Change Ideas: TC FHT is working to understand what part we can play in this complex health and social issue and how it impacts our patient population. Since 2010 we have had a policy/procedure in place for the prescribing of opioid (Narcotic) medications (posted on our website). Our policy/procedure was based on The College of Physicians and Surgeons of Ontario's 2000 Evidence-based Recommendations for Medical Management of Chronic Non-Malignant Pain. Our change ideas involve updating this existing policy/procedure to ensure we are following best practices. Our pharmacist will update the existing policy/procedure using HQO resources provided during their Feb 11, 2019 webinar that focused on opioids in primary care. We are also going to look into how we can implement an eMR toolbar with specific custom forms as per the updated policy/procedure. Lastly, we will educate prescribers about our updated policy/procedure via a fall Clinical Meeting and educate patients via our Taddler Newsletter.

5) Measure: % of patients, >=18yrs, screened for poverty
Current Performance: 2.6% Target: 5%
Quality Dimension: Equitable Care
Rationale: A recent report by Statistics Canada (Cause-specific Mortality by Income Adequacy in Canada: A 16-year Follow-up Study) demonstrated that income inequality is associated with the premature death of 40,000 Canadians a year. Income is a social determinant of health, if we start to discuss income problems we can improve health. We want to continue screening our population for poverty by asking two questions: Do you have difficulty making ends meet at the end of the month? Have you filled out and sent in your tax forms? If patients confirm they have difficulties making ends meet or have not done their taxes, we then will then educate, intervene and connect. More specifically we will provide information on free community tax clinics and federal/provincial social benefits.

Change Ideas: We are continuing with this measure (introduced in F18/19). We will continue to educate staff on using established documentation tools and the 2-Tier Process (Tier 1: Primary Care Providers to ask initial questions and provide handout, Tier 2: Refer patients to Single-Session Drop in Counselling Clinics for case management) when working with patients living in poverty.

6) Measure: % of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months
Current Performance: 59% Target: 60%
Quality Dimension: Equitable Care
Rationale: Population health is about aiming to improve health outcomes of the population or a specific population cohort. Diabetes Canada estimates that in 2015, 3.4 million or 9.3% of the population suffer from diabetes and 5.7 million or 21% of the population suffer from pre-diabetes. This is obviously a population health concern. Good diabetes care can reduce the impact of the disease (i.e. premature deaths, hospitalization for cardiovascular/renal disease, etc.). We want to make sure our patients are managing their diabetes by ensuring excellent ongoing diabetes care and one way to do that is for patients suffering from diabetes to visit us.

Change Ideas: We will provide reports of patients who have not had two or more HbA1C tests in the past 12 months in the fall of 2019 to primary care providers and to our Diabetes Education Program [for FHT patients historically seen by the DEP but not in the past 12 months (for them to follow up with these patients)].

TC FHT's QIP initiatives are ambitious but worthwhile. Our objectives are to ensure efficient transitions by providing follow up within 7 days of discharge, to improve population health by providing ongoing diabetes care and by addressing income inequity, to improve medication safety by having direct clinical interventions; and finally, to provide accessible care and a positive patient visit experience by listening to our patients' voice via our patient care survey.

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

Our greatest QI achievement in F18-19 was introducing poverty screening for patients 18 years and over.

In Sep 2017, Dr. Gary Bloch from St. Michael's Hospital Academic Family Health Team came to talk to us about treating poverty. We discussed the evidence-based argument for intervening in poverty in primary care (see image #1/2). We learned we need to asks two key questions; Do you ever have difficulties making ends meet at the end of the month? Have you filled out & sent in your tax forms? We also knew asking these questions without proper training on next steps would not be effective. The Quality Improvement Committee (QIC) decided to add a new initiative for our F18-19 QIP, the Introduction of the Centre for Effective Practice's Poverty Tool for Primary Care (see image #3). Out methods included,

1) Investigating the Ontario College of Family Physicians (OCFP) Treating Proverty Workshop
2) Allowing Primary Care Providers (PCP) to use their intuition in selecting who to screen (highest risk groups = new immigrants, women, aboriginals and LGBTQ)
3) Introducing a 2-teir process; Tier 1: PCPs to ask x2 questions & provide handout Tier 2: Refer pts to Single-Session Drop-In Counselling Clinic for further case management
4) Establishing an eMR tracking process

We did not have a current performance or target as this was our first year with this initiative.
This initiative was introduced to the Team at a May 2019 Clinical Meeting.

