Let's Make Healthy Change Happen.

2013/14 Quality Improvement Plan

PRINCE EDWARD
FAMILY HEALTH TEAM
A team approach to your good health

Prince Edward Family Health Team
March 31, 2013

Overview of Our Organization's Quality Improvement Plan

- **Overview:**

The Prince Edward Family Health Team is a multi-professional primary health care organization located in Prince Edward County in southeast Ontario. PEFHT aims to be a leader in the provision of quality rural health care, with the following goals:

- to provide access to primary care providers (physicians and nurse practitioners) to the residents of Prince Edward County and neighbouring areas
- to provide education and support to enable our patients to live well with their chronic health conditions
- to provide preventive health care services
- to promote the overall health of the community through health promotion and collaboration with community partners
- to be respectful of and responsive to the needs of our patients and our community, providing quality care as, when and where it is needed.

The PEFHT's Quality Improvement Committee's mission is to foster a culture with the PEFHT that encourages and enables individuals, programs and the organization as a whole to engage in continuous quality improvement with priorities of: safety, timeliness (access), and seamlessness (integration) of care. Our mandate includes: developing and implementing the annual PEFHT QI plan; assisting in the development and supporting the implementation of QI projects within particular practices or programs; spreading QI tools and methodology throughout the PEFHT using team updates (in person, via e-mail), small group learning sessions, tools embedded in the EMR, resources (templates, articles, etc.) posted to our web site, and expanding participation in QI and the range of projects under the QI umbrella.

PEFHT's QI history: In the spring of 2008, an invitation from Ontario's Quality Improvement and Innovation Partnership (QIIP) went out, looking for Family Health Teams willing to participate in an inaugural learning collaborative. PEFHT responded. Our team included two Family Doctors, one Nurse Practitioner, one Medical Secretary, four Registered Nurses, one EMR Specialist, a Pharmacist and a Registered Dietitian. The team learned the concepts and terminology of "QI" and applied them in areas of office access and efficiency, diabetes care and colorectal cancer screening. The team came to appreciate the function of our EMR and the importance of "clean" data to QI endeavours. In the final phase of QIIP, the team began to disseminate some of the QI methods and tools for practice reflection learned through QIIP (e.g., "Open Access", running reports, "PDSA" (rapid cycle tests of change), etc.). By the end of the QIIP initiative in fall 2009, there was a core group with established QI skills ready to tackle new areas. Our most wide-spread project to date was the documentation of smoking status which went from less than 40% to over 80% within 18 months. This effort generated enthusiasm for a smoking cessation QI endeavour which has enhanced our participation in the Ottawa Model for Smoking Cessation. A chronic pain QI project involved 2 physician offices (2 MDs, 3 NPs, 1 family practice RN) and allied health professionals in pharmacy, palliative care and mental health. Other projects have focused on access, medication list accuracy (patient safety), improved chronic disease management, improved utilization of Ministry guidelines (e.g., the 18 month enhanced well baby visit), colorectal cancer screening, and community engagement. In the more focused projects, we have involved 10 primary care offices and 7 of the PEFHT programs in QI projects involving a total of 34 people including a wide range of allied health professionals, physicians, and administrative support personnel.

The PEFHT is well-resourced for quality improvement. We have a talented EMR specialist who is also our privacy officer. This position was created in collaboration with the Prince Edward FHO which jointly funds the position; the nurse practitioners of the PEFHT have also independently supported this position through purchasing needed equipment. One of our nurse practitioner members was sponsored by the MOHLTC to attend a QI program with Intermountain Healthcare in Utah, and 2 of our physician members were sponsored by the local MRP Collaborative to attend the PMI course "Prescribing Quality Improvement." Our lead QI physician is also the physician lead for QI efforts at our local hospital.

- **Focus:**

This year's QIP will focus on the following:

1. aspects of access to include:
   a) third next available: ascertaining TNA for individual providers and group practices as well as developing an aggregate measure of TNA for the entire FHT
   b) cross-coverage: simplifying access to cross-covering primary care providers, reducing use of the Emergency Department for non-urgent health issues
   c) enhanced coverage: instituting centralized clinics for primary care access during holidays and peak periods (e.g., influenza outbreaks)
2. integration of health care, to include:
   a) ensuring follow-up appointments within 7 days of hospital discharge for patients in the specified CMGs (e.g., CHF, COPD, pneumonia, etc.)
   b) centralized booking for the follow-up appointments, allowing the hospital ward clerks to call one number to book follow-up appointments with any of the PEFHT's primary care providers
   c) working with the local hospital to develop clinical pathways involving the following components: standardizing care consistent with current guidelines for CHF, COPD, pneumonia, etc.; patient education about their condition(s) and about their medications; care planning rounds to ensure all needed services are in place at the time of discharge; arranging appropriate follow-up
3. patient-centered care, through a questionnaire looking at:
   a) patients' perception of primary care access and cross-coverage
   b) patients' perception of certain aspects of care such as level of engagement, opportunity to ask questions, and satisfaction with time spent

PEFHT is a leader in the new Healthlinks initiative, and the PEFHT's QI committee will work with the Healthlinks team to assist in developing and tracking outcomes measures for these programs.

