Let's Make Healthy Change Happen.

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

Couchiching Family Health Team
Working together. Enhancing care.

3/24/2017

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 goals and objectives of Couchiching Family Health Team's (CFHT's) 2017/18 Quality Improvement Plan (QIP) are guided by provincial priorities on quality issues, current and past performance on our annual QIPs, our CFHT Strategic Plan, as well as, the North Simcoe Muskoka Local Health Integration Network (NSM LHIN) Quality Improvement (QI) Network meetings that members of the CFHT QI Team attend regularly. Our organization's theme this coming year is improved communication and collaboration within our organization and with our community partners. For the 2017/18 fiscal year, CFHT will focus on the aim of effective care through quality issues such as effective transitions, coordinating care and population health by addressing the following indicators:

- Decreasing 30 day readmission rates for patients with COPD
- 7 day follow-up post-hospital discharge for patients with COPD
- Improve stroke prevention in patients with atrial fibrillation
- Decrease rate of fragility fractures in patients with osteoporosis

We are continuing our focus on COPD, as this population has been identified as one of the high users of our local hospital, Orillia Soldiers Memorial Hospital (OSMH), with 263 COPD discharges in fiscal year (FY) 15/16 and readmission rates approximately 1% lower for COPD than total readmission rates.

Our organization has made great strides in identifying patients with COPD earlier and increasing smoking cessation rates by implementing the Canadian Lung Health Test (CLHT) and Ocean Tablets as evidenced in our progress report and last year's narrative. We will continue to spread and monitor this work throughout our organization. Some of our challenges in spreading this work FHT wide continue to be the lack of dedicated quality improvement and information technology (IT) resources to support communication and collection and analysis of organization-wide data.

We are expanding our work this year through a collaborative indicator with OSMH, Community Care Access Centre (CCAC) and Health Link to work together to decrease readmission rates to hospital for those patients with COPD and increase follow-up with primary care providers within 7 days post-hospital discharge. This collaborative effort has involved multiple meetings over this past year in preparation for implementing the workplan and measuring and sharing the results with our partners. We are very proud of our commitment to work together as a community to work towards this shared initiative.

QI Achievements From the Past Year

Community partnerships in Orillia are strong and over the last three years silos have broken down, and many organizations work very well together to ensure the highest quality of care for our patients. An extraordinary example of this comes from the Health Link patient named Dan. Dan was homeless living in Orillia in the middle of winter dealing with extreme cold weather. Many partners in Orillia, worked together to create an action plan to provide safe and secure housing for Dan.

Following a visit to the emergency department, care providers realized Dan did not have a home to return to. They were determined to help Dan find a place to stay rather than sending him back to the streets. They made a plan that day to offer him a bed at Clint House, a transitional bed program managed by Helping Hands. From

there, the team listened to Dan's personal goals including weight loss and smoking cessation and offered services to help him meet these goals.

Dan now resides at Georgian Manor in Penetanguishene where he continues to work on weight loss with the support of the in-home dietitian. He has remained smoke free since October 2016.

To watch 'Dan's Story' visit http://www.nsmlhin.on.ca/goalsandachievements/careconnections/Care%20Connections%20Forum.aspx.

Population Health

CFHT strives to deliver programs and services designed to address specific needs of our patients and the community.
Based on in-house and acute care data, we know prevalent conditions include:

1) COPD- addressed through the Oceans program initiative, collaborative QIPs, and Health Link
2) Diabetes – addressed through diabetes clinics
3) Osteoporosis – Osteoporosis Education Class quarterly (open to all) and addressing osteoporotic fractures in this year's QIP
4) Multiple chronic conditions combined with social determinants of health issues- addressed through Health Link, Self-Management classes (open to all)
5) Geriatric Population – Geriatric Outreach Team, HFP (regional)- Sr. Care Centre
6) MUS (Medically unexplained symptoms)- addressed through a pilot program for children, Psychiatric consultations occur through the Ontario Telehealth Network and involve the child, family, a CFHT Social Worker, as well as the child's medical/psychiatric team.

Equity

The CFHT management team (ED, Finance, HR, Clinical Program Manager) is participating in modules through the Ontario ICS (Indigenous Cultural Online Safety) Health Training. The Core ICS Health is specific to those who work in the health care field and the goal is to improve access to health services and health outcomes for Aboriginal people.

This year we are focusing the QIP on improving care for vulnerable populations (COPD – multiple, complex, medical conditions often with social issues, palliative care program, partnering with Community Paramedicine). As demonstrated in our work plan, we have targeted most of our efforts on these areas to help improve access and reduce social-economic barriers to care for patients.

Integration and Continuity of Care

Couchiching Family Health Team (CFHT) will participate in a cross sectoral collaborative indicator on our 2017/18 QIP – to prevent re-hospitalization of patients with Chronic Obstructive Pulmonary Disease. Our organization has been working with a number of major partners in the Orillia community. On a macro level, these organizations have been working together in a collaborative manner since early 2013 with the inception of the Health Link. Health Link was created to support individuals who need the most help from the healthcare system, focusing on members of our community who contend with higher needs and more complex medical conditions. Patients with COPD often fall into this category. OSMH reported 263 COPD discharges in FY 15/16 – which makes COPD a high user. Readmission rates for COPD are currently about 1-1.5% lower than actual readmission rates. All of these facts guided our decision to focus in on this patient cohort.

