Let's Make Healthy Change Happen.

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

Taddle Creek
Family Health Team

3/16/2018

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.

Click here to enter text.Overview

Taddle Creek Family Health Team (TC FHT) has two sites in downtown Toronto: Bay/College & Bloor/Christie. TC FHT has 18994 enrolled patients (and about 1200 active, non rostered patients). Our clinical team consists of 16 physicians, 3 nurse practitioners, 3 registered nurses, 3 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.

Below is an overview of TC FHT's F18/19 Quality Improvement Plan (QIP). It outlines our initiatives within various quality dimensions, measure(s)/targets and anticipated challenges and strategies. In the creation of our QIP, we considered the aim of the ON MOHLTC's Patient First Act, Health Quality Ontario's (HQO) priority indicators, Toronto Central Local Health Integration Network's (TC LHIN) 2015-2018 strategic plan, TC FHT's F17/18 QIP (including Patient Care Survey results) and TC FHT's 2015 Strategic Plan.

F18/19 Quality Improvement Plan (QIP) Overview

1. Effective Transitions: 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 a complex 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 with one of these conditions, we need to contact the patient, ideally within 7 days of their discharge. We want to know if they are receiving homecare, taking their medications and following up on any specialist appointments. 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.

Measure: % of hospital discharges (for selected conditions), where timely notification was received, for which f/u was done within 7 days
Target: 60%

Challenges
-Patients too ill to travel to appt within 7 days, have transportation issues or poorly connected to homecare
-Timeliness or not receiving notice of admission or discharge from hospitals
-Unclear accountability for who should book PCP appointment (points in discharge planning for acute care to connect with PCP)
Strategy
-Encourage team approach to post discharge f/u, track when any clinical provider follow-ups with patient using any mode (i.e. phone, secure/encrypted email)

2. Population Health: 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.

Measure: % of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months
Target: 65%

Challenges
-Provider's ability to convince patients to go to our Diabetes Education Program (DEP) for ongoing care
-Patients willingness and readiness to accept referrals to our DEP
Strategies
-Prepare reports for physicians/nurse practitioners on patients not in compliance for f/u & DEP referral
-Preparing reports for DEP of patients not in compliance for them to contact to discuss importance of ongoing care

3. Equitable Care: 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 start screening our population for poverty by asking two questions of high-risk groups (new immigrants, women, aboriginals and LGBTQ): Do you ever 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.

Measure: % of patients, >18yrs, screened for poverty
Target: Creating baseline

Challenges
-Patients attending taxation clinics to complete taxes
-Educating clinicians on importance of screening for poverty (their focus has been clinical in nature and this area may be outside of their knowledge base)
Strategies
-Educate team (investigate Ontario College Family Physicians offering 'Treating Poverty Workshop')
-Connect with St. Michael's Family Health Team who has experience in this area
-Utilize our weekly 'Single Session Drop-in' Clinic as a second tier to educate patients
-Establish eMR-tracking process

4. Patient-centred: 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 an adequate sample of our patients, support a patient advisory committee (PAC) and act on what we hear to the best of our ability.

Measures:
% of patients able to see a doctor or nurse practitioner (NP) on the same or next day, when needed
Target: 83%
% 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
Target: 96%

Challenges
-Ensuring adequate supply of appointment to meet demand
-Moving from 'working for pts' to 'working with pts' requires skills & resources, for example training PAC and keeping them focused on organizational improvement
-Introducing new technology (Health Myself Pt portal for secure email & online booking) inherently brings challenges
Strategy
-Continue to monitor/share 3rd Next Available appointment (measure for access)
-Continue to administer Pt Care Survey & share results with team
-Promote Health Myself Pt Portal, especially on-line booking function
-Share experiences from recent 3 MDs/1NP/1RN who adopted e-booking with others

5. Safety: 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. We want to increase medication safety for our patients and have two initiatives we think may help do that. First, we want to continue with our de-prescribing benzodiazepine/z-drugs quality improvement initiative started last year. Studies have shown increased risk of adverse effects (i.e. falls, pneumonia, interference with cognition) when taking these drugs. Our initiative is about informing patients of the risks and offering support if they wish to taper or stop taking these drugs and about informing providers of the risks and how to support patients. Our second initiative is about systematically introducing a team-based approach to medication reconciliation. The Institute for Health Care Improvement defines medication reconciliation as the process of creating the most accurate list possible of all medications a patient is taking and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications. We want to outline an internal process for medication reconciliation that involves the patient and then educate the team on the what, the who, the where and the why.

