Let's Make Healthy Change Happen.

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

Aurora·Newmarket Family Health Team

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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 Aurora-Newmarket Family Health (ANFHT) Quality, Health and Patient Safety Committee (QHPSC) was established in 2013. The committee consists of an inter-professional team and reports to the Board of Directors. We meet quarterly and at the call of the chairperson(s) for new initiatives, ideas, concerns and when reporting approvals are needed, with a minimum of 5 meetings per year. Through these meetings, we continuously review and improve goals and objectives to meet our quality initiatives and annual targets that are set on an annual basis.

Each member works to establish their timelines and activities to meet the goals and objectives that are assigned to them, based on our annual QIP. As a team, we review MOHLTC requirements and align our FHT obligations based on Schedule A of our Annual Operating Plan submission. We review, re-establish and enhance internal initiatives that have been set to meet our QIP. Our focus is to build on our previous year of goal setting and re-examine our timelines and plans to meet and/or exceed our overall goals.

Our team has continued to provide timely access to our services and programs and worked to integrate with our community partners to give our patients enhanced quality care. Since the onset of the COVID-19 Pandemic our group worked to successfully convert our Programs and Services to a virtual platform with success and an increased interest from our patient population. Our social media platforms and website are an important tool to be used by both our team members and our patients.

We have been “early adopters” on quality initiatives, such as timely access and integration. This allows comprehensive care with all health care providers and a demographic that has access to quality health care. Our team actively participates HQO/ICES Primary Care Practice Report (PCP) initiative. This data, feedback and information assists us in goal setting, strategic planning and communication with our key stakeholders.

As a team, we focus on utilizing our QIP and Schedule A as “living” documents. We have aligned the two Quality Tools to develop, enhance and capture the requirements of our internal initiatives; this includes what is required by the MOHLTC and Ontario Health.

By utilizing the MOHLTC /AFHTO Program Planning and Evaluation tool, we are able to re-examine our existing programs and services and re-establish targets and outcomes. During this exercise, our team captures new (and existing) programs and services that will complete and complement our vision and quality requirements. Throughout this annual mandate we are able to determine what the needs of our demographic are and ensure our teams are offering efficient well-balanced programs and services. This year the focus was on revamping our programs and services to fit in to our new virtual landscape, while continuing to deliver meaningful, effective preventative health options to our patients.

Our goals and objectives for 2022-2023 are as follows:

- Integration of care after 2 years of COVID-19 Pandemic restrictions.
- Review and recommend methods to improve quality of our programs, procedures, policies and technologies ensuring identification of evidence based best practices to include virtual implementation, acceptance and attendance.
- Choose primary care indicators to track that are mandated, useful and feasible.
- Identify content and documentation procedures for our EMR.
- Find a strong balance between the virtual landscape and in-person care (in-person always when appropriate).
- Submit our annual Quality Improvement Plan (QIP) to Ontario Health and the Ministry of Health, Long-Term Care (MOHLTC) as part of our annual operating plan submission.
- Identify, evaluate, educate, train and make recommendations regarding occupational health and safety, workplace violence and harassment awareness.
- Work with our Southlake OHT and community partners to engage in patient centered care and assist in navigation of the healthcare system to support population health management.
- Continue to work with our OHT to progress through virtual care and tools and resources that are available to us.

Through our work in quality, our Clinicians and IHP’s support each other, discuss patient care, and most importantly involve the patient.

By balancing the work, we do on improving healthcare quality and patient safety, we work to distinguish between the physical needs of the patient in a safe environment and the external environment that can be an influence. By focusing on improving efficiency, creativity and productivity, our goal must remain “patients who are engaged and at the centre of the circle of care”.

Reflections since your last QIP submission

Our biggest achievement was the tremendous effort put in by our team to battle COVID-19 effect and maintain our efficient, effective practice, with the everchanging requirements to keep everyone safe.

Since March 2020, our team has reviewed, revised and implemented COVID-19 procedures, policies, processes and any other means to ensure the safety of our team and our patients and in tandem with Public Health and Ministry guidelines.

The ANFHT Clinical Team continues holding monthly COVID-19 meetings, with a standing agenda, PPE inventory update, quality concerns and action plans.

Our team has maintained urgent in-person care/visits since March 13, 2020. This was necessary to ensure timely access to care for those needing in-person care and to reduce unneccesary visits to the emergency department or random walk-in-clinics.

