Let's Make Healthy Change Happen.

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

McMaster University | FAMILY MEDICINE
McMaster Family Health Team

4/4/2018

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.

Overview

This QIP is focused on the McMaster Family Health Team (MFHT), which consists of the Stonechurch Family Health Centre (SFHC), McMaster Family Practice (MFP), and the Maternity Centre of Hamilton (MCH).
As in previous years, we will continue to focus on sustainable models of care and prioritize indicators that provide improvements to patient care, that are meaningful, that involve our multidisciplinary team and that are relevant for our FHT setting and resources in 2018/19. When possible, we will use opportunities to refine our QIP objectives and work with patients and staff to ensure a continued high level of patient care and high-quality working environment.

As data quality plays a key role in the success of our quality improvement (QI) efforts, we continue to place emphasis on ensuring that our electronic environment supports accurate and standardized data entry in OSCAR EMR and includes module improvement where necessary. The MFHT is also the first primary care organization in LHIN 4 to participate in the Primary Care Data Sharing (PCDS) and Integrated Decision Support (IDS) programs and contributing data to better connect health information across the continuum of care.

The annual transition of medical residents provides opportunities for learning and re-vamping of programs, and we continue to prioritize and adapt clinic programs that meet the needs of our constantly increasing enrolled and non-enrolled patient populations. In 2018/19 the MFHT health program priorities will include focusing on Diabetes, Smoking Cessation, Palliative Care, HIV, Mental Health, Activity, Cancer Screening and Seniors Care. Population health and equity considerations will be addressed in specific initiatives including cultural sensitivity training for staff and clinicians regarding our indigenous and LGBTQ communities, Legal Health clinics, and ongoing work and program development with community partners. Furthermore, our continued work with our recently established Patient Advisory Committee will focus on the roles, rights and responsibilities of both the patients and the MFHT in order to create ongoing successful relationships.

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

Patients First: Embedding Care Coordinators in Primary Care – The MFHT has been chosen in our sub region by the LHIN to be one of the initial primary care organizations to assist in the trial of embedding Care Coordinators within our clinics. To date meetings have occurred and input provided in job descriptions, visioning the implementation of the roles and how the roles would connect and communicate as part of the primary care team. Ongoing work for this trial will continue with regular reviews and assessments before rolling the initiative out more broadly in primary care.

Health TAPESTRY – This research project was successful in receiving additional funding to continue as an ongoing program in the MFHT. Health TAPESTRY shifts the focus of care to prevention by identifying people at risk before they need invasive and expensive interventions, like attending Emergency Departments or being admitted to hospital. The original project focused on those older than 55 years, but the program has now expanded to include all those over 18 years. Trained volunteers, through a partnership with the Red Cross, visit a patient in their homes and obtain key information related to their health and overall wellness goals. This includes nutrition, physical activity, social supports, memory and cognition domains. A report is generated and communicated back to the interdisciplinary primary care team, who then can proactively connect the individual to services, or see them in clinic to follow up.

Dialectical Behavior Therapy (DBT) - The expertise in treating issues of emotional regulation and distress tolerance, and the need for developing interpersonal skills have long been recognized in primary care. Dialectical behavior therapy (DBT), one of the treatments of choice for these issues is a highly sought-after service; available services often have long wait lists. The MFHT social workers attended comprehensive DBT training with support from the HNHB LHIN, and used the knowledge gained to develop a program focused on enhancing coping skills in everyday life and emotional regulation, based on the principles of DBT. This program targets people who may not need the comprehensive year-long DBT program and focuses primarily on the skills development aspect of DBT. The SMYLE (Skills for Managing Your Life Everyday) program runs for 14 weeks and is co-facilitated by 2 MFHT social workers. We have piloted the group 5 times in the past year, and we are in the process of determining ways to move forward based on patient and clinician feedback. To date feedback has been overall positive, with some participants noting that the opportunity for intense skills training has been beneficial, and these benefits have been described as 'life-changing' by participants.