Measures
% of patients, 65 and over, tapered and/or stopped benzodiazepine or z-drugs
Target: 21%
% patients who received med rec within 30 days, after discharge from hospital, for mental health conditions when discharge summary received within 14 days of discharge
Target: 39%
% of patients with medication reconciliations in the past year
Target: Collecting baseline

Challenges
-Last year 56% of pts received the intervention/17% tapered or stopped, cohort has not changed so achieving 21% may be difficult b/c pts left may be resistant
-Receipt of discharge summary from hospitals within 14 days (for mental health discharges) does not always occur
-Patients, discharged for mental health conditions, may go to for specialized treatment (i.e. mental health hospital or be seen by psychiatrist) making timely med rec difficult
-Multiple sources to perform a comprehensive med rec.

Strategy
-Notify physicians/NPs of patients that have not yet tapered/stopped
-Continue to alert pharmacist of mental health discharges to perform medication reconciliation
-Sub Committee of Quality Improvement Committee to draft team based approach to medication reconciliation identifying sources, how/who to do and how to involve patients
-Educate entire FHT on team-based approach to medication reconciliation

TC FHT's QIP initiatives are ambitious but worthwhile. Our objectives are to ensure effective transitions by providing follow up within 7 days of discharge, to improve population health by providing ongoing diabetes care and by addressing income equity, to improve medication safety by having direct clinical interventions and by introducing team-based medication reconciliation; and finally, to provide accessible care and a positive patient visit experience by listening and hearing the patient voice.

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

Our greatest QI achievement in F17-18 was our de-prescribing of benzodiazepine & z-drug initiative. On Feb 9, 2017 TC FHT's Quality Improvement Committee (QIC) and St. Michael's Hospital's Mental Health & Addiction Service Research Team, discussed the De-prescribing (tapering & stopping) of benzodiazepines & Z-Drugs QI initiative. The purpose of the initiative was, 'to reduce unnecessary use of benzodiazepines or Z-drugs among older adults (age 65 and above).' The QIC created a 10 step Work-plan to be completed in Feb-Mar as follows:

1. QIC Sub Group to develop:
-Criteria for Primary Care Providers (PCPs) to identify pts that should be excluded from the initiative
-Identify PCP & patient de-prescribing/tapering intervention tools
Completed: Feb/Mar 2017

2. Build and run search to create lists by PCP
Completed: Mar 2017

3. Draft communiqué to PCPs that,
-Attach PCP & pt de-prescribing/tapering intervention tools
-Attach list of pts from search
-Provide steps on how to run search, within eMR, so they can quickly go to the chart to review
-Provide pt inclusion/exclusion criteria
-Request list be returned with pts to be excluded by mid-Jun
-Requests PCP provide: Reason for excluding/Reason for prescribing, initial date prescribed, dose and frequency
-Outline interventions
-Advise that prescribed benzodiazepines & Z-drugs by specialists should still be considered
-Outline supports available (x5 CBT-Insomnia courses & weekly Benzo Drop-in Support Group)
Completed: May 2017

4. In-Suite Marketing Material
-Get Pt/PCP Tools & Posters printed
-Get 'Benzo Drop-In Support Group' posters printed in color
Completed: May 2017

5. Organize for PCP Lunch n Learn to launch initiative & provide communiqué (i.e. create PowerPoint, assign parts, prepare packages, etc.)

