Timmins FHT Quality Management Work Plan 2014-2015

- The ***TFHT Quality Management Workplan*** is to be used with the ***TFHT Board & ED Workplan*** as well as the ***TFHT Administration Workplan*** that identifies target timeframes for activities listed.
- Reporting on the ***TFHT Quality Management Workplan*** will be completed on the ***TFHT Data Report Dashboard***

Reference Documents:

1. TFHT 2013/14 to 2017/18 Strategic Plan
2. TFHT 2014/15 Quality Improvement Plan
3. TFHT 2014/15 Service Plan – Schedule A
4. MOHLTC FHT Accountability Reform Application
5. OHA Current Governance Process & Policies Checklist

STRATEGIC DIRECTION	STRATEGY STATEMENT	STRATEGIC INITIATIVE	OUTCOME MEASURES (TFHT Quality Improvement Plan)	PERFORMANCE MEASURES (TFHT Service Plan Schedule A)	ACTIVITIES (TFHT Strategic Plan)	SUCCESS MEASURES (TFHT Strategic Plan)	DATA SOURCES
1. Access and Care Transitions	**Enhance patient access to the care team and facilitate a collaborative care experience.**	**Develop internal strategies to provide timelier patient access to the care team.**	1. 80% of patients will be able to see a doctor or nurse practitioner on the same day or next day 2. Patients without a PCP will decrease by 20% in Timmins, based on the number of patients registered with Health Care Connect. 3. 50% of TFHT patients discharged from hospital will be assessed by their PCP within 7 days of discharge.	Discharge Planning 1) 75% of patients discharged from hospital will be contacted and will have health status assessed within 72 hours of discharge notification. 2) 50% of patients discharged from hospital will have an appointment with the PCP within 7 days of discharge notification.	Evaluate scheduling practices of all care team professionals to ensure they are responsive to patients' needs (i.e., extended hours, after hours, weekend hours).	# of patient encounters by IHPs # of patient encounters in WIC	Staff Portal WP FHN
					Consider means of expanding patient access by providing more primary care and/or supportive services on-site and off-site (for example expand diabetes programming offered on-site and increase on-site laboratory services, etc.).	# of patient encounters by Home Visit # of patient encounters by telephone visit # of patient encounters by telemedicine # of patient encounters on-site by expanded programs (eg. DEC) # of new positions/programs established # of new physicians to TFHT	Staff Portal OTN Report Specific Programs ED Board Reports
					Improve upon system navigation practices from patient, care team and clerical perspectives (i.e., referrals to care team, to OTN and Telehomecare, to wellness programs, to chronic disease programs, to renew medication, web-based referrals, etc.).	# of patient referrals to Integrated Health Professionals # of referrals to Telehomecare # of referrals to Health Lifestyles Sessions	Staff Portal CCAC

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		Enhance access to care for patients with complex needs and the senior population.	1. 70% of patient population over age 65 will receive influenza immunization.		Lead the development of a business plan for the Timmins Health Link Partnership.	Acceptance of Business Plan by MOHLTC for Health Link Initiative	HL
					Enhance linkages with area health care providers and develop a more responsive continuum of care.	Participation on Palliative Resource Team Participation on Regional Geriatric Group Participation on NESGS Steering Committee	Meeting Minutes
					Collaborate on the development of strategies to alleviate systemic pressures (i.e., ED volumes, ALC rates, high needs/complex population, etc.).	Participation on TADH ALC Committee Track and Assess ED Visits for TFHT patients	Meeting Minutes TBD
					Enhance preventative care and discharge planning strategies for complex/high needs population groups (i.e., palliative care, geriatric care, diabetes care, etc.).	# of patient follow-ups post discharge # of patients with HL assessments completed	TBD
					Explore means of addressing the needs of orphaned patients with complex care needs (i.e., frail elderly, palliative, multiple chronic conditions, etc.).	# of patients rostered with TFHT # of new patients rostered # of new patients rostered who have complex care needs	Patient Roster Report TBD – Sites
		Develop more consistent linkages among (external) partners in care to facilitate the timely flow and sharing of patient information.	1. 50% of patients identified as high users of the health care system and those who are high risk will be assessed by their PCP and care team within 7 days of identification.		Establish a more prominent and defined role as the point of contact for communication regarding patient care transitions and system navigation for both patients and partners in care.	# of collaborative partners with whom the TFHT works # of service integration agreements established	MOHLTC ED Office
					Review processes and tools used to facilitate the sharing of information, isolate needs and develop an implementation plan. Include all key service providers (i.e., hospital, laboratories, CCAC, community support services, mental health and addictions, etc.).	# of agencies with whom formal patient referral pathways are established # of agencies with whom meetings were held to discuss improving information flow and patient flow processes List of agencies to be included	ED Board Report MOHLTC Report