Memory Clinic – The Memory Clinic is a multidisciplinary team consisting of family physicians, social workers, nurses, occupational therapists and a representative from the Alzheimer's Society. The team continues to work collaboratively with our family physicians to provide assessments, early diagnosis, treatment and support of daily challenges associated with memory loss, with the goal of reducing crisis visits to the family physician and the hospital and ensuring the appropriate use of specialist referrals and community supports. In this model of care, the patient's own family physician maintains a central role in management. The Memory Clinic Team acts as a resource to the patient's own family doctor providing comprehensive assessments and management plans and guiding the family physician with detailed, understandable clinic notes and intermittent reassessments. Each of our sites at the MFHT has a fully trained Memory Clinic Team and runs 1 clinic/month with approximately 6-8 patients assessed/clinic.
Exercise is Medicine – Acknowledging the benefit of physical activity for those living with chronic illnesses and/or co-morbidities, this program includes change readiness assessments and support, education regarding the importance of physical activity, personalized training options and regular follow-up by phone and in person with the FHT physiotherapists. The first year of the program has involved specific measures of effectiveness, as well as patient satisfaction tools. The initial outcome measures were positive, and the program tools will be validated through a formal research project.

PCDS – this year, the MFHT participated in the Connecting South West Ontario (cSWO) Primary care Data Sharing (PCDS) proof-of-concept project, aimed at identifying the feasibility of broadly sharing primary care data across the continuum of care. We were the first organization in the collaboration to go live, and in addition to OSCAR enhancements that improve data quality, we are building on the philosophy of enhanced patient experience and outcomes. We believe that access to patient information in this data set will enhance clinical decision-making, improve patient management, transitions and safety, and reduce the need to request external information.

Data Discipline - OSCAR EMR is used for clinical documentation at MFHT, and it is important that clinical data are documented in a standardized manner. To encourage a high level of data quality, we have started providing physicians with Data Discipline Scorecards, identifying eight key areas of care that reflect varying levels of data quality, and that provide opportunities for enhancements in patient care and outcomes.

Allergies Documentation – We recognize that an accurate list of allergies is an important component of excellent patient care and necessary to ensure patient safety. Driven by the PCDS project, the OSCAR EMR allergies module was enhanced to ensure accurate data capture. Patient allergies' lists will be updated at each patient visit and maintained collaboratively by the clinical staff of the MFHT with information provided by the patients. All allergies will be recorded in the OSCAR allergy module and documentation will include reaction type and severity. No known drug allergies will be documented as a custom allergy with the letters "NKDA". We have so far seen a 24% increase in allergy documentation in the OSCAR.

Immunizations Documentation - We recognize that an accurate list of immunizations is an important component of excellent patient care and necessary to ensure patient safety. We have developed a set of standard operating procedures that guide the documentation of immunizations in OSCAR, and that are to be followed at every patient visit. The immunizations module has been updated to identify immunizations administered at a facility external to any of the MFHT clinics. Immunizations lists will be maintained collaboratively by the clinical staff of the MFHT with information provided within the clinics as well by the patients.

OSCAR Billing Module – In our continued efforts to ensure a high level of data quality, the OSCAR EMR billing module was enhanced to provide a billing quick-pick list of 45 clinician friendly terms and features a diagnostic code map to help support automatic disease registry coding. The quick-pick list is aimed at aiding clinicians in the selection of chronic disease codes that represent the patient encounter for which they are billing. The user-friendly presentation of specific codes to represent a given condition is meant to standardize billing diagnostic code selection across the MFHT.

OSCAR Disease Registry – The OSCAR EMR disease registry module was enhanced to simplify and stream-line the process by which standardized disease registry terms are added to patient's record. This is intended to support increased, high quality data collection into the disease registry. So far, we have seen significant gains in disease registry coding after the implementation of the new features in OSCAR, and anticipate that initiatives like the Data Discipline project mentioned above, will help provide the impetus for continued data quality in our clinics.