Completed: Jun 2017

6. Build Custom Form (CF) in eMR
Name: De-prescribing Benzodiazepine & Z-Drugs (F17-18 QI Initiative)

#1 Date PCP identifies Pt for QI initiative: _____
#2 Reason for prescribing: _____
#3 Initial Date prescribed (by anyone): _____
#4 Current Dose/frequency: _____

Q1 (as of Jun 30, 2017)
Pt received intervention Y/N
Tapering and/or tapered off Y/N
Stopped Y/N
Comments: _____
Q2 (as of Sep 30, 2017)
Pt received intervention Y/N
Tapering and/or tapered off Y/N
Stopped Y/N
Comments: _____
Q3 (as of Dec 31, 2017)
Pt received intervention Y/N
Tapering and/or tapered off Y/N
Stopped Y/N
Comments: _____
Q4 (as of Mar 31, 2017)
Pt received intervention Y/N
Tapering and/or tapered off Y/N
Stopped Y/N
Comments: _____
Completed: May 2017

7. For pts identified on returned PCP lists,
-Insert CF, apply reminders and fill-in questions #1-5 on CF
-Note: Patients identified on returned lists created our 'De-prescribing Registry' (the denominator)
Completed: Jun 2017

8. Organize/communicate/facilitate Benzo Drop-In Support Group
Start Jul 1st & 3rd Wed of mth
Ongoing

9. Quarterly Chart Audit Steps
Ongoing

10. Outcome Reporting

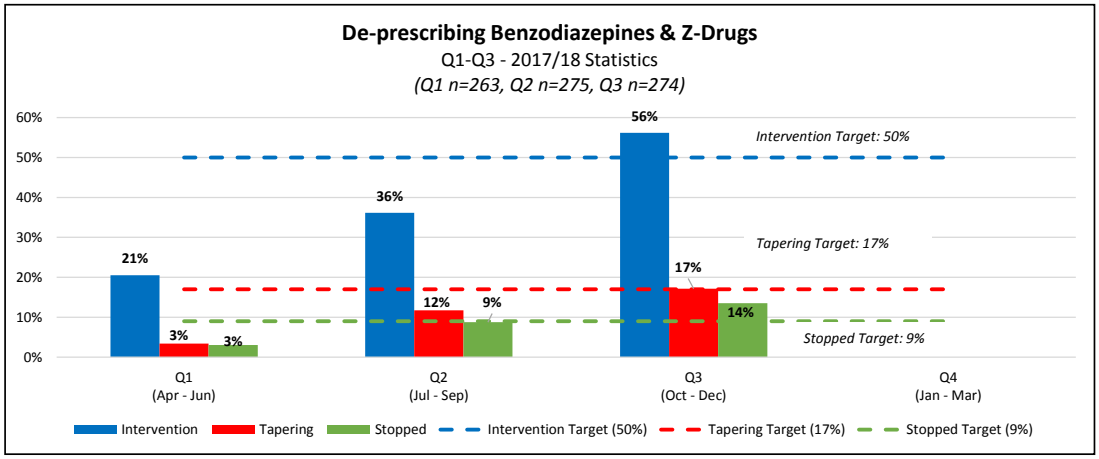
Outcome	Target
% Received intervention at least once during FY	50% (est. 150/300 pts)
% Tapering and/or Stopped as of reporting period	17% (est. 53/300 pts)
% Stopped as of reporting period	9% (est. 27/300 pts)

Targets justified by looking at similar studies of published research.
Ongoing

We now have 3 quarters of data for F17-18 (see below) and we are very proud of our results. We have surpassed our targets for all 3 outcomes. We attribute our success to working with St. Michael's Hospital's Mental Health & Addiction Service Research Team in choosing a safety clinical outcome that spoke to the PCPs. The

PCPs want to prescribe safely and this initiative was something they felt could make a difference in their patients' lives. We also attribute our success to having a good Work Plan, an exceptional QIDSS and 'ready made' marketing material.

