Ontario Health
Quality

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 19, 2020

Peterborough
FAMILY HEALTH TEAM

OVERVIEW

Peterborough Family Health Team (PFHT) is one of the first and largest Family Health Teams in Ontario. We are deeply rooted in the City and County of Peterborough as a trusted source for family medicine and the delivery of comprehensive primary care. We provide a team-based approach to patient care through our skilled, responsive and caring employees and clinicians

Our team includes over 90 physicians, 12 Queen's medical residents and over 80 interprofessional health care providers who provide high-quality comprehensive primary care to over 110,000 residents of Peterborough City and County.

We are committed to putting patients first and engaging in quality improvement in primary care. We are leaders in the delivery of collaborative family medicine and our mission is to "coordinate and empower family practice centered multidisciplinary teams to provide high quality, evidence-based, primary care to meet the needs of all residents of Peterborough County."

Through our Quality Improvement Plan, and the work of our Quality Committee and Quality Facilitator, we continue to demonstrate our commitment to quality while fulfilling our vision and mission. We have a robust program planning and evaluation framework and are actively reviewing each of our programs and services to ensure that we are delivering high quality service to the residents of our community.

Our quality improvement plan initiatives for 2020/21 are focused on:

#1: Timely follow-up for patients discharged with AECOPD
#2: Addressing the social determinants of health through connections to local community services and supports and
#3: Increasing timely access to experience-based specialist knowledge through eConsult

DESCRIBE YOUR ORGANIZATION'S GREATEST QI ACHIEVEMENT FROM THE PAST YEAR

We continue to operate our two clinics for unattached patients. To date, over 4,000 linkages/referrals have been made to a variety of health services and partners. As many of these patients have not had primary care in quite some time, often they require basic lab and diagnostic tests to help diagnose or monitor existing conditions. To date, we have made 1,723 referrals for lab services, 628 referrals for diagnostic imaging/ultrasound services, and have conducted 311 cancer screening tests. Further to this, we have made 1,019 referrals to specialists for further investigations. We estimate that we have diverted 1,223 visits from local emergency departments due to the existence of these clinics.

Prior to the formation of the Peterborough OHT (POHT), our local mental health and addictions planning table had been exploring how we could work together to provide better care and support in our community. Subsequently, our OHT chose mental health and addictions as a priority population for year one so this work has continued and intensified. POHT partners are planning to open a walk-in mental health clinic which will be a collaborative partnership

among several community agencies. This walk in clinic will provide immediate access to patients requiring mental health care. The clinic will be supported by mental health clinicians as well as a registered nurse and nurse practitioner, thus providing comprehensive mental health care. At full operational scale, the clinic will also provide care pathways and central intake for community mental health organizations.

We continue our partnership with Ontario Shores to offer manualized protocol Cognitive Based Therapy (CBT) that aligns with the Health Quality Ontario Depression Standard. Three (3) clinicians who specialize in the CBT modality of care have been working with us and seeing patients who would benefit from this type of treatment. To date, this service has received 409 referrals and 285 patients.

Additionally, we continue to offer our Collaborative Care psychiatric model. Through this model, a psychiatrist is on-site at clinics to see patients and provide formal and informal education to the clinicians. To date this model has received 801 referrals: 604 for direct patient assessments, 14 for indirect patient assessments, 109 for diagnosis clarification/confirmation, and 74 for management recommendations.

Through our program planning and evaluation process, we evaluated four (4) of our programs to ensure we are meeting the needs of our residents. These evaluations include a review of process and performance measure data as well as feedback from our patients and key stakeholders.

COLLABORATION AND INTEGRATION

In December, the Peterborough Ontario Health Team (POHT) was announced as one of the first 24 teams in the province to implement a new model of organizing and delivering health care that better connects patients and providers in their communities to improve patient outcomes. The team will break down silos of services by bringing together 22 partner organizations in its first year to find the right health care solutions for patients. By improving transitions of care between agencies, patients will benefit from better patient and caregiver experiences, better health outcomes, better value in efficiency and better provider experiences.