As we developed strategies and new processes, our Physicians, NP and RN's have continued to see patients with all visits beginning with a virtual visit (phone or OTN). Clinicians and IHPs conduct wellness calls to patients identified as vulnerable and high risk. During these calls, they provide support, resources and connect them with services to keep them safe at home.

Virtual counselling for chronic disease management, health promotion and prevention, and mental health is ongoing.
The ANFHT provided care to unattached newborns and moms, who did not have access to their family physician after discharge from Southlake Regional Health Centre during COVID-19 restrictions. We continued this process until other physicians office opened and in-person access to their family physician resumed.

The clinical team continued to administer necessary immunizations for our rostered patients, as well as unattached babies and pregnant women in office, if they did not have access to their own physicians. We have had successful Flu Clinics for our rostered patients.

There are a number of stable (Child, Adolescence and Young Adult Eating Disorders Program) patients who were being followed by their family physician for medical monitoring, however, due to COVID-19 some practices switched to virtual care with no in-person visits. This has increased the potential for these patients to become de-stabilized. As such, our team stepped up and completed the "in office medical monitoring" of these patients.

Our Occupational Therapist introduced our new feature, Wellness Wednesdays, where we share helpful information on our Facebook page and website, each week to support our patient's health and well-being while staying home.

Our Social Worker, Dietitian and Occupational Therapist maintained their appointments virtually and have been running virtual groups (based on our Schedule A Programs and Services). For example, Caring for the Caregiver or Diabetes conversation, a group of patients living with type 2 diabetes are important to run when patients are at home and looking for helpful resources.

Our "What The tech" is imbedded in all our virtual programs where online heath apllications or resources are provided for patients to utilize.

Other programs similarly noticed good uptake, beyond expectations. Health promotion and prevention strategies continued to prove effective, even during the pandemic.

Patient/client/resident partnering and relations

Our team works on Patient Engagement, through surveys, our website, groups and programs. Data collection is a key initiative to ensure that effective data would drive our programs and service indicators.

The ANFHT continues to focus on maintaining and improving access and efficiency activities and to ensure patients are satisfied with provider availability and they are seen in a timely manner. This includes post discharge within 7 days "when appropriate", newborns within 48 hours, same day access and post ER visits for those patients who require ongoing assessment.

Our team has been pro-active in seeing our patients post ER visit - which were managed in the ER for 24-36 hours, not admitted to hospital and require ongoing evaluation.

Our "Program and Services" Board has flyers that have information on all of our programs and services. Each exam room has a flyer with relevant information on what our FHT offers. Our website is kept up to date and our Quarterly Newsletter contains current information on new projects. Our goal is to release an informative document that can be shared with our patients on our progress as their primary care provider.

Our "Patient Information Station" in our waiting room displays our Quality achievements. Our goal was to share our quality data with our patients, to allow them a better understanding of where our team ranks in both our LHIN and in Ontario. Another board in our waiting room is dedicated to community resources, information and activities. A television that runs on a continuous loop, assists us to advertise our programs and services. Our website also showcases this information.

All of our programs initiate a survey for patient feedback at the completion of the program. This is useful in evaluating our programs and enable change if warranted. Our team initiated a virtual delivery process that will evolve and improve as each program is rolled out and we re-visit with lessons learned and improvement ideas from our patients and participants.

Through patient feedback and data, we were able to ensure our patients are benefitting and knowledgeable about the resources that are available to them. Patient surveys are sent out on a monthly basis, with feedback through our scorecard. Issues/concerns are reviewed at our daily huddle and/or team meetings, with action plans put into to place if required.

When our team reviews our goals and objectives for the next fiscal year, we will start the conversation regarding patient involvement in our QI initiatives. Our team will investigate approaches to define the requirements that will encompass feedback and engagement of our patient population.

By participating as an anchor partner with the OHT, our team will be involved in the planning and integration of the model(s) of care that will fulfill the mandate of Ontario Health and the MOHLTC. We will work collaboratively with our partners on care coordination and patient navigation and care management.

Provider experience

The COVID 19 pandemic has meant many objectives previously prioritized, have been sidelined by the need to offer patient care in completely different ways to other years. This has been evident in the switch to Virtual Care, instead of having in person visits almost 100% of the time (as in previous years), Virtual Care has become an important form of patient interaction. This has had a considerable effect on the way appointments are booked, the data captured after each encounter and the type of issues that can be dealt with during a visit. By the end of the 2021 year, more than half of all encounters were virtual, and managing the QI impact of this transition was one of the biggest successes of 2021/2022.