Quality Improvement Initative
De-prescribing Benzodiazepines Z-Drugs



	No. of Patients			
	Q1	Q2	Q3	Q4
Intervention	54	99	154	
Tapering	9	32	47	
Stopped	8	24	37	

	% of Pts				
	Q1 *(Apr - Jun)*	Q2 *(Jul - Sep)*	Q3 *(Oct - Dec)*	Q4 *(Jan - Mar)*	Target
Intervention	21%	36%	56%		50%
Tapering	3%	12%	17%		17%
Stopped	3%	9%	14%		9%

Prepared by: R. Shardha
Date created: Feb 19-18

Resident, Patient, Client Engagement

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, group/clinic evaluations and via our website feedback mechanism; all are used for FHT planning and priority setting.

SAVI is a patient engagement committee (10-12 seniors) that meet quarterly with the Executive Director, a physician and an interdisciplinary health provider. 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. For example, a SAVI member advised an internal TC FHT Strategic Planning Co. tasked with looking at developing an 'Enhanced Senior Appointment.' We also now have SAVI members on staff recruitment panels; this has proven to be very effective. SAVI also plans to write an article for our Spring Taddler (newsletter). Also on SAVI's F17-18 Work Plan is to organize and facilitate a Seniors Seminar on a topic of interest to seniors (either osteoporosis

or legal issues of interest to seniors). SAVI will review our F17-18 Patient Care Survey results and provide improvement ideas.

In Sep 2017 we held a focus group to receive patient feedback on a new DEP group; Let's Get Moving. The purpose was to learn more about their experience in the group and how it can be improved. We carefully crafted questions, recorded responses and then did a thematic analysis. We then summarized our learning for participants and made program revisions (i.e. to length and content).

Our F17-18 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, 83% of our patients told us that the last time they were sick or concerned about a health problem, they were able to see their doctor/NP on the same or next day. This is 1% above our F16-17 result and well above the TC LHIN average of 57%.

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 IHP performance.

We welcome patient comments via our website feedback mechanism. All comments and complaints are treated as a learning opportunity for improved patient care/service. Patients are also encouraged to contribute to our Newsletter and this year one patient wrote an article on their experience with diabetes.

TC FHT's Board has been a physician led Board since 2007 but recently voted to become a 'skills based Board.' With this decision, and careful attention to the patient/community voice, we anticipate someday having patients on our board contributing key skills (i.e. financial mgt, legal, business, etc.).

Collaboration and Integration

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. Lead Physician is an active member of the Primary and Community Care Committee (PCCC)
2. Executive Director (ED) is an active member of the Models, Approaches & Organization of Care Task Group (Task Group under the Care Coordination Working Group)
3. Both Lead Physician and ED are active members of Mid-West FHT Collaborative
4. Regular attendance at Mid-West Local Collaboratives hosted by TC LHIN
5. Lead Physician/ED present at TC-LHIN Attachment, Access and Continuity Working Group Meeting
6. Participate in MWTHL Referral from ED (RED) meetings

Here are some examples of how we integrate within our sub-region and with our sub-region partners:
1. Mid-West Local Collaborative identified (based on population health outcomes) a large number of young women in Kensington-Chinatown with low primary care attachment using emergency departments for issues that could be dealt with by primary care resulting in more expensive care, and longer waiting times.

- TC FHT responds by agreeing to accept 27 patients for calendar 2018
2. Mid-West Toronto Health Link (MWTHL) 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 37 RED patients for calendar 2018
3. MWTHL identifies benefit of Telemedicine Impact Plus (TIP) clinics for community physician's complex patients (inter-professional clinics using telemedicine)
- TC FHT responds by hosting 5 TIPs by the 3rd Q in F17-18
4. MWTHL identifies the benefits of coordinated care plans (CCPs) for patients with complex health needs
- TC FHT responds by completing 21 CCPs and 11 in progress by the 3rd Q in F17-18
5. 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.
6. Leadership Sinai Centre for Diabetes and TC FHT's Diabetes Education Program (DEP) form partnership to provide diabetes education/services for women with gestational diabetes.

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.