Diabetes - We have a large population with type 2 diabetes. Work has been focused on enhancing the ability to document in a standardized manner. We have already modified the diabetes flow sheet in OSCAR to ensure proper and meaningful documentation and continue to support physicians by providing scorecards that offer individualized feedback about diabetic patients who are less than 65 years old. Our initial focus with the scorecards was to help identify patients who were not well-engaged in their diabetes care and who had not had a HBA1c test in the past year. Our chosen intervention was to contact patients, offering a clinic appointment with preliminary lab work-up. Add what percentage have received intervention.

Patient Advisory Committee (PAC) – In 2017, the MFHT Patient Advisory Committee was launched. This QI initiative's purpose was to provide a forum for patient feedback and involvement in operational decision-making. The PAC was comprised of four patients, a Resident, two family physicians, a facilitator and a Clinic Director. The group met quarterly and focused on the care Residents provide within the MFHT learning environment. The committee was co-led by a project manager and a patient, and recommendations were provided to the leaders of the MFHT for consideration in future resident training and patient education.

Legal Clinic - The MFP Legal Clinic is a partnership developed with Legal Aid Ontario (LAO), Hamilton Community Legal Clinic (HCLC) and MFHT. Lawyers provide free legal consultation on a range of legal issues to our patients in the clinic setting. Through a screening tool provided by HCLC, The Legal Health Check Up, patients are able to identify issues in their everyday life that could become legal issues. Some of these could include family concerns, problems with employers, housing or landlord concerns, financial issues and education. Once the screening tool identifies the issue, the patient is offered an appointment with a lawyer who has knowledge in the specific area of law. With the patient's consent there is information shared between the patient, lawyer and clinic as part of the patients circle of care. As a result, the patient may receive information on their rights, receive resources where they can access information or further services, be referred to a lawyer for representation or even be represented by the lawyer that they see that day. This formal partnership was part of a formal research project from which has provided objective positive outcomes regarding the improvement of the social determinants of health for participants, which ultimately has led to better overall health status.

Resident, Patient, Client Engagement

The MFHT implementation of a Patient Advisory Committee (PAC) was a successful first step in bringing patient's voice to a more targeted area focus for our clinics. In 2017 the group focused on Resident care and the patient perspective. This year the PAC priorities are focused on patients assisting in the development of a Code of Conduct (Patient Rights and Responsibilities) for our clinics, and on developing a communication plan that will guide the implementation of the Code of Conduct. The Committee will outline expectations that patients can receive, as well as what we hope patients can bring to the relationship with us.

With consistently high results from patient feedback, the frequency of our patient surveys will be reduced from quarterly to semi-annually. We will continue to alternate surveys focused on appointments with physicians/residents/nurse practitioner, with that of our IHP team. To ensure an adequate sample size for each survey, we will increase the survey duration from one to two weeks.

Finally, we will continue to provide a patient services venue specifically for patients to connect with us on a daily basis regarding questions, concerns and ideas. This service is available via our websites, email connection, in person, and via social media.

Collaboration and Integration

Many of our initiatives that have started this past year are focused around the sharing of data with our partners and improving our own ability to access data about our patients' encounters with the rest of the system in a timely manner. We are currently participating in the Primary Care Data Sharing (PCDS) project which will see Primary Care Data contributed to Clinical Connect, the regional viewer. Furthermore, we aim to also contribute data to our region's Integrated Decision Support (IDS) system and are working with Hamilton Health Sciences to do so. Connecting primary care data, to existing hospital, CCAC, and CHC data at the patient level, will make for an even stronger decision support tool, as a large proportion of a person's clinical journey will be accessible in one place. Functionalities such as geographic and socioeconomic planning tools will improve the ability of the region to conduct population health planning.

Beyond the above-mentioned collaborations and programs, other important collaborations the MFHT is involved in include:

Alzheimer's Society – As a part of our Memory Clinics, an individual from the Alzheimer's society acts as an integral part of the team that reviews cases. Her role is to ensure continuity of care and to provide support in the community. Approximately 50% of patients who are assessed by the Memory Clinics receive services ongoing from the Alzheimer's society.