For method #1, we held 2 -1/2 day internal OCFP treating poverty workshop in Oct 2018 for all clinicians. This was a practical, active learning workshop designed

to develop relevant clinical skills and to obtain a better understanding of the federal and provincial income security systems and other related resources for people living in proverty. The learning objectives were as follows:

1. Intervene in poverty using the Poverty Tool
2. Guide patients to relevant income benefit programs and critically assess income benefit programs that require physician input
3. Build and empower a practice team to address poverty and social determinants of health
4. Advocate for patients living in poverty

For method #2, we created a Sub Co. of the QIC to look at how we could start screening for poverty and took a Six Sigma/Lean approach. The Sub Co. developed the Problem & Aim statements as follows:

Problem Statement: Poverty is a barrier to health and clinicians may not be aware of patients living in poverty because either patients/clinicians are reluctant to talk about it or patients are overburdened / incapable/ anxious to take next steps. Poverty can impact anyone across their lifespan, however research indicates certain population at risk. There is no systematic method to screen and help.
Aim Statement: 5% of rostered patients, seen by clinicians from Nov'18 – Jan '19, will be screened for poverty

For method #3/4, the Sub Group looked at introducing the 2-teir process to the team and how to standardize the method to collect data in our eMR for measurement. Data collection was enabled by adopting Cognisant's Socioeconomic Status Screen (see image #4). The data could be collected using an Ocean tablet or a custom form in our eMR. There was flexibility to also use two already implemented tools: Senior Care Custom Form and the Diabetes Education Program's New Client Intake Form (both have similar poverty screening questions). The Socioeconomic Status Screen (Tier 1) has key resources linked directly in the custom form, for example the OCFP Poverty Clinical Tool (see image #5) and the OCFP Patient Brochure on Income Supports (see image #6) were one click away. Clinicians could then refresh their memory on key government websites, access the Patient Brochure and advise patients to visit our Single Session Drop in Counselling Clinics (Tier 2) for additional case management support by one of our social workers.

Getting to this point took most of F18/19 but we were able to determine 2.6% of patients seen from Nov 1, 2018 to Jan 31, 2019 were screened for poverty. We have decided to continue with this QI initiative for F19/20 and our target is now 5%. We have learned many lessons on this journey. We learned that supporting patients living in poverty can be complicated and time consuming and that even with training, clinicians may be reluctant to start the conversation. We also learned that creating a QIC Poverty Sub-Group was difficult to maintain (in addition to our QIC) due to the small size of our organization. The Sub-Group did however enjoy learning about Six-sigma and Lean tools.

thestar.com
COMMENTARY

Income inequality is killing thousands of Canadians every year

A new study from Statistics Canada shows that income inequality is associated with the premature death of 40,000 Canadians per year.

Disease	RR[1]		Excess Deaths[2]	
	Men	Women	Men	Women
Cardiovascular Disease	1.67	1.53	19%	18%
Cancers	1.46	1.30	16%	11%
Diabetes	2.49	2.64	36%	38%
Respiratory Disease	2.31	2.11	37%	30%
HIV - AIDS	3.57	11.1	39%	69%
Injuries	1.88	1.83	18%	17%

Raphael, Dennis & Bryant, Toba. Income inequality is killing thousands of Canadians every year. November 23, 2014. http://www.thestar.com/opinion/commentary/2014/11/23/income_inequality_is_killing_thousands_of_canadians_every_year.html ; Table: http://www.thinkupstream.net/health_effects_of_income_inequality

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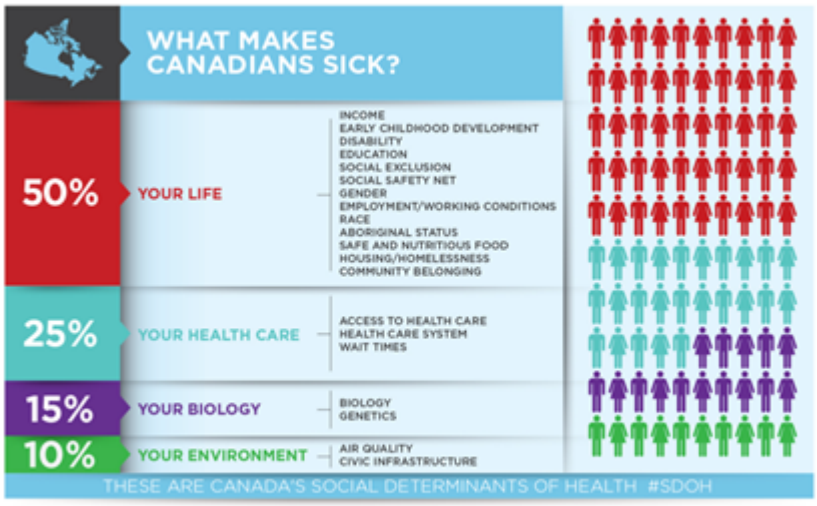

