Let's Make Healthy Change Happen.

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

3/30/2017

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 Quality Improvement Goals put forward align with the GNPLC strategic plan and fulfill our accountability agreement with the MOHLTC. Our plan focuses on the key priorities set out in the Ministry of Health and Long Term Care Action Plan for Health; 'Keeping Ontario Healthy 'through 'Faster Access to Stronger Family Health Care' and providing the 'Right Care, Right Time, Right Place' and right provider. Our goals incorporate integration with the Central LHIN, our local Health Link, the Canadian Mental Health Association, CCAC and our local hospitals to ensure advanced accessibility to quality health care for the residents of The Town of Georgina. We are committed to quality improvement, fostering and developing new partnerships and working collaboratively with other sectors in healthcare.

The objectives outlined in our QIP will improve access to and the quality of care our clients receive. We will demonstrate that our clients have increased awareness regarding the clinics expanded access to care through same day and next day appointment availability. Clients will also have primary care follow up (by phone or in person) within 7 days of being discharged from the hospital through enhanced electronic communication with local hospitals and manual tracking. Clients will have the opportunity to share their views on the services provided by the clinic through annual satisfaction surveys that focus on patient centeredness. Goals this year again include a focus on ensuring our clients have all of the appropriate cancer screening as well as appropriate A1c monitoring for clients with diabetes. We have added annual medication reconciliations as well as a new goal on improving coordination of care for those with diabetes through enhanced Registered Dietitian support. We look forward to working with HQO, the MOHLTC, the Central LHIN and our clients over the next year.

QI Achievements From the Past Year

We provide multidisciplinary primary health care to approximately 3000 patients. We have a waiting list of over 50 and are continuously inviting new patients for intake appointments. With approval received to temporarily use unspent RN dollars to hire a part-time NP, we have been able to cover health/education/vacation time for the Nurse Practitioners thereby improving access to primary care. Feedback from our clients has been positive regarding this addition to our team. We are hopeful with the upcoming funding request to expand our NP team to 5 full time NPs thus increasing access to care for more residents of the Town of Georgina....especially due to the increased number of new developments in the immediate area.

In addition, the clinic continues to provide client access to a Registered Dietitian for nutrition support and counseling. Our RD does outreach work to the local indigenous community, our local food bank and has spoken at the primary schools. She has also supported the diabetes program and has obtained her Diabetes Educator certificate. The clinic clients also have access to individual, family and group counseling with our Master of Social Worker. Our clients have access to our Physiotherapist if they have mobility issues, musculoskeletal pain, balance problems, Osteoporosis or osteoarthritis challenges. GNPLC clients also have the benefit of accessing our 'on site' laboratory where our Lab Tech or Registered Practical Nurse provide basic phlebotomy, urinalysis and ECGs.
We have recently sent our new RPN on the Basic Foot Care course and we will be re-starting this program in spring 2017.

In reflecting on our QIP goals for the 2016-2017 planning year, the Georgina NPLC has been able to maintain or improve on most of our targets for this year. Our cancer screening rates are between 48% (Colon) above Provincial average and

54%(cervical) below Provincial average. Our Work Plan will outline how we intend to improve on our cervical screening for the 2017-2018 year.
We are very happy with our patient satisfaction question results that have ranked between 95% and 97% this year, an increase of 2%.

Our results on same day or next day appointments as a self-report from the survey shows 61%. This is much higher than the Provincial average of 48% (as per the Quality Compass). The clinic has also had negative feedback from patients about this model of booking as they find it confusing to not be able to book appointments ahead of time at a date and time of their choosing. To accommodate same day/ next day bookings half of our appointments are blocked to pre-booking and opened the day prior. This method of booking leads to increased phone calls to the clinic by clients trying to book in a time that works in their lives. The Clinic did perform a PDSA with slight verbiage changes to see if there would be less confusion regarding the term 'next day', however the results were not statistically significant.

In relation to our goal to connect with patients within 7 days post discharge with designated diagnosis, the clinic was unable to reliably book patients. NPs are still unable to roster/register patients and thus we are not receiving data from OHIP to notify the clinic when a person should be seen post discharge.
The clinic has been able to perform some manual tracking of reports and has booked as many as possible, however we cannot compare this to any reliable data set. We look forward to the MOHLTC moving ahead with NPs rostering/ registering in 2017.