The PEFHT QI committee will continue to support projects in the following areas:

Patient safety: medication list accuracy
Appropriately resourced: ensuring multiple providers are trained in smoking cessation and self-management
Access: supporting primary care providers in patient-centered access or advanced access
Effective and efficient: ongoing evaluation of the efficacy and efficiency of PEFHT programs
Equitable: minimizing barriers to care (literacy, mobility, distance, cost)
Population health: awareness of smoking cessation & cancer screening; consistent 18 month enhanced well baby visits

- **Use of the Electronic Medical Record (EMR):**

We adopted Bell EMR (X-wave) in 2006 and it is in use in all PCP offices and PEFHT programs; 25 of 27 PCPs are using the EMR to its full extent. One physician and our collaboratively-funded EMR specialist provide regular education sessions to PCPs, allied health professionals and support staff to encourage enhanced utilization of the EMR. Consistency of documentation (med lists, problem lists, vital signs, etc.) is an on-going endeavour. We work with our EMR provider to add tools, new data fields and new templates to the software. We use EMR reports and inquiries extensively for QI projects. We are developing guidelines for use of the data obtained from the EMR for QI purposes.

- **Integration and continuity of care:**

In addition to the projects outlined above, PEFHT continues to work in a pro-active way with the region's hospital corporation (Quinte Health Care) and with the regional CCAC providers to integrate and enhance the continuity of care. IT changes support this: CCAC case managers have access to our EMR files; reports from the hospital flow directly into our EMR. As mentioned above, one physician on our QI committee is also working on the physicians' QI committee at the local hospital. Many of the PEFHT physicians work in the ER and/or have admitting privileges to the hospital.

- **Community profile:**

Prince Edward County is a large rural area of 800 sq km in southeastern Ontario with a population of ~ 25,000 people. The principal drivers of the economy are agriculture and tourism. "The County" is also a popular retirement area, with increasing portions of its economy related to winemaking and the arts. The influx of retirees combined with an emigration of the County's young people to urban areas means that our population is significantly above the provincial average. In addition to higher-than-average rates per capita of heart disease, stroke, type 2 diabetes, we also have higher than average rates of asthma and rheumatoid arthritis. There are also high rates of disability and marginal literacy.

- **Practice/FHT profile:**

The Prince Edward Family Health Team has 23 family physicians and 4 primary care nurse practitioners looking after 19906 rostered and 3415 non-rostered patients through 15 separate offices, 13 located in Picton, 1 in Wellington and 1 in Rossmore. The PEFHT also has dedicated programs to assist our patients in areas of: mental health, palliative care, diabetes, asthma, COPD, CHF, cardiac rehabilitation, family health, smoking cessation, Stanford self management (Chronic Disease and Chronic Pain) and nutrition. Specialist consultations are available through PEFHT in: Psychiatry, Cardiology (CHF, cardiac rehab), Pediatrics, Respirology, and Orthopedics. Telehealth consultations are available in Dermatology, Endocrinology and Psychiatry.

- **Chronic disease management and prevention:**

Projects include: smoking cessation (now as part of the Ottawa Model for Smoking Cessation), diabetes flowsheet, diabetes self-management; Chronic Disease and Chronic Pain Self Management programs; COPD self management; participation in the Canadian Primary Care Sentinel Surveillance Network (with practice-specific feedback); participation in PC-DATA project on dementia

- **Accountability management:**

The PEFHT QI committee is a standing committee reporting to the Board of Directors of the PEFHT. Members of the QI committee are available on an ongoing basis for consultation or support of QI endeavours throughout the PEFHT. The Committee meets quarterly to review the status of the various QI projects underway; work continues on the projects by subcommittees between meetings. The Committee is responsible for developing the annual QI Plan which is approved by the PEFHT Board. The Committee reports quarterly to the PEFHT Board and to the PEFHT monthly Members' meetings.

- **Challenges and risks:**

1. Lack of time and resources to dedicate to QI;
2. Relationship between the PEFHT and the primary care practices has been one of voluntary co-operation and not all primary care providers are equally keen on QI processes so adoption has been uneven;
3. Difficulty getting information from the local hospital – e.g., re: Emergency Department visits, admissions, etc.

Our Improvement Targets and Initiatives

See attached Excel template

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan

Elizabeth Christie, MD	Sally Cowan, RN	Mary Camp
Board President	*Clinical Services Co-ordinator*	*Business Manager acting Executive Director*