Let's Make Healthy Change Happen.

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

Lakehead
Nurse Practitioner-Led Clinic

**3/29/2018**

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.



Ontario

## Overview

Lakehead NPLC continues to focus on the metrics of quality highlighted by the MOHLTC for primary care: Timely, Effective, Efficient, Patient Experience; along with Equitable (formerly Access, Integration, and Patient-Centeredness; along with Population Health).

We are addressing these areas through a multi-pronged approach aimed at increasing patients' ability to see their provider when they need to (expanding access to the clinic with more hours and walk-inc clinics), and giving them more opportunities to provide feedback (paper-based and electronic surveys, email communication), while coordinating care as much as possible between other health organizations where the patients may be receiving health care service, and having screenings done (efficient data sharing of lab results, hospital and emergency room reports).

We have expanded our clinic staff and hours of operation, so access to same-day and next-day appointments is available through a walk-in clinic for LNPLC patients six days per week, and an availability of same-day appointment bookings, every day.

Communication with the Thunder Bay Regional Health Sciences Centre remains open, so that emergency department, and admissions/discharge data is available for our patients and we can follow-up as necessary. We commit to follow-up with these patients as soon as possible after this encounter, as appropriate. All patients discharged from hospital are telephoned by the clinic RN the following week, and booked in for an appointment as needed.

Revisions to our patient survey for 2017-2018 focus on patient engagement and involvement in decision-making about their health, with an online/tablet survey having been rolled out last year. We consolidated our survey from four pages to one page, still collecting all of the QIP metrics, but dropping extra data that was repetitive. Expectations are for continued stellar results being obtained for a sixth year in a row.

Population Health metrics have decreased slightly after achieving high results in the past. We are accepting many more patients, so as we get them up to date on screening, we anticipate that these will return to their targets. New this year is a screening for HbA1C levels in diabetic patients over 40. Baselines have been established for these measures with diligent work done by our administrative and reception staff in capturing these stats in our EMR and querying the results.

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

We are proud of the great work done by our Quality Improvement Committee, and all of the clinic staff in implementing the many improvements resulting from this QIP.

The greatest change was an implementation of expanded clinic hours which increases access substantially. We received funding through our Annual Operating Plan from the MOHLTC for two additional NPs, and support staff. We've hired the staff and opened two evenings per week – to 8:00 PM, and also on Saturday from 10-2. This increases our walk-in access from two days a week to six days a week. We also are able to book appointments in the evening on Tuesdays and Thursdays. This allows patients to access the clinic any time, so despite the survey question not clearly collecting the true access for same-day and next-day appointments, it is now available to all patients.

The Registered Nurse continues to conduct follow-up calls with all patients discharged from hospital, and we are booking them with their provider as appropriate. Focus has been drawn to booking consultations with the pharmacist for

medication reconciliation for those patients who have been discharged and any changes made to their medications.
The pilot data transmission project with TBRHSC which sends admission and ED presentation data, real-time into our EMR for NPs to review continues. This is going well and is a great evolution of data sharing.

Using our EMR, tasks have been set up to generate reminders for every screening as it comes due for patients. The RPN, admin staff and medical receptionists are proactively calling patients as their screenings are due, to inform them to have the test done at the appropriate service location, or come to the clinic for an appointment if appropriate. This has kept us on top of all cancer screenings for our patients. While the results are based on patients following through with their screenings, we have done our due diligence in informing them that screenings are due.

Our same day appointments continue to be used more and more, trending upwards year over year from 100 in the 1st quarter of 2013-2014 to a new high of 327 in the 2nd quarter of 2017-2018 Our walk-in clinic visits remain steady as well, and we are glad to offer this increased access for our patients, and we continue to work to reduce any wait time to get an appointment. We anticipate these numbers to continue to increase with the expansion of our walk-in clinics.

## Resident, Patient, Client Engagement

Our patient satisfaction survey includes a number of questions on engagement, and understanding of the plan of care and treatment options. "Please rate how well your clinician involved/engaged you in healthcare and treatment decisions to the level you would like?" obtains excellent feedback, and feedback on program development and delivery is also collected from program participants. There is also a comments section for additional feedback.