In 2017 the GNPLC was successful in our application to the Central LHIN for a 1.0 FTE Aboriginal Navigator
in collaboration with Black Creek CHC and CMHA. This full-time position was intended to assist the local Indigenous population, both on and off reserve, in navigating through the health care system. Unfortunately the number of referrals to this service were very low. Thus, the data did not support a full time position and the program ended in February 2017.

The GNPLC has continued to work with the CLHIN and the local Chippewa Band and have returned to the planning phase to develop a support position for local Indigenous peoples. We have continued to provide service to the local Indigenous population who reside on Georgina Island by sending a Nurse Practitioner providing primary care one half day a week as well as our Registered Dietitian for diabetes groups monthly and individual nutrition counseling.

Population Health

The clinic's demographics consist of:

Children < 18 = 20.6% of our population
Adults 18 < 65 = 61.3%
Seniors 65+ = 18.1%

For the clinic's children and youth, the clinic provides primary health care right from conception. Prenatal care is provided until transfer to a midwife or OB and Ontario Antenatal forms are completed. The clinic supports breast feeding and has equipment and a designated space for moms who require support. We have expertise in the form of a previously registered lactation consultant (NP).
All immunizations are provided by the clinic and we use pain reducing strategies in our care. We provide comprehensive well baby and well child examinations and

utilize best practice screening tools to identify children with growth, developmental, nutrition or safety issues.

For clients in the adult population we focus on cancer screening as well as screening for diabetes, hypercholesterolemia and hypertension with our annual visits. Blood pressure is measured at every adult appointment to screen for hypertension.
Our seniors care includes a specialized senior's physical exam template, a malnutrition screen, osteoporosis and osteoarthritis programs as well as access to our physiotherapist for any mobility strengthening work.

The GNPLC has a high population of patient's with a mental health diagnosis (28.6%) and many of these individuals also deal with addictions and chronic diseases.
The clinic provides access to a multidisciplinary team to aid in supporting these clients through their health care needs. Our Master of Social Worker does excellent counseling support. They have access to our Registered Dietitian for supports when appropriate and she has also offered direction to local group homes regarding diet planning.
In addition, primary care is provided offsite to two local group homes and two homeless shelters.
We will also discuss below the provision of comprehensive home care for our clients in the palliative phase of care.

Equity

In terms of equitable access, please also see below where we discuss access for patients with palliative care needs, out-patient visits for group homes, homeless shelters and the Chippewas of Georgina Island services.

Diabetes Care:
The clinic provides space weekly for the local hospital to send the Diabetes Education Clinic (DEC) team consisting of a registered nurse and registered dietitian. They provide care to local clients as booked through Southlake Regional Health Centre for both our patients and all other local providers patients.

Indigenous Population:
We provide weekly visits to Georgina Island (Chippewas of Georgina Island) to provide primary care via an NP. Patients do not need to be registered to the Georgina NPLC to receive care.
The Registered Dietitian provides monthly services to Georgina Island and is a Certified Diabetes Educator.
The clinic is working with the CLHIN and the Chippewa Band to plan a support role in the form of a case manager or navigator for the 2017-2018 year.

Low Income:
Our registered dietitian provides nutrition outreach services in the form of monthly food demonstrations to the local food pantry. Social determinants of health amongst this client population, such as low income and food insecurity, places them at higher risk for poor nutritional health. The goal of this service is to support food pantry clients to be better able to plan and prepare healthy meals using the available foods at the food pantry.

Sexual Health:

The clinic supports an NP attending the Sexual Health clinics at 2 local high schools to provide prescriptive and diagnostic support to the RNs working with Public Health.