Engagement of Clinicians, Leadership & Staff

TC FHT has a Quality Improvement Committee (QIC) that meets quarterly and has physician, interdisciplinary health providers and administration representation from both sites. Our QIDSS (Quality Improvement Decision Support Specialist), in conjunction with the Executive Director, leads the QIC. The QIC develops the QIP, implements change ideas and monitors progress at each QIC meeting.

The Executive Director discusses the QIP with the Board in March seeking approval and then reports progress quarterly. Once approved, the QIP is then presented at a spring Clinical Meeting where most staff are present. On-going progress is then reported at Team Meetings.

Population Health and Equity Considerations

Population Health

The majority of our patients (99.3%) live in urban areas and are female (64%). The mean age is 41 and age groups in descending order are as follows: 50-64 (26%), 35-49 (24%), 19-34 (22%), 1-18 (15%) and ≥65 (13%). The majority (50%) of our patients are in the highest two income quintiles while 33% in the lowest two income quintiles (17% in middle quintile). TC FHT is above the provincial average for all 3 cancer screening rates (pap, mammogram and colorectal) but below in 4/5 diabetes management measures (HbA1C, LDL & retinal testing, ACE inhibitors/ARB, statin). TC FHT's emergency department visits per 1,000, readmissions within 30 days and ambulatory care sensitive conditions admissions are all lower than the provincial average. The percentage of patients with hypertension, congestive heart failure, acute myocardial infarction, diabetes are lower than the provincial average with the exception of mental health (TC FHT 25%/Ontario 19%). This year's QIP works to address these two highlighted populations. For patients living with diabetes, if they have not received two HbA1C tests within the past 12 months, we will be preparing reports for the PCPs and our Diabetes Education Program. For patients living with mental health conditions, we will continue to alert our pharmacist of the mental health discharges in order to perform medication reconciliation. We will also be continuing with our benzodiazepine/z-drug de-prescribing quality initiative.

Note: Statistics in this section are from the F16/17 HQO Practice Profile Group Report.

Equity Considerations

At our Sep 26, 2017 FHT Clinical Meeting, Dr. Gary Bloch, from St. Michael's FHT, came to TC FHT to talk to us about clinical tools for Primary Care to treat poverty. This was a powerful presentation and spurred the QIC (and the team) to want to make a difference. This year's QIP will have a major QI initiative in the equity domain. We plan to introduce the Centre for Effective Practices Poverty Tool for Primary Care (see Overview section, #3). In addition to this QI initiative, here is a list of some of the ways TC FHT works to incorporate an equity lens in the care/services we provide:

-Keeps a current eMR list of OHIP/and non OHIP covered CBT & Mindfulness Groups
-Keeps a current eMR list of OHIP/and non OHIP covered Children/Youth, Couples, Family & Individual Adult psychotherapy agencies
-Ensure referral forms prompt referrer to ask 'means' questions to decide if referral should be made to TC FHT's limited program resources
-Offer paid, limited, external psychological counselling to patients with limited funds
-Case Management Service help patients navigate for financial aid (i.e. ODSP, OW, Trillium applications)
-Offer interpretation service (Language Line)
-Provide clinical information in other languages (i.e. in our DEP)
-Provide in-house clinician education on servicing vulnerable populations

Access to the Right Level of Care - Addressing ALC

Alternative Level of Care (ALC) is a cross-sector challenge. Many patients continue to be in the wrong level of care (in an acute hospital bed) waiting to be transferred to another care environment. TC FHT works closely with one TC LHIN Care Coordinator (previously CCAC Care Coordinator) to ensure patients receive adequate homecare to stay as long as possible in their homes and when they can no longer stay in their home TC FHT care providers (PCPs and social workers) work collaboratively with our Care Coordinator to find alternative care. TC FHT also has a Primary Care @ Home Program that supports up to 70 community based homebound patients. Again this work is done in conjunction with our assigned Care Coordinator.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

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 in 2016 reported 717 ED visits, 186 deaths and 223 hospitalizations. Canada is facing a national opioid crisis (Health Canada).

