Let's Make Healthy Change Happen.

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

PRINCE EDWARD FAMILY HEALTH TEAM

Your partner for best health

03/05/2019

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

The Prince Edward Family Health Team (PEFHT), a not for profit corporation formed in 2006, was established to provide and expand primary healthcare services in Prince Edward County (PEC). Located in south-eastern Ontario, the PEFHT consists of 23 affiliated Family Physicians, over 35 Inter-professional Healthcare Providers including Nurse Practitioners, Nurses, Registered Dietitians, Mental Health Counsellors, administrators and finally a number of Visiting Specialists bringing their expertise to residents.

According to the 2016 census, there are 24,735 people in PEC. Many of those residents are elderly with multiple, complex chronic health conditions. PEC is a common tourist destination resulting in seasonal in-migration with cottagers and tourists (visitors 550,000 per year), which puts pressure on the local, 12-bed hospital's Emergency Department that is staffed by PEFHT family physicians. PEFHT services are offered in four different locations, three within the town of Picton and one in Wellington. The PEFHT is governed by a Board of Directors. Current Board composition is five physicians and two community directors.

The PEFHT provides care that is patient-centred and data-informed. Its Vision of: "*Prince Edward County residents have the best possible health throughout life*" is accomplished through its Mission of: "*Partners in providing high quality person-centred integrated primary care*". PEFHT adopted these statements to recognize the patients as true partners and also that appreciating local and regional disease prevalence and health care utilization statistics must be used to inform its programming decisions. Programming is further informed by clinical guidelines and research reviews through the revised program review process. PEFHT, in striving to meet the health care needs of the population it serves in PEC, invests in its EMR and data entry, data cleaning and data analysis protocols to ensure the most accurate information is used in meeting the needs of the population.

PEFHT's dedication to Quality Improvement began at its inception with formative members supporting QI training as early adopters of the methodology in the province. In 2012, the Board institutionalized this commitment by creating a QI Committee as a subcommittee of the Board. The QI Committee membership consists of a physician, office practice staff and PEFHT staff members including a QI & Program Performance Lead as chair, a Clinical Services Coordinator, the PEFHT Engagement Lead, and the Executive Director. The QI Committee supports program reviews with quarterly monitoring of quality indicators/trends, allowing all 17 clinical programs and services to make adjustments or pilot new ideas to determine if there are better outcomes for patients. The Committee provides support, oversight and direction for QI initiatives across the organization. Its mission is to foster a culture of continuous quality improvement across both the PEFHT and the affiliated Family Physicians' practices. Finally, the QI Committee has the accountability over producing the PEFHT's Quality Improvement Plan (QIP).

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

The PEFHT's Collaborative Care Program (CCP) seeks to offer care in the home to the most fragile of its residents. The CCP is Nurse Practitioner (NP) led and offers wrap-around care to ensure patients are connected to the appropriate community supports they require as often there are social determinants of health needs required in this population. The CCP is PEFHT's program that most closely resembles Health Link with the exception that the eligibility criteria is at the discretion of the primary care provider to determine if the individual is at risk for transitions in care and is fragile.

At the start of the 2018/2019 fiscal year, the NPs began using the Health Link intake form in earnest as a starting point to define the therapeutic relationship with the patient and caregiver. This was actively decided upon recognizing the importance of patient centred care and while care will be tailored to the individual, there was a recognition that the variability in basic information about the patient shouldn't be variable.

Importantly the categories of information collected relate to medical history, medication lists, advance care planning preferences and patient goals. The health professionals identified that patient goals represented a way of respecting the patient voice and it has been the goal of all NPs that this part of the intake form must be completed as soon as reasonably possible should the initial visit be dealing with highly acute scenarios. The efforts around this are evidenced in the chart below:

Measure/Indicator	2017/2018	2018/2019 to date Q3
% active CCP patients with documented patients goals in the EMR	11.85%	89.62%

What can be seen is that there is over a 77% gain in completed care plans with patient goals set out. The PEFHT believes this is a significant accomplishment when it reviewed this number at the end of the previous fiscal year and made an active decision in investing in this part of the patient-provider relationship. Intake sessions, assuming there is not an acute or urgent issue to address, do take longer to ensure a respectful and time-appropriate conversation takes place with the patient. Booking those appointments has been supported by administrative leadership to ensure there is scheduling support to achieve this important quality improvement effort.