Integration and Continuity of Care

The GNPLC works closely with CCAC through individual client meetings as needed and quarterly reports received from CCAC for clients who are receiving homecare services.
The clinic also works with the local Health LINK with referrals, feedback and use of Telehomecare when appropriate. The Clinic Director is also the co-chair for the Health LINK and provides support to the ongoing development of the program.
The 2 local hospitals have been successful in sending HRM reports to NPs and we now receive DI and specialists reports in a timely fashion, leading to better follow up care.
One of the local hospitals notifies the clinic immediately when a patient has been seen in the ED and sent home on the same day. The larger of the local hospitals still struggles with this technology and sends handwritten notes several days (to weeks) after an ED visit.
The clinic has good relations with most local specialists and contacts directly when needed for clarity around client treatment plans.
The NPs also have access to eConsult through OntarioMD for queries about client care when needed. This service has helped reduce travel time for patients and has increased access to specialists for the NPs.
Both GNPLC clients, and others as needed, have access to OTN at our site. We often have northern living individuals utilize the service to access specialists connected to the University of Health Network and the Hospital for Sick Children from our location OTN equipment.

Access to the Right Level of Care - Addressing ALC Issues

Three of our Nurse Practitioners have completed the Palliative Care program and are able to provide palliative care in the home. One NP in particular does most of the palliative care home visits for patients registered with our clinic. She is recognized as being excellent at this service and was asked by CCAC in the past to train new NP-Pal Care employees. This NP is often asked by CCAC to take on clients needing palliative support who are orphaned by local doctors who do not provide such care. We are hopeful that the CCAC NP will be taking on more of these cases. This NP works closely with Southlake Regional Health Centre palliative care team and has been working with the CLHIN Palliative Planning Committee.
All of the NPs provide home visits for clients who are elderly or immobile and cannot otherwise attend clinic visits without hardship. We also provide outpatient visits to 2 local group homes for primary care as well as antipsychotic injections and to 2 local homeless shelters.
The GNPLC provided 507 home visits in the first 3 quarters of this year with an anticipated total of 675 home visits for the 2016-2017 year.

Engagement of Clinicians, Leadership & Staff

All staff are invited to participate in the QIP plan review and in general quality improvement throughout the year via PDSAs. The clinical team meet weekly to discuss programs, services and cases. The administrative team meet bi-weekly to discuss client flow, systems and support processes.
The QIP goals are reviewed quarterly with all of the staff at our staff meetings as well as with the Board.

In terms of engagement in the broader healthcare system:
Clinic Director and Lead Administrator continue to participate monthly in the NPAO-NPLC Teleconferences
as well as the AFHTO-NPLC Teleconferences.
The Clinic Director sits on the AFTHO Board as the representative for NPLCs and is now the Treasurer (progressive board- president in 2 years) [Quarterly meeting]
They also sit on a LHIN Health Professionals Committee as well as the Health Link Steering Committee at Southlake – Quarterly meetings have been HELD since OMA and MOH dispute
One of our NPs is on the LHIN Cancer Care – Primary Care Committee - Quarterly
Another NP is on the LHIN Palliative Care Program Planning Committee – Q 2 months, as well as Hospice Georgina Meetings quarterly.
An NP was invited to the LHIN Mental Health Program Planning Committee but it has yet to get under way
Our RD participates in AFHTO monthly RD meetings as well.

Resident, Patient, Client Engagement

The GNPLC has excellent client relations and patients are routinely encouraged to become involved in their decisions about their care and treatment (survey stats are at 96%).
The clinic celebrated our 5-year anniversary last September and all clients were invited via newspaper announcement and posters.
The clinic hosts an annual AGM that is also open to our clients and an invitation is published in the newspaper.
The GNPLC runs the smoking cessation program the "STOP Program" that is open to both our clients and the general local population through our MSW. This program is supported by CAMH with education materials and pharmacotherapy supplies. We have also run an interactive Osteoporosis Sessions with our Physiotherapist, RD and an NP, where both our patients and the general public were invited.

Staff Safety & Workplace Violence

The GNPLC Policies for harassment and violence were rewritten to include the new legislative changes.
To provide the staff with access to help when needed, 'panic buttons' were installed at all workstations and a response protocol was developed. If a panic button is activated all staff are to leave their clinic suits and congregate in the center hallway. Staff are counted and if a member is missing then their room is approached by the group. The monitoring security company also calls with the location of the triggered station. We have had simulated events to support this protocol.
The clinic has also installed a sliding lock on the patient access door to clinic suites.
We have also modified the patient code of conduct poster which is posted in both waiting rooms.
The clinic staff have all had enhanced privacy training in relation to current legislation.

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Other

NA

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)