The year one priority populations for the POHT are:
- Patients with CHF and COPD, including those with comorbidities such as diabetes as well as those at the palliative state of their illness
- Patients requiring care for mental health and addictions

These patients represent a high percentage of those accessing healthcare services in Peterborough, face great challenges to achieving positive health outcomes, are among the highest utilizers of care, and would be the greatest beneficiaries of more integrated, coordinated care among the many providers that serve them.

To care for patients with CHF and COPD, the POHT will work towards implementing integrated care models and care pathways.

For patients requiring care for mental health and addictions, the POHT is planning a walk-in mental health clinic. Care needs will

range from individuals with mild to moderate situational crises, to clients with a previous mental health or addiction diagnosis who are using the clinic to supplement/complement their existing resources.

We are confident that we can provide integrated care to our full attributed population at maturity, as our partners already have a successful track record of focused, successful integrated care initiatives and collaboration.

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

Our Patient and Family Advisory Council (PFAC) meets quarterly. The mandate of this council is to improve patient care experiences at PFHT. The council serves in an advisory capacity, making recommendations on matters that impact the experience of patients and families. One of our PFAC members also sits on our Board of Directors and is a voting member.

Our patient experience survey is available on our website allowing us to capture our patient's perspective on the care we provide. This survey is also available through our CoHealth mobile app. In addition, we continue to gather patient feedback from all our programs and services we offer.

We continue to use social media platforms such as Facebook and Twitter to engage with our patients and share program information. We have a semi-annual community newsletter which is shared via social media and posted to our website.

We are currently developing a new strategic plan and as part of that process, we held three (3) community engagement sessions and invited residents to come and share feedback with us.

WORKPLACE VIOLENCE PREVENTION

In accordance with Bill 168, we have a policy on violence in the workplace and are committed to building and preserving a safe working environment. Annually, employees must complete a training module related to violence in the workplace. Completion rates for this and other mandatory training are reported on quarterly to the Board of Directors through our organizational dashboard, this holds the organization accountable to the 100% completion target. PFHT takes this training seriously and employees who do not complete the mandatory training are suspended until such time as the training is completed.

We have a formal communication algorithm for both clinical and HR related issues or concerns. Staff are encouraged to access these algorithms to bring forward any work related issues.

ALTERNATE LEVEL OF CARE

We strive to provide timely access to primary care with the goal of preventing hospitalizations. Many practices offer same/next day appointments and our FHOs provide a robust extended hours service. Same/next day appointments are also available with our interprofessional healthcare providers when needed and we provide primary care to patients without a primary care providers through our two unattached patient clinics.

Our Clinical Support Services (CSS) team focuses on improving coordination of care for high-needs patients with complex conditions and supporting patient transitions from hospital to community. CSS conducts their work with a focus on health equity and supports patients with challenges involving social determinants of health through local community connections. We foresee this work strengthening through our newly formed OHT.

VIRTUAL CARE

Our Virtual Care Clinic (a partnership with the Virtual Physician Network) allows unattached patients see a doctor over a secure telemedicine network assisted by a registered practical nurse. Although we haven't formally entered the domain of virtual visits with our primary care providers, many practices are exploring/using patient portals which includes online scheduling and secure email communication. We have been working on promoting and facilitating uptake of Ontario's eConsult Program and this will be a focus of our 2020/21 QIP.

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 on _____

_____
Board Chair

_____
Quality Committee Chair or delegate

_____
Executive Director/Administrative Lead

_____
Other leadership as appropriate

_____

Equity | Equitable | Custom Indicator

Indicator #3

Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period (Peterborough FHT)

Last Year		This Year	
61	**66**	**76.58**	**--**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Identify who, in the target group, is unscreened. Provide screening rate comparators within FHO/ in CE LHIN/ Provincially/ Quality Benchmarks and best performers in other jurisdictions.