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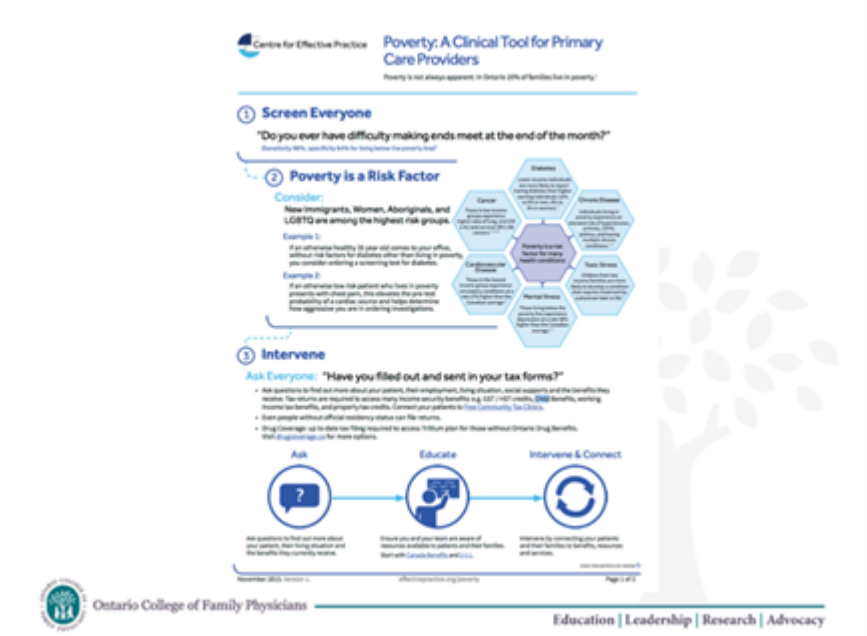

Centre for Effective Practice

Poverty: A Clinical Tool for Primary Care Providers

Poverty is not always apparent. In Ontario 20% of families live in poverty.[1]

1 Screen Everyone

"Do you ever have difficulty making ends meet at the end of the month?"

(Sensitivity 86%, specificity 64% for living below the poverty line)[2]

2 Poverty is a Risk Factor

Consider:

New immigrants, Women, Aboriginals, and LGBTQ are among the highest risk groups.

Example 1:

If an otherwise healthy 35 year old comes to your office, without risk factors for diabetes other than living in poverty, you consider ordering a screening test for diabetes.

Example 2:

If an otherwise low risk patient who lives in poverty presents with chest pain, this elevates the pre-test probability of a cardiac source and helps determine how aggressive you are in ordering investigations.

Diabetes

Cancer

Chronic Disease

Poverty is a risk factor for many health conditions

Cardiovascular Disease

Toxic Stress

Mental Illness

3 Intervene

Ask Everyone: "Have you filled out and sent in your tax forms?"

- Ask questions to find out more about your patient, their employment, living situation, social supports and the benefits they receive. Tax returns are required to access many income security benefits e.g. GST / HST credits, Child Benefits, working income tax benefits, and property tax credits. Connect your patients to Free Community Tax Clinics.
- Even people without official residency status can file returns.
- Drug Coverage: up to date tax filing required to access Trillium plan for those without Ontario Drug Benefits. Visit drugcoverage.ca for more options.

Ask

Educate

Intervene & Connect

Ask questions to find out more about your patient, their living situation and the benefits they currently receive.

Ensure you and your team are aware of resources available to patients and their families. Start with Canada Benefits and 211.

Intervene by connecting your patients and their families to benefits, resources and services.

[1] www.thecanadianissue.ca

November 2015, Version 1.1 effectivepractice.org/poverty Page 1 of 2

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TCFHT- Socioeconomic Status Screen

Do you ever have difficulty making ends meet at the end of the month?