CCAC – Similarly, a CCAC care coordinator sits at the interprofessional team huddle which meets weekly to review Health Links and other patients with complex health conditions. This results in joint care-planning. This is also an ideal venue for information sharing when a care plan is initiated by the CCAC for a MFHT patient. New collaboration opportunities are also outlined in the QI section of this document.

Hamilton YMCA/Mac2Hope – MFHT Occupational Therapists and Physiotherapists see patients from the community in a YMCA setting in downtown Hamilton ½ a day/week. Services are offered at no cost to participants. This program is a joint venture with McMaster's School of Rehabilitation and involves these staff supervising students in this venue.

Children's Services – collaboration with Contact Hamilton, Child & Youth Services, McMaster Children's Hospital, School Health, Public Health is part of daily work at the MFHT and we also have a partnership with a local group of pediatricians who will see our patients onsite to create joint care plans.

Community Support Services – A Community of Practice exists for the FHT System Navigators who work with city-wide supports regarding community services beyond tertiary and primary services. The System Navigators works with partners such as Wesley Urban Ministries, Good Shepard, Salvation Army, Ontario Works, Ontario Disability Support Program, Catholic Family Health Services, Hamilton Community Legal Aid Clinic and others. This role facilitates income and housing support leadership in tandem with the patient's healthcare.

Other FHTs – We collaborate regularly with the other FHTs in HNHB LHIN through regular meetings related to the Quality Improvement Decision Support Specialist, which is a shared role in our LHIN. Planning is underway to align our reporting whenever possible. Specific program collaboration has taken place with the Hamilton FHT, and cross referrals now occur for Mental Health, Physiotherapy and Lactation programs. Further collaboration is planned for the future.

Hamilton Public Health –Co-location with Hamilton Public Health has enabled our organizations to cross-refer and program plan together (i.e. our patients can be referred to PH programs, and we are able to see patients who lack a primary care provider). Work has also focused on bringing staff and physicians from both organizations together in discussion about opportunities to work together.

Health Leaders in Hamilton – Through the Hamilton Community Care Coalition members of our leadership team regularly meet with leaders of other health sector organizations in our region. This group involves the MFHT, the 2 major Hamilton hospital systems and the Hamilton FHT. This group meets regularly to discuss continuity of care, Emergency Department avoidance and cross-sector program development (e.g. chronic pain). Looking at future alignment with QIPs within and across sector (among other FHTs and hospitals).

Engagement of Clinicians, Leadership & Staff

MFHT physicians and staff have many opportunities to engage with quality improvement initiatives. Physicians and staff are encouraged to work to their full scopes of practice and to experiment with PDSA cycles of service improvement to improve access and quality of the patient and clinician experience.

Monthly staff and clinicians meetings are a venue at which QI updates are provided, and all participants have the opportunity to be engaged in planning. Additionally, a quarterly MFHT Summit is held to work on implementing components of QI and measurement work specific to FHT programming. Finally, MFHT Leaders and staff are engaged through two key decision-making committees; the Quality Council and the Health Services Operations Council.

Population Health and Equity Considerations

Our region has unique health needs. The HNHB LHIN, and specifically the Greater Hamilton Region, our has higher rates of smoking, obesity, alcohol abuse and avoidable hospitalizations compared to the Ontario average. Additionally, a larger proportion of Hamilton residents are considered low income (16% versus 13% across HNHB LHIN), and there are vast differences in health-related outcomes within neighbourhoods in the City of Hamilton. For this reason, the MFHT acknowledges social determinants of health in our program development and service delivery. We work in collaboration with the LHIN, local hospitals, CCAC, Public Health, other FHTs and a variety of other community partners to provide programs and services designed to improve the health equity and social determinants of health for all populations.

Examples of inclusive program and service delivery for populations in our FHT and community consist of:

Maternity Centre of Hamilton (MCH) - This program is co-located with our MFP clinic in downtown Hamilton. The MCH cares for approximately 800 patients yearly, and provides maternal and child services to orphaned patients, many of whom are part of high risk and vulnerable populations. Shared MFHT services include mental health, nutrition, lactation and physiotherapy programs targeted to this population. The MCH facilitates ongoing primary healthcare by connecting patients with family physicians, including many who are then rostered to the MFHT.