We monitor our email and Facebook site which receives feedback as well, and respond to any messages arriving that way. Directly calling or contacting the clinic is also done by patients, and we respond that way as well.

The idea of having a patient engagement group has been discussed and tabled with the clinical staff as well as the Board of Directors, but has not yet been implemented. We continue to look at feasible ways to implement this.

## Collaboration and Integration

Continuity of care across sectors can be largely driven by a positive and accommodating primary care experience. Our clinic continues to focus on reduction of unnecessary Emergency Department visits, and hospital readmissions, and minimizing the use of outside walk-in clinics for conditions best managed elsewhere. Our clinic now offers six walk-in clinics per week (expanded from two), and has expanded same-day appointment access. By seeing their regular provider when needed, patients are able to experience greater continuity of care and avoid repeating their health concerns to multiple providers or organizations. The potential for miscommunication of pertinent health information between organizations is also reduced.

This QIP aims to further focus on increasing integration and information sharing with other health organizations. Our patient satisfaction survey collects data on how patients feel the clinic assisted them in coordinating care across the health care system with pharmacies, labs, and specialists, with excellent results.

We continue to improve information sharing with the Thunder Bay Regional Health Sciences Centre, yet face a number of barriers in collecting some of the QIP metrics which require data sharing around re-admissions etc. We are glad to see

the elimination of the flu-shot data which was difficult to collect when given at other settings.

## Engagement of Clinicians, Leadership & Staff

This QIP is subject to approval by the Lakehead NPLC Board of Directors, and to quarterly review and evaluation by a Quality Improvement Committee, established in March 2013. The Quality Improvement Committee is represented by a member from each of the Board, the executive committee, and of the clinic staff (+ alternate for each). Quarterly updates are made to the Board of Directors, and any necessary steps are taken to ensure that quality care, patient safety, and privacy are considered as overarching decision criteria. The QIP Committee regularly monitors ED use, Same-Day and Walk-In Clinic use, time to third-next-available for each provider, patient satisfaction feedback, and population health screening stats.

Clinical staff and administration staff are engaged in all operational changes in order to reach our QIP goals, and other modifications as recommended by the Quality Improvement Committee as described above. Updates in data collection, administration of patient surveys, and re-focused patient education are things that we continually discuss among the entire clinic staff. Our Board of Directors is familiar with the challenges faced by the clinic, as described above. The Board helps to direct advocacy initiatives to help mitigate these challenges.

## Population Health and Equity Considerations

Our clinic serves patients across the lifespan, so the demographics are wide. Patients in this LHIN reportedly have higher rates of chronic conditions like diabetes, COPD, as well as higher rates of smoking, alcohol use, and overweight populations. However, our clinic does not target any specific population in accepting patients, so it would be representative of our region. Our programming to date has focused on these illnesses.

We do, however, spend abundant efforts on tracking and reporting on colorectal and cervical cancer screening rates, and now HbA1C screenings for diabetic patients.

We have facilitated a number of immunization clinics for flu shots, childhood immunizations, and shingles vaccinations for eligible patients.

We do not specifically target any groups, but our community support initiatives have been aimed to target more marginalized areas of the city. We do partner in some shared services with NorWest CHCs in Thunder Bay, which does more focused targeting of vulnerable populations.

## Access to the Right Level of Care - Addressing ALC

Diversion from the Emergency Department for patients who do not actually require emergency services is very important. Aside from manually producing lists of patients who present to the ED every month to the lead NP, and in turn to each primary care provider, we can address individual patients who are high users, or inappropriate presentations for emergency services when they could be best managed elsewhere.

We've been made aware of a significant shortage of personal support workers, and there is an inability to open 64 long-term-care beds in Thunder Bay because of the inability to provide staff to operate them. Finding PSW staff to work here would immediately alleviate a number of patients who are occupying beds in the TBRHSC who should not be in that facility.

There is more that needs to be done, but it is beyond our organization's role. For example, a second stream for non-urgent presentations and primary care needs must be established in the emergency department which is staffed by salaried providers and not billed as a fee-for-service emergency visit. For example, patients are

directed to return to the ED for regular IV antibiotics administration multiple times. There is also a significant population in Thunder Bay who access the emergency department on a daily basis, with charts and bills being created every time. This is not appropriate to be dealt with in the ED, but the lack of another avenue results in this being used. It is a terrible waste of resources when fee-for-service bills are created for non-emergency presentations. A salaried model to address these 'urgent care' patients would be very beneficial in terms of costs, and patient experience.

## Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Being the first year where Nurse Practitioners can prescribe controlled substances, extensive training was done with all NPs around this practice. All NPs became certified in prescribing controlled substances, and we developed a contract to be signed by any patients being treated with controlled substances.

All providers follow the 'Treating Chronic Pain, Our Shared Responsibility' guidelines from Responsible Use of Opioids. We optimize non-opioid pharmacotherapy and non-pharmacological therapy, rather than a trial of opioids. This applies to all controlled substances.

## Workplace Violence Prevention

In the past, Ontario Ministry of Labour was on site to perform a health & safety audit. From that process, we implemented a workplace violence & harassment policy and training. We also have standard Occupational Health & Safety policies that all staff and students review upon working with our organization.

Additional Policies include an Workplace Violence and Harassment Prevention Protocol, encompassing the individual policies and procedures related to a safe environment.

We have a Health & Safety committee made up of staff members who conduct regular walk-throughs of the clinic to identify any risks that need to be addressed.

## Contact Information

Kyle Jessiman, MHA, HBComm
Clinic Administrator
Lakehead Nurse Practitioner-Led Clinic
101 - 325 Archibald St. S
Thunder Bay, ON P7E 1G6

T: (807) 475-9595
F: (807) 475-9797
kyle.jessiman@lnplc.ca

http://www.lnplc.com/

## Other

Challenge, Risks & Mitigation Strategies:

It is a challenge to get an accurate reflection of the access provided for same-day and next-day appointments. It is understood that our survey question asking if a patient "waited longer than expected to see their provider", is subjective, the existing question to capture if the patient was seen on the same-day or next-day is worded in a confusing way. Ninety-one percent of respondents claim not to have waited longer than expected for an appointment. The survey question for this metric does not account for patients who were offered same or next day, but chose to take a later appointment due to their own availability. We hope that this is cleared up with either better wording, or a new metric to accurately reflect the access we're providing.

An ongoing challenge continues to be in capturing accurate screening rates for the metrics under 'Population Health'. While we perform and order many of these procedures with our patients at their clinic appointments, Cancer Care Ontario does not provide a Screening Activity Report to Nurse Practitioners at NPLCs as the patients are not 'rostered' in an enrolment model through OHIP. This is a significant barrier to continuity of care and follow-up for our patients, and we will strongly advocate for change in this structure sgain this year.

In addition, having an official 'roster' of patients, linked to the primary care provider (NP in our case) will eliminate the patient attrition we experience due to Health Care Connect's lack of integration with NPLCs. Currently, patients of our clinic who had signed up with Health Care Connect continue to be contacted by the service, with the expectation that they must 'find a doctor'. This structure fails to recognize the NPs as the patients' primary care provider, and undermines the access and excellent care provided at our clinics. Again, having patients enrolled and connected to the NP will alleviate this.

A final note on having a 'roster' – While we've made notable improvements in the information flow with the Thunder Bay Regional Health Sciences Centre, capturing patients admitted and discharged from the hospital, there are still instances when we are unaware that a patient has presented at, or is currently admitted to the hospital. If a patient fails to inform the hospital of their NP primary care provider, or if the hospital fails to capture this info, it is not passed on to the responsible NP. Hopefully, enrolled patients would have the primary care provider linked through their OHIP number, and this information would flow directly through these channels without being missed. Patients have the right to this type of continuity and follow-up. Their most responsible provider must have knowledge of what is going on. This will be one of our primary points of advocacy with the MOHLTC and our member associations this year. Physicians who are sending reports back to the NPs at our clinic are also uninformed about the primary care provider role that the NPs are providing for the patients, and this shows that further education is required for these physicians.

## 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 Trina Diner _____ (signature)
Quality Committee Chair or delegate Calvin Pelletier _____ (signature)
Executive Director / Administrative Lead Kyle Jessiman _____ (signature)
Other leadership as appropriate Pam Delgaty _____ (signature)