Have you filled out and mailed your income tax forms?

Do you receive old age security and guaranteed income supplement?

Do you cared for any children?

Do you receive the child benefit on the 20th of every month?

Do you receive national or provincial disability benefits?

Are you status First Nations?

Have you applied for extra income supplements?

Have you applied for special diet allowance?

Have you applied for transportation allowance?

Are you able to afford your medications(s)?

If you might, have you applied for ODSP?

Have you explored canadabenefits.gc.ca to see whether there are other government resources that may help?

NOTE: you may also call 211 for a listing of services in your community that may help.

Clinical point-of-care resources for poverty assistance:

- OCFP Patient Brochure on Income Supports
- OCFP Poverty Clinical Tool
- OCFP Child Poverty Clinical Tool
- canadabenefits.gc.ca
- 211ontario.ca
- yourlegalrights.on.ca

Have you filed your tax return?

Even if you made no money, you should file a return each year. This is how you can get many government benefits, such as:

GST/HST Credit
The Government pays you back some of the sales tax you paid.

Working Income Tax Benefits
This is a tax credit for working people with low incomes.

Child Benefits
These payments help you support your children.

If you do not have your resident status yet, you can still file a tax return. You may be able to get some of these benefits.

Get advice at a free income tax clinic
To find one where you live, go to 211ontario.ca or call 2-1-1.

More income for older people
If you file a tax return, the government will tell you how to apply for these benefits.

Canadian Pension Plan – Retirement (CPP-R)
If you worked in Canada and paid into CPP, you can start getting pension at age 60. If you are still working, you can wait as long as age 70 and collect a larger pension. CPP is paid monthly, based on how much you paid into the plan.

Old Age Security (OAS)
Anyone who has lived in Canada at least 10 years can get some OAS. If you have lived here most of your life, you can get full OAS. This monthly payment goes up with the cost of living. Apply 6 months before you turn 65.

Guaranteed Income Supplement (GIS)
This income supplement is for low-income seniors. To get an application form, call 1-800-277-9914 (TTY: 1-800-255-4786). Once you are getting the supplement, you re-apply each year by filing your tax return.

Useful Websites and Phone Numbers

3 easy to use guides to government benefits:

Service Canada
www.servicecanada.gc.ca

Canada Benefits
www.canadabenefits.gc.ca

Ontario Benefits
www.ontario.ca/taxes-and-benefits/taxes-and-benefits

Your Legal Rights
www.yourlegalrights.on.ca Plain-language information on social assistance, housing, health, family law and more, in many languages.

Income Security Advocacy Centre
www.incomesecurity.org. This website can tell you about recent changes in major income supports.

St. Christopher House
www.stchrishouse.org or call 416-848-7980.
This community centre in Toronto gives free, personal financial advice.

Legal Clinics
To find a free legal clinic near you, visit **www.legalaid.on.ca** or call 1-800-668-8258.

2-1-1 (phone) or 211ontario.ca
This is a free, complete directory of supports and services in Ontario, including housing, employment and other social supports.

Toronto People With Aids (PWA) Foundation
www.pwatoronto.org or call 416-506-1400. People living with HIV/AIDS can contact a case manager for financial counseling and help with applying to income support programs.

Wellspring Money Matters Resource Centre
www.wellspring.ca or call 416-961-1493. Cancer patients can access financial consultation and clinics.

Developed by Christine Herrera, MD Candidate, and Dr. Gary Bloch, MD CCFP
(Revised September 2013)