Smoking Cessation – Smoking Cessation is now available in all three clinics – recruitment and services have been expanded to the MCH patients and their partners. This program is offered in our FHT by professionals trained in smoking cessation. Evidence suggests that smoking cessation attempts can be influenced by a partner's smoking status, and that long-term abstinence from smoking may be encouraged by partner support. This may be especially true for vulnerable groups including pregnant women. Pregnancy can be a powerful impetus for smoking cessation for both mothers and fathers, and it is an especially beneficial timeframe in which to offer smoking cessation services. All MFHT patients and their partners who are current smokers stand to benefit from smoking cessation services.

Mental Health – A variety of programs are provided to populations suffering from depression, anxiety, and chronic pain. Programs are specific to teens and adults. One-to-one counselling is also available for a broad range of needs and for all ages at the MFHT. We have also expanded access to a variety of mental health services through a cross referral system with the Hamilton Family Health Team and North Hamilton Community Health Centre programs.

Orphaned Palliative Care Patients –Working closely with hospitals and CCAC partners, the MFHT ensures that patients with a palliative care designation but who are not rostered to a Family Physician are provided with primary care services in the last weeks or months of life.

Diabetes – We have a large population with type 2 diabetes. Work has been focused on enhancing the ability to document in a standardized manner, by altering the Diabetes flow sheet. We are also starting a trial where clinicians receive individualized feedback about their diabetic patients and are reaching out to individuals who lack an HbA1c in the past year to pick up a lab requisition to do so and schedule a clinic appointment.

HIV - With 2 Family Physicians and 2 RPNs in our FHT specializing in care for this population, we offer the largest primary care program for this diagnosis in the GHA. We currently provide care to over 200 patients.

Legal Clinic - The MFP Legal Clinic is a partnership developed with Legal Aid Ontario (LAO), Hamilton Community Legal Clinic(HCLC) and MFHT. Lawyers provide free legal consultation on a range of legal issues for our patients in the clinic setting. Through a screening tool provided by HCLC, The Legal Health Check Up, patients are able to identify issues in their everyday life that could become legal issues. Some of these could include family concerns, problems with employers, housing or landlord concerns, financial issues and education. Once the screening tool identifies the issue, the patient is offered an appointment with a lawyer who has some specific knowledge in the area of law. With the patient's consent there is information shared between the patient, lawyer and clinic as part of the patients circle of care. As a result, the patient may receive information on their rights, receive resources where they can access information or further services, be referred to a lawyer for representation or even be represented by the lawyer that they see that day. This partnership has led to the improvement of the social determinants of health for participants, which ultimately has led to better overall health status.

Cultural Sensitivity – Staff and physicians in the MFHT are always participating in educational opportunities regarding diversity and cultural sensitivity in an ongoing way. For example, in recent months approximately 50 staff and physicians attended Positive Space training offered through Rainbow Health. This session focused on learning of culturally competent practices, cultural safety and humility, and how to provide good care for LGBTQ individuals. Staff have also participated in Indigenous Cultural Sensitivity online course sponsored by the HNHB LHIN and in 2018 a focus on further indigenous experiences at the Woodman Cultural Centre will take place for all staff. Working to improve our health services for the Indigenous population is a priority.

Primary Care Access - The MFHT seeks to ensure primary care access for all populations within the City of Hamilton. New patients are widely accepted via multiple channels (Health Care Connect, hospital and community partner referrals, patient self-referral and Health Links).
Newcomer Populations - Hamilton has a higher percentage of recent immigrants than any other area in the HNHB LHIN, and the MFHT continues to provide ongoing primary care to newcomers wanting to roster with our services or through Interim Federal Health. To enable these individuals to receive comprehensive primary care we altered our clinic orientation session, translate clinic materials where needed, and have a list of staff members who can speak a variety of languages and can speak to cultural orientation.