Target for process measure

- # of physicians who review their SAR report is increased by 10%

Lessons Learned

While we didn't implement this change idea as it was intended, our Quality Facilitator (who is also an LRA) is still available to support our primary care providers in getting connected to their CCO SAR.

By encouraging the use of the SAR to identify the unscreened population, we also encouraged PCPs to improve performance as they were able to see how they compare to the province.

We've found that some providers find value in this tool while others prefer to use their EMR as a means to track and facilitate preventive care screening.

Change Idea #2

Contact overdue patients to inform them of their preventive care status and recommended screening

Target for process measure

- # of patients who are contacted is 10% of our unscreened total population. (39% of 32,872 eligible women x 10% = 1,282 patients contacted)

Lessons Learned

16 practices made phone calls and collectively contacted a total of 861 women. Women contacted were offered an appointment during regular clinic hours or through one of the after hours pap clinics being offered.

We learned that practices incorporate screening calls into their daily work making it difficult to collect robust data for this change idea.

Change Idea #3

Screen more patients by: Supporting clinics/FHOs to hold Women Wellness days on evenings/weekend, supporting practice level nurses to do paps, continuing to support use of preventive care toolbar by all PCPs.

Target for process measure

- 100 patients receive cervical screening at Well Women days 4 Well Women days to be spread throughout 2019 year # of nurses who perform pap tests independently increased by 10%

Lessons Learned

17 pap clinics were run and 161 paps were completed. Sixteen (16) of these pap clinics took place after hours to accommodate women who may not have been able to attend during regular clinic hours.

Due to the size/complexity of our FHT, if we embarked on a similar initiative in future, we would plan to hold centralized pap clinics in an effort to increase efficiency and numbers and decrease administrative burden.

Theme I: Timely and Efficient Transitions | Efficient | Custom Indicator

Indicator #2

Percentage of medical patients with AECOPD for whom discharge notification was received who were followed up within 7 days of discharge from PRHC, by phone or in-person visit, with any clinician. (Peterborough FHT)

Last Year		This Year	
98	**98**	**95.90**	**--**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Use our Clinical Support Services (CSS) team to facilitate post-discharge follow-up care.

Target for process measure

- 98% of patients discharged with AECOPD will receive a follow-up care within 7 days by phone or in-person with any clinician.

Lessons Learned

The CSS team works closely with PRHC to facilitate transitions of care for our patients with AECOPD post-discharge. They receive daily discharge lists which are used to ensure that proper follow-up care is arranged and that patients are connected with services and supports in the community, as needed. We will continue this work into 2020/21. We are exploring streamlined processes for receiving accurate discharge lists and how the team might be able to connect with these patients while they are still in hospital to start the navigation work prior to discharge.

Theme III: Safe and Effective Care | Effective | Custom Indicator

Indicator #1

Percentage of AECOPD patients with an improvement in their CAT score by 2 points from initial to final interaction with Clinical Support Services (CSS) (Peterborough FHT)

Last Year		This Year	
CB	CB	55.30	--
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Use our CSS team to implement an evidence based patient QoL survey (e.g., CAT score) and administer at initial and final interaction. The subset of patients to receive this questionnaire will be those who are complex/have severe COPD and are engaged in preventing further exacerbations and progression of their condition.

Target for process measure

- We hope >=70% of patients will fall into this category and will be administered a CAT test. A difference or change of 2 or more units from initial to final interaction with CSS

Lessons Learned

The CSS team has found value in using the CAT questionnaire at their initial interaction to assess baseline however has found it difficult to obtain meaningful post/final interaction data with this population. It is also believed that obtaining a baseline CAT score is helpful to the PCP's involved in the patient's COPD care.

The time lapse between initial and final interaction varies greatly and a lot can change with a patient during this time. The team feels that post score data may be skewed and not representative of the service that has been provided.