Our organization recognized this need and began planning for our collaborative indicators over the past year. We have been meeting regularly with the North Simcoe Muskoka Community Care Access Centre (CCAC), our local hospital, Orillia Soldier's Memorial Hospital (OSMH), and the Couchiching Community Health Link. We have also consulted with other community partners such as Helping Hands, VON Home at Last Program, Community Paramedicine, HQO and our LHIN. We wanted to create indicators that built on the strength of each of our organizations and that were easily transferrable over various sectors (primary care, emergency care, complex and chronic health conditions). A major factor contributing to the existing high level of health care quality in the Orillia area is the strong sense of partnership, collaboration, and generative relationships.

In addition to our dedicated Collaborative QI planning committee, our Clinical Program Manager and Executive Director sit on the Couchiching Community Health Link Steering Committee to ensure commitment to quality and ensure that the Health Link aligns with the CFHT Quality Improvement plans. CCAC and OSMH are also key members of this committee. Additionally, on a practical level, CCAC, OSMH, the Health Link, and CFHT have staff who collaborate and consult on shared patients on a regular basis. The healthcare in Orillia has been synergistic for a number of years, and we feel that our collaborative indicator will not only highlight that, but will offer further opportunities to decrease silos and ensure seamless communication and coordination of care for the patients of Orillia.

We have already identified evidence of the value of partnerships in the community. OSMH has reported meeting length of stay (LOS) indicators for COPD , a decrease in mortality rate, and overall visits have decreased. In addition, through partner engagement, there has been an increase in referrals to the Telehomecare program over the previous year. On a qualitative level, patient satisfaction reports, both formally and anecdotally, are strong. The CFHT and our partnerships have been highlighted at the Association of Family Health Teams of Ontario (AFHTO) Conference, The Canada Health Infoway Awards, the North Simcoe Muskoka Care Connections Forum, and in various articles in the Orillia Packet and Times.

Access to the Right Level of Care - Addressing ALC Issues

The ALC rate at OSMH has declined over the last year from 18.9% (2015/16) to 14.6% as of December 2016 and forecasting 16.3% for year end. Part of this decline can be attributed to combined efforts of OSMH working with community partners of which Health Link and CFHT are a major part of.

Members of the CFHT are currently developing a plan to create and build a Hospice Care facility in Orillia to help ensure patients are receiving care in the most appropriate location.

Engagement of Clinicians, Leadership & Staff

Our Quality Improvement Team membership includes physicians from both of our FHOs, as well as our lead physician and chairman of the CFHT Board, our Clinical Program Manager, the administrator for both FHOs, a physician office receptionist, a registered nurse, pharmacist, marketing and communications administrator/IT back-up, and QIDSS (Quality Improvement Decision Support Specialist). The QI Team meets monthly and reports to the CFHT Board quarterly.

Resident, Patient, Client Engagement

CFHT engages patients each year through a patient satisfaction and access survey. We have used the results of those surveys to inform and guide our QIPs. We also

use patient surveys for many of our programs and group education sessions (e.g. Single Session Counselling Clinic and Healthy Living Groups) to help with evaluating and improving our services. The use of the Ocean Tablets promotes patient engagement allowing patients to share updated contact information and consent for email communication. Current re-development of the CFHT website will improve patients access to information through an accessible design, enabling patients to select the most appropriate program and services to meet their needs.

Staff Safety & Workplace Violence

Staff and workplace safety is a priority for the Couchiching Family Health Team. In addition to strict adherence to legislation around Occupational Health and Safety, we have developed policies to maximize the safety of the workplace. The following include both legislated and additional policies:

1) Dealing with Difficult Patients
2) Home Visit Policy
3) Anti-harassment and Discrimination Policy
4) Workplace Violence Prevention Policy
5) Drug and Alcohol Policy
6) Code White Policy (violent patient)

Our policies and procedures provide guidance for the CFHT and allow us to not only track incidents, but also provide training on how to handle and prevent future incidents. As an organization, we require staff to become certified in Non Violent Crisis Intervention Training through CPI, and we offer both Safe Talk and Mental Health First Aid for staff members. During our orientation process, staff are required to complete Health and Safety Awareness training.

As we have moved forward with our attention to workplace safety, we have created a number of tools/procedures to maximize safety of our staff. When faced with a violent individual, staff has an emergency paging system both on their phone and on the Electronic Medical Record. Reception at the front of the building also has access to a 'panic button'. If working outside regular hours, staff are required to work in offices within the After Hours Clinic, or use the group room next to the clinic to ensure other staff members are close by. We conduct yearly Code White (violent patient) drills and have a process for reporting and review of incident reports involving out Health and Safety Committee. In the fall of 2016, we conducted a thorough risk assessment within the CFHT, involving the Health and Safety Committee. The purpose of this assessment was to identify all possibly risks and develop controls in conjunction with the Health and Safety Committee.

Our next task is to draft a Code Silver policy (individual with gun in building) which will involve a lockdown procedure. The team is in the process of developing procedures for front-line staff in reception who are directly dealing with incidents in the lobby. Finally, in an effort to provide further safety to staff and patients, the Board of Directors at the CFHT just approved the idea of a policy requiring new staff to have a Criminal Reference Check and Vulnerability Sector Check completed for all new staff members. This new policy will be drafted and presented to the Board of Directors.

As a FHT, safety is one of our highest priorities, for staff members and patients alike.

Contact Information

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