Patient/client/resident partnering and relations

The PEFHT adopted its current strategic plan in 2017/18. In that plan was a deliberate commitment to survey a number of stakeholder groups' satisfaction, year upon year, to determine if PEFHT was meeting or exceeding the expectations of its stakeholder groups. Patients was one such stakeholder group.

The first year of surveying patients revealed a small variance in the answers from the chronic disease-based patient groups in their understanding of how to best manage their chronic condition. Focus groups were conducted in 2018/2019 with three different chronic disease-based program patients to understand that variability in a deeper way: Diabetes Management patients, Heart Failure patients and Coordinated Care Program Patients (fragile patients seen at home and a description is provided above).

Each patient group revealed different nuances that drove the variability from the surveys. As a result of the gathered information, there were changes incorporated in the program delivery. A summary of this is as follows:

PEFHT Program involving Patient Focus Groups	**Information Gathered from Patient Focus Groups in 2018/19**	**Changes in Program Delivery**
Diabetes Education	Variability in the profile of each patient's health status suggests that individual coaching in disease management is needed.	Program delivery continues at a 1:1, patient: provider approach. Investigation into group education for broader education sessions put on hold to respect the idiosyncratic drivers of health needs.
Heart Function	Recognition that the caregiver is a significant support to those formally enrolled into the program. Their request, along with the patients' was for more low salt refresher sessions.	More education sessions specifically for low salt cooking were added to this year's programming. Caregivers are encouraged to attend these sessions.
Coordinated Care Program	The recognition that often this patient population can be too fragile or be in states that are not optimal for health teaching; the caregiver involvement is critical to successful at-home condition management.	This program already involves both patients and caregivers in home visits and health teaching. The results served to underscore the awareness of the role of the caregiver and take additional time if needed to ensure clarity with caregivers should there be any care management needed and where the patient may have challenges in implementing same.

Workplace violence prevention

In 2018/19, the PEFHT Board adopted a refreshed Risk Management Framework. This comprehensive document aligns to the third pillar in its 2017/2018 – 2020/2021 Strategic Plan, "Responsible Stewardship." The Framework is comprehensive with seven categories of risk, a description of each risk and the mitigating action taken to diminish the risk. "Our People/Human Resources" is the category where Workplace Violence prevention is nested.

The PEFHT undertook a refresh of all its employee policies in the 2018/19 fiscal year and did so with the help of an outside consulting firm to strengthen the compliance with the most current best practice and legislation.

Workplace Violence (Policy 2.4) is part of PEFHT's, "Standards of Conduct Policies" and has been refreshed in this 2018/2019 fiscal year to describe what will not be tolerated in our workplace. The policy is explicit and offers examples of conduct that may be considered as threats or acts of violence. There is also a direct escalation path for employees to follow regarding reporting of known incidents of threats or acts of violence employees may experience directly or may be aware of. Each employee is given a copy of this employee policy as well as all policies at the time of onboarding and electronic copies are available on PEFHT's intranet.

Health & Safety is taken very seriously at the PEFHT. There is a Health & Safety subcommittee to ensure reporting aligns to the highest level of organizational governance. Workplace Violence is a frequent topic at our Health & Safety Committee meetings, held every 6 weeks.

Finally, the PEFHT also hosts monthly staff meetings. Workplace Violence was covered as our standing Health & Safety topic in the 2018/19 year, providing education on de-escalation strategies for PEFHT team members.

Contact Information

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Other

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)