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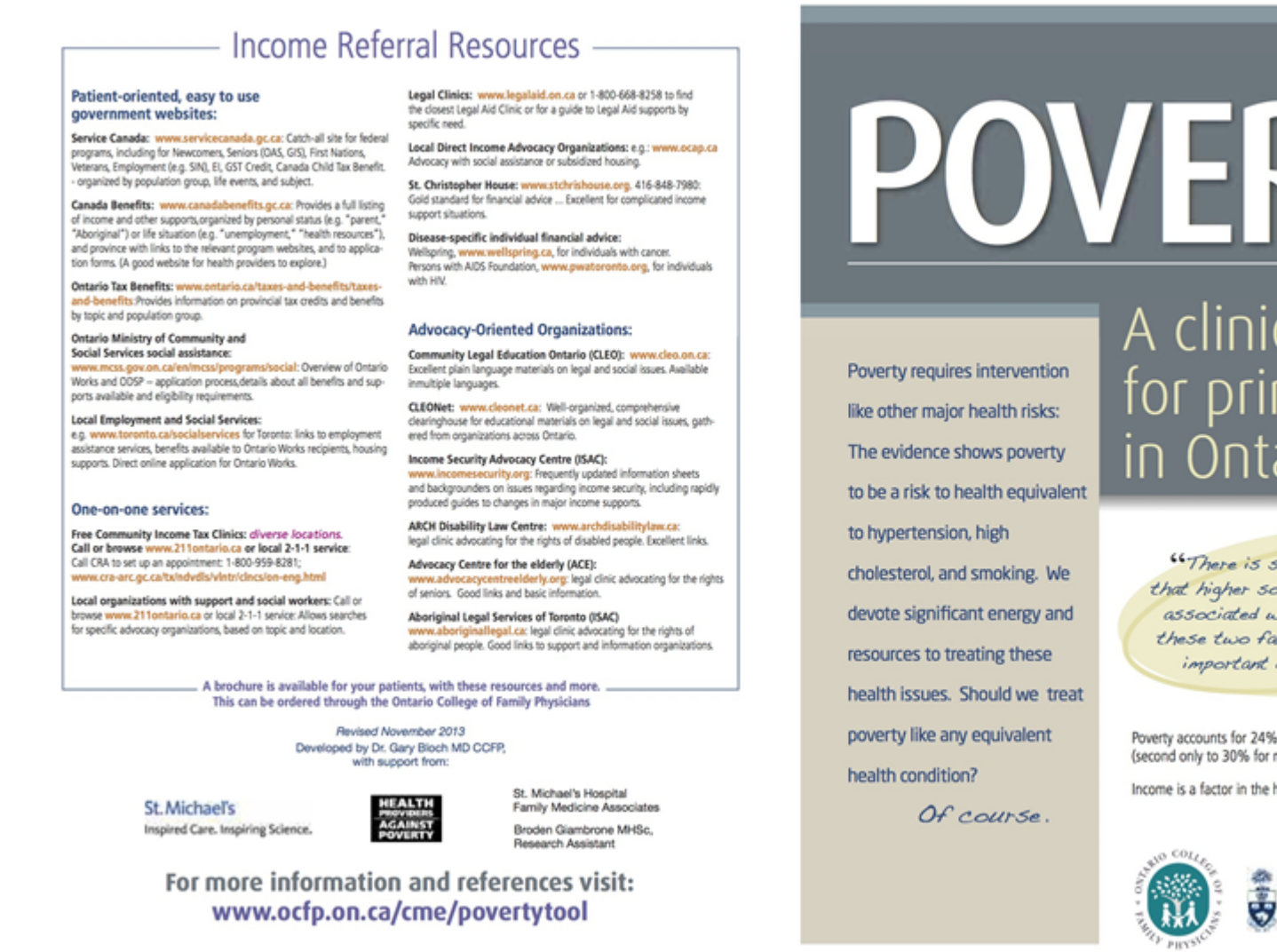

Income Referral Resources

Patient-oriented, easy to use government websites:

Service Canada: www.servicecanada.gc.ca: Catch-all site for federal programs, including for Newcomers, Seniors (OAS, GIS), First Nations, Veterans, Employment (e.g. SIN), EI, GST Credit, Canada Child Tax Benefit. - organized by population group, life events, and subject.

Canada Benefits: www.canadabenefits.gc.ca: Provides a full listing of income and other supports,organized by personal status (e.g. "parent," "Aboriginal") or life situation (e.g. "unemployment," "health resources"), and province with links to the relevant program websites, and to application forms. (A good website for health providers to explore.)

Ontario Tax Benefits: www.ontario.ca/taxes-and-benefits/taxes-and-benefits:Provides information on provincial tax credits and benefits by topic and population group.

Ontario Ministry of Community and Social Services social assistance: www.mcss.gov.on.ca/en/mcss/programs/social: Overview of Ontario Works and ODSP – application process,details about all benefits and supports available and eligibility requirements.

Local Employment and Social Services: e.g. www.toronto.ca/socialservices for Toronto: links to employment assistance services, benefits available to Ontario Works recipients, housing supports. Direct online application for Ontario Works.

