Let's Make Healthy Change Happen.

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

Ingersoll Nurse Practitioner-Led Clinic

Ontario

4/1/2016

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 Ingersoll Nurse Practitioner-Led Clinic team is committed to providing comprehensive primary health care to our patients, families, and in the community.

Our Clinic is moving into its fifth year of operation which has brought with it a new NP lead, 2 new additions to our staff team, site sharing and exciting new collaborative programs. It is our team's pleasure to report that, not only do we have a full staff compliment, but we have an amazing staff that have embraced goals of our QIP and our change ideas enabling the NPLC to make vast improvements in our screening strategies for chronic disease management and prevention.

During the past year the NPLC implemented new processes to improve efficiency within the clinical team. They include the development of clinical pathways to ensure evidence-based practice is provided by all members of the team, a new prescription renewal process, a formalized mental health referral, and the addition of mental health rounds.

If there were a word to describe 2015 it would be change. What has not changed is our dedication and commitment to our patients, families and community. Our team continues to provide accessible, equitable and evidence-based care.

QI Achievements From the Past Year

Cancer Screening

Although the NPLC does not receive the same reports as physicians around cancer screening, our team was able to improve the current performance in all three indicators of the QIP. Manual methods were used to track and inform patients that required the screening, and monitoring reports using software like OLIS we managed to determine what patients had the screening done. Our change ideas and progress is further detailed in our progress report.

Third Next Available Appointment

Our team continues to improve our third next available rate. Although we have improved our current performance we still struggle in this area. This indicator is reviewed monthly and balanced with our same day next day appointments as our performance for this indicator surpasses our target. Our change ideas and progress is further detailed in our progress report.

Clinical Pathways & Directives

In order to improve access to clinical services and ensure continuity of care, the NPLC initiated formal clinical pathways and directives to allow for a shared care approach for some health conditions. For example, the Registered Practical Nurses took on responsibility for the initial prenatal visit, routine immunizations and some acute health conditions such as urinary tract infections and streptococcal pharyngitis (strep throat).

Prescription Renewal Policy

The NPLC implemented a new prescription renewal policy that phased out faxed-in renewal requests for long-term prescriptions. Patients have their medications

reviewed at regularly scheduled appointments and are given enough medication until their next review is needed. The change reduced the risk of prescription errors or misuses as well as any lapse in medication use and decreased the Nurse Practitioners administrative time collectively by 2-4 hours/week.

Chronic Disease Prevention Coordinator Role Enhancement

The Chronic Disease Prevention Coordinator's role was further developed to include elevated cholesterol monitoring and obesity management. Standardized and custom forms were developed to facilitate communication and evidenced based practice for chronic disease management, so that the patient would receive the same quality care from all members of the team. In order to integrate self-management into our chronic disease program, the addition of education programs are offered in a group format.

Integration & Continuity of Care

Internal Collaboration:

Mental Health Rounds

With the addition of a new social worker, a number of changes were made to facilitate referrals and coordination of care between the clinical and mental health teams. A formal process allowing the NP's to refer electronically to the mental health team and share pertinent health and social information was developed to facilitate communication between providers and patient continuity of care. Monthly Mental Health Rounds were implemented to provide the NP's and Social Workers an opportunity to present cases and learn from each other in a multidisciplinary format.

Ongoing Community Collaborative Projects:

Oxford Situation Table

This emerging collaborative project was mentioned in our 2015 QIP narrative, but it is this year where we have been able to advance the project and provide solid data to support change in our community. While anecdotally from police and health care partners we realize the change, we continue to work with Public Health to dig deeper into the data collection in order to determine where this project has allowed us to divert situations from emergency rooms and police apprehensions. This project currently has 16 consistent community agencies represented that meet weekly to hear situations and apply 104 risk factors to determine if they meet the threshold of risk to share information within circle of care to mobilize resources to reduce that risk. These are situations that are complex and where risk is applicable across multiple sectors, where there is strong likelihood of harm , death, an emergency department visit or incarceration, homelessness, or child protection issue are imminent. Over the past year the situation table has engaged 16 community partners who meet weekly and have reviewed 84 situations. The results and data related to the first 6 month pilot are included in this document for review.
In response to media attention to the October 2015 community report, AFTO noted the accomplishments of this project and recommended it be put forward for 2016 award and recognition.

Oxford Addiction Treatment Strategy

The NPLC continues to collaborate with Addiction Services of Thames Valley, Woodstock & Area Community Health Centre and the Canadian Mental Health Association Oxford to implement coordinated access to quality addiction and concurrent disorder treatment in Oxford County. Five walk-in intake and assessment groups are offered per month at 3 different sites across the County. Services are offered at various times of day to ensure accessibility

New Collaborative Projects:

Canadian Mental Health Association (CMHA) Walk-In Counselling

In 2015 the NPLC increased our capacity to provide accessible, quality mental health care in our community by joining other community agencies in partnering with the Canadian Mental Health Association (CMHA) to offer walk-in counselling. This service is staffed by CMHA and is located at the Ingersoll NPLC through a shared space agreement. Walk-in brief therapy counselling services are offered for 4 hours once weekly to anyone in Oxford County. The partnership provides an opportunity to collaborate and consult with other counsellors and facilitates soft referrals and system navigation, as well as an opportunity for information sharing learning between NPLC and CMHA counsellors.

Oxford Oral Health Access Project

The Ingersoll NPLC has partnered with Oxford Public Health, Woodstock & Area Community Health Centre, Western University, local dentists, and community members to address the significant lack of affordable dental services available to marginalized individuals in Oxford County. The collaborative group has received a United Way grant to hire a Dental Health Access Coordinator for the purpose of:

- Documenting the need for dental treatment services for people with financial barriers and/or living on low incomes in Oxford County;
- Increasing awareness regarding the significance of dental health with stakeholders and policy makers
- Enhancing communication by providing networking opportunities between stakeholders and community partners
- Act as a system navigator for service recipients;
- Ensuring the sustainability of this project by applying for additional sources of funding.