Theme I: Timely and Efficient Transitions

Dimension: Efficient

Measure

Indicator #1	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of medical patients with AECOPD for whom discharge notification was received who were followed up within 7 days of discharge from PRHC, by phone or in-person visit, with any clinician.	C	%	In house data collection / April 2020 - March 2021	95.90	98.00	We aim to follow-up with all patients with AECOPD discharged from medical floors at PRHC within 7 days of discharge.	Peterborough Regional Health Centre

Change Ideas

Change Idea #1 Use our Clinical Support Services (CSS) team to facilitate post-discharge follow-up care. As patients with COPD are a year one priority for the Peterborough OHT, we will be actively working with this population and exploring more streamlined and efficient methods with PRHC of identifying our target population.

Methods	Process measures	Target for process measure	Comments
Review daily discharge lists from medical floors and contact patients who have been discharged with AECOPD to ensure follow up care is arranged. For patients at high risk of readmission or identified as needing additional supports, link to appropriate community services.	# discharges for AECOPD # patients with 7-day follow-up # linkages to community services	98% of patients discharged with AECOPD will receive follow-up care within 7 days by phone or in-person with any clinician.	

Theme III: Safe and Effective Care

Dimension: Effective

Measure

Indicator #2	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of primary care providers registered for eConsult thereby increasing timely access to specialist knowledge	C	%	In house data collection / April 2020 - March 2021	CB	CB	Collecting Baseline	

Change Ideas

Change Idea #1 Assist primary care providers with Ontario eConsult Program registration

Methods	Process measures	Target for process measure	Comments
Assist primary providers with the registration process (removal of barriers) Provide resources specific to our region.	# primary care providers registered # of education sessions provided	We aim to register 60% or greater of our primary care providers. As per eCOE, in calendar 2019 the provincial rate was 72.0% and CE LHIN is 58.9%.	

Measure

Indicator #3	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of registered primary care providers who are active with the eConsult service (as defined by the eCOE, an active user sent at least 3 eConsults in the last 6 months)	C	%	In house data collection / April 2020 - March 2021	CB	CB	Collecting Baseline	

Change Ideas

Change Idea #1 Encourage ongoing use of eConsult

Methods	Process measures	Target for process measure	Comments
Provide resources and education sessions, including that of championing local specialist providers on the eConsult registry to pair familiarity with specialists with uptake of new technology for accessing those specialists. Gather/share testimonials and good news stories to highlight champions within the FHT.	# of registered primary care providers who submit 3 or more eConsults in the last 6 months per quarter # eConsults submitted per month	We will encourage registered primary care providers to submit 3 or more eConsults in a 6 month period.	

Equity

Dimension: Equitable

Measure

Indicator #4	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of referrals for which a community connection was made by Clinical Support Services (CSS) to support patients with challenges involving social determinants of health	C	%	In house data collection / April 2020 - March 2021	CB	CB	Collecting Baseline According to the results of the 2019 Commonwealth Fund Survey, although 60% of family doctors in Canada screen their patients for social needs, fewer frequently coordinate care with social services (43%). This is an area where CSS can support providers. Historically/currently, social service organizations tend to exist in silos, with little connection between the various organizations that might be needed to support any one patient. CSS is working to be a bridge between these organizations, or a hub (including the patient at the centre), for resource connection.	

Change Ideas

Change Idea #1 Use our Clinical Support Services (CSS) team to assess health equity needs and make community connections to address social determinants of health

Methods	Process measures	Target for process measure	Comments
CSS will review referrals received and assess patient need re social determinants of health. CSS will liaise with community agencies to make connections.	# connections to housing # connections to transportation # connections to food resources # connections to financial supports # connections to legal services # connections to health services/homecare # social connections # of meetings with community agencies	60% of referrals to the health equity program will have a community connection/referral made	