One-on-one services:

Free Community Income Tax Clinics: *diverse locations.* **Call or browse www.211ontario.ca or local 2-1-1 service:** Call CRA to set up an appointment: 1-800-959-8281; www.cra-arc.gc.ca/tx/ndvdls/vlntr/clncs/on-eng.html

Local organizations with support and social workers: Call or browse www.211ontario.ca or local 2-1-1 service: Allows searches for specific advocacy organizations, based on topic and location.

Legal Clinics: www.legalaid.on.ca or 1-800-668-8258 to find the closest Legal Aid Clinic or for a guide to Legal Aid supports by specific need.

Local Direct Income Advocacy Organizations: e.g.: www.ocap.ca Advocacy with social assistance or subsidized housing.

St. Christopher House: www.stchrishouse.org, 416-848-7980: Gold standard for financial advice ... Excellent for complicated income support situations.

Disease-specific individual financial advice: Wellspring, www.wellspring.ca, for individuals with cancer. Persons with AIDS Foundation, www.pwatoronto.org, for individuals with HIV.

Advocacy-Oriented Organizations:

Community Legal Education Ontario (CLEO): www.cleo.on.ca: Excellent plain language materials on legal and social issues. Available inmultiple languages.

CLEONet: www.cleonet.ca: Well-organized, comprehensive clearinghouse for educational materials on legal and social issues, gathered from organizations across Ontario.

Income Security Advocacy Centre (ISAC): www.incomesecurity.org: Frequently updated information sheets and backgrounders on issues regarding income security, including rapidly produced guides to changes in major income supports.

ARCH Disability Law Centre: www.archdisabilitylaw.ca: legal clinic advocating for the rights of disabled people. Excellent links.

Advocacy Centre for the elderly (ACE): www.advocacycentreelderly.org: legal clinic advocating for the rights of seniors. Good links and basic information.

Aboriginal Legal Services of Toronto (ISAC) www.aboriginallegal.ca: legal clinic advocating for the rights of aboriginal people. Good links to support and information organizations.

A brochure is available for your patients, with these resources and more.
This can be ordered through the Ontario College of Family Physicians

Revised November 2013
Developed by Dr. Gary Bloch MD CCFP,
with support from:

St. Michael's
Inspired Care. Inspiring Science.

HEALTH PROVIDERS AGAINST POVERTY

St. Michael's Hospital
Family Medicine Associates

Broden Giambrone MHSc,
Research Assistant

For more information and references visit:
www.ocfp.on.ca/cme/povertytool

POVER

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for pri
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Poverty requires intervention like other major health risks: The evidence shows poverty to be a risk to health equivalent to hypertension, high cholesterol, and smoking. We devote significant energy and resources to treating these health issues. Should we treat poverty like any equivalent health condition?

Of course.

"There is s
that higher so
associated w
these two fa
important

Poverty accounts for 24%
(second only to 30% for r

Income is a factor in the h

Patient/client/resident partnering and relations

Our patient engagement strategy includes both formal and informal mechanisms. Formal patient engagement is received via Seniors Advisory Volunteer Initiative (SAVI) and by conducting focus groups. Informal patient input is received via our annual Patient Care Surveys and group/clinic evaluations all of which are used for FHT planning and priority setting.

SAVI is TC FHT's patient engagement committee (10-12 seniors) that meet quarterly with the Executive Director and a physician. The purpose of SAVI is to receive input on FHT program/clinical activities, to promote senior services at TC FHT and to disseminate knowledge/ideas related to the health and well being of seniors. The following is a list of how SAVI fulfilled its purpose in F18/19:
- Advises an internal TC FHT Strategic Planning Co. tasked with looking at developing an 'Enhanced Senior Appointment'
- Presents at a Clinical Meeting (where most clinicians are present) to explain their purpose and how they can be helpful
- Sit on staff recruitment panels
- Wrote Taddler (newsletter) articles; one about who SAVI is and one about the importance of seeing an optometrist regularly
- Organized a Seniors Seminar on Future Planning with 50+ senior attendees
- Reviews our Patient Care Survey results and provides improvement ideas

Our last focus group was In Sep 2017 to receive patient feedback on a new DEP group; Let's Get Moving. We are planning another focus group in the Spring of 2019, to receive feedback on another new DEP group; Intuitive Eating.