Safe Care / Medication Safety - In 2017 our pharmacists engaged in a pilot project aimed at providing medication reconciliation to our patients where necessary. Through the pilot project, we have identified a need for training for all appropriate staff, while targeting patients from three distinct groups (new patients, patients discharged from hospitals and patients for whom medication reviews are available from community pharmacies) for our program activities. We believe that the update of OSCAR EMR will provide enhancements that will enable better data entry, tracking and reporting for medication safety.

Access to the Right Level of Care - Addressing ALC

As a Family Health Team, we see focus on ALC avoidance by working with individuals in streams of prevention, chronic disease management and holistic care in order to avoid hospitalization and ALC.

Key initiatives include:

Memory Clinic – This program aims to support seniors and keep them in the community with their families through a multidisciplinary team review and care plans. Support to both the patient and their families are key. This team also includes a representative from the Alzheimer's Society who is able to extend the support of the team into the home or community.

Health Links/Complex Patient Rounds - An interdisciplinary group (OT, NP, PT, dietitian, physician, SW) meets weekly in order to conduct coordinated care planning and conduct case reviews. This year, there has been CCAC representation at the weekly team huddles, which has enhanced integration between teams and extended the care planning more effectively into the community.

Health TAPESTRY – Trained volunteers visit a patient in their home and obtain key information related to their health and overall wellness goals. Examples of domains captured include nutrition, physical activity, social supports, memory and cognition. A report is generated and communicated back to the interdisciplinary team, who then can proactively connect the individual to services, or see them in clinic as follow up. This project initially focused on those 55+ years old, but has been expanded to be offered this to all patients over the age of 18 years.

Home visits - 100% of physicians and 80% of the MFHT Allied Health professionals and nurses will provide home visits to our patient population.

Healthy Aging Series – Two times per year, a lecture series is provided to the public regarding key health issues in aging. These lectures are very well attended and address the following issues: Fitness & Function, Nutrition and Aging, Bowel & Bladder Health, Advanced Care Planning: Essential Discussions. Each session is led by a physician and interdisciplinary healthcare team members.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Treatment of Pain and Use of Opioids - Our LHIN has higher-than-average rates for Opioid management for non-palliative patients (when compared provincially) in the following categories: Opioids dispensed, New Opioids dispensed, Opioids and Benzodiazepines, and High-dose Opioids dispensed. Together with the other FHTs in our LHIN (QIDSS collaborative), we will report on a common QIP indicator focused on Opioid management.

The Health Quality Ontario (HQO) MyPractice Reports provide valuable information about our prescribed opioids and may be helpful in identifying pharmacy resource requirements. Our goal for this year is to ensure that all physicians are signed up (through HQO) for their MyPractice Report. In addition, we will ensure that clinicians have the proper electronic tools available for managing patients on opioids, that the appropriate patients have signed contracts in their eCharts and that urine drug screens are being tracked.

Workplace Violence Prevention

The MFHT is a partnership between McMaster University and Hamilton Health Sciences and as such, both organizations have extensive policies in place regarding workplace violence and harassment issues. Managers and supervisors are trained to follow these policies and provide the relevant interventions and supports when issues arise. Monthly Health and Safety Meetings take place, as well, staff are provided with a "health and safety tip of the month" in staff meetings. The Health and Safety Boards in staff areas are updated regularly with relevant policies and staff complete mandatory online and paper code reviews annually. A Code of Conduct exists for both staff and physicians. Upon enrolling in the clinics patients are informed about the expectations. Mediation is set up when there is a concern, in person and in writing. The 2018 PAC will be focusing on creating a formal document and marketing program for the collaborative roles, rights and responsibilities of patients, staff and physicians in their ongoing relationships in the clinics.

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: Cathy Risdon _____ (signature)

Quality Committee Chair or delegate: Jill Berridge & Kathy DeCaire _____ (signature)

Executive Director / Administrative Lead: Jill Berridge _____ (signature)

Other leadership as appropriate: Kathy DeCaire - Co-Executive Director _____ (signature)