TC FHT is working to understand what part we can play in this complex health and social issue and how this is impacting our patient population. Since 2010 we have had a policy/procedure for prescribing opioids (posted on our website) that is based on CPSO's 2000 Evidence-based Recommendations for Medical Management of Chronic Non-Malignant Pain. The policy states TC FHT prescribers will prescribe opioids in a rational and accountable manner. Here are some highlights of the procedure,

-Prior to prescribing any opioid medication, the prescriber must make a diagnosis and provide treatment for the underlying cause(s) of pain, where possible
-Non-opioid analgesics should be used as first-line therapy, where appropriate
-If chronic opioid analgesia is required, prescribers should assess patient's risk for addictive behaviour, using the "Opioid Risk Tool – Clinician Form" (an eMR custom form)
-For patients at medium-high risk of addictive behaviours, it is recommended that the prescriber prescribe opioids in consultation with a specialist in addiction medicine
-Prescribers are to perform a baseline pain assessment using the "Opioid Brief Pain Inventory" (an eMR custom form)
-When appropriate, screen for depression, anxiety and other conditions that may contribute to pain
-Review and sign "Opioid Treatment Agreement" with patient (an eMR handouts)
-Obtain contact information for patient's community pharmacist and fax "Opioid Letter to Pharmacist" along with the written prescription for the opioid (eMR custom form)
-Provide patient with lab requisition to obtain baseline blood work (ie., LFTs, renal function [sCr, BUN], CBC etc.)
-Book appointment for patient to be followed-up within a month
-Pursuant to a request by a patient or his/her pharmacy for a refill, the prescriber should conduct an assessment prior to approving renewal
-Duration to next assessment/renewal should not exceed 100 days

TC FHT understands the important of continual team education and partnering when it comes to this crisis. In October 2017, we had a specialist in addiction medicine from Women's College Hospital's Substance Use Service come to speak to us about their Rapid Access Addiction Medicine Clinic (RAAM) and about anti-craving medications. RAAM is a walk-in service for patients needing urgent assessment of substance use. More specifically, treatment of patients going through active withdrawal, have had a recent overdose, have had a recent admission to ED/hospital/detox, at risk of withdrawal/overdose or ready to discuss a change/plan. In Mar 2018, the same speaker came to talk to us about Opioid Use Disorder. In the fall of 2017, we ensured all 7 Suites had naloxone kits and in-service education on how to administer.

Moving forward in 2018, TC FHT's strategy to address the opioid crisis is as follows:
1. Get an understanding if this is a problem within our patient population. We recently determined about 2.5% of our active population have a prescription for opioids in the last year and had an action on that prescription (i.e. started, renewed and/or dosage adjusted). We plan to have our pharmacist do an in-depth audit of patients identified to determine if our policy/procedure is being followed and whether more education is required.
2. Review Health Quality Ontario's FHT Practice Report to see if we are above/below the TC LHIN or provincial average.
3. Engage in the ON MOHLTC funded 'Opioid De-Implementation & Support for Primary Care Initiative' led by CAMH. We have completed/submitted the readiness assessment and look forward to hearing the interventions recommended.

Workplace Violence Prevention

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

1.Implementation of policies and procedures related to workplace violence
-Staff Safety
Ensures availability of personal safety alarms & a procedure to identify potentially violent patients
-Safety Reporting System

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
Commitment to the prevention of workplace violence and harassment by providing an environment of mutual respect and free from threats of violence

2.Quarterly Joint Health and Safety Committee meetings where any workplace violent incidents will be reviewed with an eye to prevention.

3.Conducting Annual Occupational Health & Safety Day, in 2017 we had,
-Two 1/2 day Defusing Anger, Resistance & Hostility Training sessions by The Canadian Training Institute (87% staff attend)
-Mandatory completion of on-line training module on Workplace Violence & Harassment (87% staff complete)

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

Contact Information

Sherry Kennedy, Executive Director
Taddle Creek Family Health Team (TC FHT)
790 Bay Street, Suite 306, Box 57
Toronto, Ontario
M5G 1N8
416-260-1315 ext.307
Cell 416-570-0560

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