Our F18-19 Patient Care Survey (sample size >10% population) tells us what we are doing well (access, collaboration, technology and care) and what we could improve (customer service, phone system and ease of appointment making). Our Patient Care Survey is a very powerful motivator for TC FHT staff. For example, the 2018 Patient Care Survey showed three service provider groups (DEP, SW, RNs) with a 1% increase (already very high 96%, 96%, 95% respectively) in patients ranking their service as excellent. We also saw a 4% increase in patients responding always/often upon arrival being greeted warmly.

We also receive informal patient input via group/clinic evaluations. TC FHT provides a plethora of groups/clinics and evaluations are analyzed to assist with planning and priorities. In addition to using evaluation analysis data for program changes, it is also used to improve clinician performance.

Workplace violence prevention

TC FHT has taken the following steps to prevent workplace violence.

1.Policies and procedures related to workplace violence
-Staff Safety (1.01)
Ensures availability of personal safety alarms & a procedure to identify potentially violent patients
-Safety Reporting System (1.04)
Establishes process for the reporting, investigating and reviewing of “incidents” in an open, safe and fair environment with a view to identifying root causes and system failures
-Workplace Violence and Harassment (2.01)
Commitment to the prevention of workplace violence and harassment by providing an environment of mutual respect and free from threats of violence

Note: Joint Health & Safety Committee (JHSC) will be revamping our Staff Safety P&P in 2019 using the Public Services Health & Safety Associations, Communicating the Risk of Violence handbook to ensure our flagging program is effective.

2. In 2018 completed Occupational Health & Safety Council (OHSCO) Workplace Violence Assessments for both sites. Completed the General Physical Environment Assessment and then the individual assessments for working directly with clients, working with unstable or volatile clients. Recommendations (i.e. installing reception glass barriers, not hosting After Hour Clinics alone, locks on doors between waiting room and reception area, signage Re: No narcotics on site, etc.) are all being seriously considered for implementation.

3.Quarterly JHSC meetings where,
- workplace violent incidents are reviewed with an eye to prevention
- monthly/quarterly inspections with checklists for safety items (i.e. sharp objects out of sight, panic alarms functional, etc.)

4.Conducted Annual Occupational Health & Safety Day in Nov 2018 where staff had to complete on-line training module on Workplace Violence & Harassment (90% staff complete).

TC FHT takes staff, patient and visitor's safety very seriously.

Contact Information

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Other

TC FHT collaborates with the TC LHIN to improve healthcare performance in the Mid-West Toronto Sub Region (MWTSR). We work with our MWTSR partners (see TC LHIN website for list) to align services with other sectors (i.e. community support agencies, acute care, long term/home care and other primary care agencies) and to improve integration.

Here are some examples of how we collaborate with the TC LHIN and within our sub-region:
1. Active member of the Primary and Community Care Committee (PCCC)
2. Active members of Mid-West FHT Collaborative
3. Regular attendance at Mid-West Local Collaboratives hosted by TC LHIN

Here are some examples of how we integrate within our sub-region and with our sub-region partners:
1. MWTSR identifies complex, unattached patients frequenting UHN's Emergency Department and creates RED (Referrals from UHN's Emergency Department) Project
- TC FHT continues to participate in RED project by agreeing to accept 23 RED patients for calendar 2019
2. Centre for Addiction and Mental Health (CAMH) and TC FHT's Mental Health Program form partnership in Jan 2018 to provide quicker access to Cognitive

Behavioural Therapy (CBT) Groups at TC FHT for patients suffering from mild to moderate depression and anxiety.
- This partnership grows very strong in F18/19 with 7 CBT groups held by the 3rd Q and 47 patients completing.
3. MWTSR identifies benefit of Telemedicine Impact Plus (TIP) clinics for community physician's complex patients (inter-professional clinics using telemedicine)
- TC FHT responds by hosting 6 TIPs by the 3rd Q in F18-19
4. MWTSR identifies the benefits of coordinated care plans (CCPs) for patients with complex health needs
- TC FHT responds by completing 20 CCPs by the 3rd Q in F18-19

By working with the TC LHIN and by collaborating/integrating with our MWTSR partners, TC FHT is in a better position to align services with other sectors, to integrate care and to improve the overall performance of our healthcare system.

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 _____ (signature)
Quality Committee Chair or delegate _____ (signature)
Executive Director/Administrative Lead _____ (signature)
Other leadership as appropriate _____ (signature)