Although different and challenging, even a bit disruptive for everyone, the increase in virtual visits was well adopted by the team and patients.

Our team focused on revamping our programs and services to fit in to our new virtual landscape, while continuing to deliver meaningful, effective preventative health options to our patients and ensuring that our team and patients are safe in a new COVID-19 environment.

Our biggest achievement was the tremendous effort put in by our team to battle the COVID-19 effect and maintain our efficient, effective Schedule A, with the everchanging requirements to keep everyone safe.

Over the past 2 years, the entire ANFHT Team has maintained a professional, compassionate, respectful attitude toward each other and most of all to our patients. We are all proud of the efforts of everyone and hope that soon we will be able to celebrate our achievements and the fight against COVID-19.

Other

The ANFHT is registered to receive the Primary Care Practice Report, Health Quality Ontario provides us with quality indicators related to our Family Health Team and our ranking within our LHIN and Ontario. The report measures a range of indicators, including those related to our cancer screening, diabetes management and indicators required by HQO.

Through our MOHLTC Annual Operating Plan, specifically our Schedule A document, we identify those programs and services that address the needs of our demographic population.

Our team collaborates on diabetes, cardiovascular, women's health management as well as 15 programs and 14 services that consider the needs of our patient population. Our programs are also designed around Preventative Health needs such as the STOP (Smoking Cessation) Program, which we partner with CAMH. We continue to collect and analyze data based on those targets.

We identify a population for the purpose of Preventative Cancer Screening. We work through our patient population to identify, notify and follow up with those who are eligible based on their cancer screening needs. We are using the Screening Activity Reports, generated by the MOHLTC and Cancer Care Ontario to ensure accurate records and testing accountability within the Cancer Care Ontario guidelines. Our Registered Nurse is certified to perform Papanicolaou Tests (PAPS) and with the mentoring of our Nurse Practitioner, works through our screening lists. As a result, we continue to improve our current performance rate to within the expected 10% that we set as a target. Our team is working through our quality initiative to review this process to work through any backlog to establish blitzes for screening for Mammograms, Paps and FIT testing that has been caused by COVID-19.

Our Occupational Therapist sent out a blast to our patients over 65, to encourage awareness of Falls Prevention and to encourage safety this winter. Our Falls Prevention program identifies patients at risk for falls and provides appropriate intervention in order to reduce future risk of falling.

We work with outside partners to achieve a "circle of care" for our patients. We utilize Southlake Regional Health Centre for partnerships in mental health care and projects that will give our patients opportunities to be linked to community resources in a timely manner, such as palliative care programs and services.

One of the programs we refer to for mental health support is "Bounce Back. This CAMH evidence-based mood-improvement program is designed to assist our team in working with our patients. Bounce Back offers an instructional DVD, easy-to-understand independent workbooks, and telephone coaching by trained experts to help people boost and maintain their mental health. As a self-guided tool, Bounce Back offers some of the same benefits as seeing a trained professional, without having to pay for the service.

We have a program that identifies pediatric patients with gross motor/fine motor, behavioral, speech or social developmental concerns. These patients are referred to the OT, who completes a developmental screen with the patient and their caregiver to determine if the infant or child has a developmental delay. If a delay is present the patient may be referred to early intervention services or another appropriate program. The OT also provides strategies to the caregiver to assist with meeting developmental milestones as well as system navigation assistance with pediatric services.

Our Immunization and Vaccine service runs in collaboration with York Region Public Health to ensure immunization for all patients in a timely, accessible manner. We maintain two cold-chain fridges for the specific purpose of storing these vaccines. We communicate often with PHN's with vaccine questions and/or questions regarding any public health update.

We host a compassionate IUD program for patients who do not have a source of funding due to their lower income status. We also offer STI medication as part of our Sexual Health program.

Our clinicians support our patients who may not be able to afford medications and services not covered by OHIP. They advocate on behalf of them to pharmaceutical companies, to enquire if they can offer sample medications. We also assist patients in connecting to programs and services that will provide them financial support and housing.

We offer alternate language pamphlets for information on programs and services, such as cancer screening. Our postpartum packages contain multi-cultural resources and handouts.

Our team of clinicians are sensitive to gender identity within our patient base. In the past, we hosted an 2SLGBTQ+ community awareness and information session for our team to better understand how we can support and make our space a welcoming one.