These activities will help address the obvious gap that exists in services for dental treatment. Not only that, this can act as an model of care that is a cost effective alternative for people who rely on emergency rooms for dental concerns. This project has been a year in the making and great work has gone into it over the 2015 year.

Oxford OPP Partnership

The NPLC has entered into a shared space agreement with the Oxford OPP detachment to utilize a counselling room and OTN for the purpose of providing the OPP with a safe space for domestic violence, child protection and mental health incidents where interviewing and additional supports are required. The NPLC’s addiction and

mental health providers support the education of this specialized team by offering ongoing education to better serve both our own patients and other community members who may be engaged in the justice system.

On behalf of our own patients, our team was asked to participate in the Mental Health focus groups directed by the Ontario Provincial Police to assist in developing their Mental Health Strategy for the Province of Ontario. This included topics such as stigma experienced by patients, system navigation issues, and hospital admission/discharge experiences.

Engagement of Leadership, Clinicians and Staff

The year 2015 brought more changes to our leadership team at the Ingersoll NPLC with the retirement of our NP Lead and the transition to a new NP Lead. This change impacted the team for several months while the transition occurred and a new NP was recruited, which had some impact on our data and statistics and ability to register new patients. The consistency of our Business Lead and the dynamic new NP Lead combination has ensured that leadership remains dedicated to providing ongoing opportunities to engage all staff in quality improvement.

Leadership Engagement:

The NPLC Leadership Team represent the NPLC on a number of community tables and committees. Among these are the Board of Directors of the Ingersoll Services for Seniors; Health Links; The Oxford County Health Providers Table; the Oxford Mental Health And Addiction Network; the Oxford Addiction Treatment Strategy, and the Clinical Quality Improvement Table through the Southwest LHIN.

Interdisciplinary Team Leadership Engagement:

Our Community Services Coordinator is involved at a leadership level in several community collaborations. This includes co-chairing the Oxford Situation Table and the Oxford Addictions Treatment Strategy Working Group as well as being a Director on the Board for the Oxford-Elgin Child and Youth Centre (OECYC). The Community Service Coordinator is also involved in consultations for the new 'Lead Agency' initiative undertaken by OECYC.

Representatives from the clinical, administrative and mental health teams are responsible for supporting and implementing the QIP each year. Their contributions are invaluable through their first hand knowledge of the clinic and our patients. Additionally, key quality objectives are used for performance evaluation, ensuring alignment of our efforts and that the priority of the QIP objectives is clear and all staff are involved in assuring accessibility and quality care. Our Board Members review the QIP and provide feedback and direction to the team as needed.

Employee Wellness:

The NPLC values the importance of a positive work environment and a balanced work-life routine. In addition, our leadership recognizes the importance of a healthy and cohesive team environment. We know from work done by Canada’s Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative the importance of ‘well care providers’. Our leadership strives to create conditions for our providers to work together in the most positive, effective and efficient way so that they are at their peak to provide the best health care outcomes for our patients. As such, the Ingersoll Nurse Practitioner-Led Clinic offers quarterly

wellness events that support communication, holistic wellness, and foster positive, collaborative relationships in the workplace. Our wellness committee has grown over the past year to provide opportunities for our inter-health team to have input into wellness events and they provide consistent evaluation of these events and their outcomes.

Patient/Resident/Client Engagement

Patient Surveys:

The Ingersoll Nurse Practitioner-Led Clinic engages with patients throughout the year through patient surveys. These involve quality evaluation from a patient perspective. Surveys include the indicators of the QIP as well as additional options to provide anecdotal feedback.

Our counselling and chronic disease management team have engaged patients through an annual questionnaire to survey desired psycho-education, group topics, and support program preferences. This also included preferred times, including months, days of the week and times of day, for groups to be facilitated.

Ocean Tablet:

The NPLC expanded the capacity and use of our electronic medical record by introducing the use of a tablet called the OCEAN. The OCEAN is a PS Suite tool that allows patients to complete screening questionnaires as well as standardized and custom health forms in the waiting room prior to seeing their provider. The patient's OCEAN entry is downloaded directly onto their electronic medical record. The OCEAN has decreased the amount of time needed to take a patient history and has provided the NPLC with an avenue to complete HQO questionnaires as well as collect valuable patient data and increase patient engagement in their care.

Waiting Room Activities:

The NPLC hosts a community network in our waiting area to provide regular information to patients about our services, programs and our team to ensure patients are kept up to date on new additions to our staff and services.

The Chronic Disease Coordinator develops interactive displays that coincide with health promotion themed weeks and months. For example, during the month of November 2015, educational materials promoting influenza immunization were displayed in the waiting room to encourage patients to get their flu shot.

Website:

The NPLC website is updated regularly to inform patients and the community about the programs and services offered at our clinic. Many of our patients make regular use of our website feedback option where they can provide comments, share experiences or leave their questions or concerns.

Other

In reviewing the workplan for 2016/17 we have clearly focused efforts in the collection and improvement of clinical data as our team is satisfied with maintaining current performance levels in the areas of patient experience and timely service.

The Ingersoll Nurse Practitioner-Led Clinic team is excited about the upcoming year with a planned addition to our Board of Directors and the expectation of taking on new patients now that we have a full complement of Nurse Practitioners. It is our hope that with new Provincial announcements related to remuneration, the retention of our primary health care providers will ensure an ongoing full complement to our amazing team!

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 Gord Adam
Administrative Lead Linda Chudiak
Clinical/NP Lead Sue Tobin