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					Develop protocols and identify common clinical screening tools for collaborative care arrangements.	# of clinical screening tolls reviewed with external partner agencies	TBD
		Enhance access to primary care by ensuring that the care team is using its full scope of practice.	1. Patients seen by TFHT IHP's will increase by 10%.		Ensure the enhanced scope of practice of NPs, RNs, and pharmacists are fully integrated within the model of care (role refinement and training to fully implement the model of care).	# of positions for whom the scope of practice was enhanced # of professional development sessions held to enhance knowledge and skills of IHP position	ED Board Report Staff Portal
					Help change patient expectations by referring to the most appropriate care team member.	# of patient encounters in IHP led clinics # of responses received on patient feedback questionnaire where patients were satisfied with care received	Staff Portal Pt Feedback Summary QIP Report
					Ensure that patients have access to test results without having to see the PCP unnecessarily.	# of test results provided by IHPs # of test results provided by IHPs in office # of test results provided by IHPs by phone	Staff Portal
2. Quality Outcome Based Services and Programs	**Deliver quality outcome-based services and programs, and empower individuals to be more engaged in their health and wellness journey.**	**Develop data standards and internal capacity to analyze electronically patient profiles, and clinical information across all sites.**	1. 75% of patients will state that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) give them the opportunity to ask questions about recommended treatment. 2. 85% of patients will state that when they see their doctor or nurse practitioner, they or someone else in the office		Develop supports internally first then work collaboratively on implementation.	% of programs for which evidence based outcome measures are identified # of new EMR tools developed in order to track primary care data # of EMR tools implemented	MOHLTC QM Report
					Address quality control concerns and ensure that data can be linked to key indicators and outcome measures.	% of programs that have outcome measure data available	QM Report
					Provide staff training and education to ensure that they have the skills to maximize EMR functionality.	# of staff educations sessions provided to review data collection through EMR	Staff Portal

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			(always/often) involve them as much as they want to be in decisions about their care and treatment. 1. 90% of patients will state that when they see their doctor or nurse practitioner, they or someone else in the office (always/often) spend enough time with them.		Develop capacity to gather and analyze information via the EMR on the linguistic, cultural and accessibility needs of patients.	# of patients for which linguistic, cultural and accessibility information is recorded in EMR	TBD
					Use the patient profiles to design strategies that incorporate identified needs into organizational and clinical practices.	# of patients invited to participate in program activities based on needs identified through the EMR	TBD
		Review chronic disease management programs, processes and outcome measures.		Asthma 1) 50% of patients with Asthma will have documented self-management goals in the EMR. 2) 80% of patients over the age of 18 with asthma will report that they are not currently smoking at their most recent visit. CHF/Cardiovascular Disease 1) 50% of patients with CHF will have documented self-management goals in the EMR. COPD	Assess patient needs on an ongoing basis.	# of patient encounters in IHP program areas	Staff Portal
					Provide patients with self-management support.	# of patients with identified self-management goals in the EMR # of patients who attended the Chronic Disease and Chronic Pain Self-Management Sessions	EMR Search
					Identify program objectives and outcome measures.	% of programs for which there are established objectives and outcome measures	Program Protocols ED Board Report
					Work with IT to ensure that data can be inputted/extracted/analyzed/summarized using EMR.	# of EMR tracking tools developed through QIDSS # of EMR tracking tools implemented	QM Report

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				1) 80% of patients over the age of 18 with COPD will report that they are not currently smoking at their most recent visit. 2) 80% of patients over the age of 18 with COPD will have influenza vaccine in the past 365 days.	Develop and implement tools or a mechanism to assess the patient's experience.	# of patient feedback questionnaires completed # of patient feedback questionnaires completed at each TFHT site # of questionnaires completed on paper and on-line # of Patient Discovery Interviews completed	Pt Feedback Summary TBD

				3) 60% of patients over the age of 18 with COPD will receive pneumococcal vaccine. 4) 50% of patients over the age of 18 with COPD will have a documented chronic disease management plan that includes self-management. Diabetes 1) 0% of patients age 50-74 with diabetes will have an acute MI in the past 12 months. 2) 0% of patients age 50-74 with diabetes will have an above or below-knee amputation in the past 12 months. 3) 0% of patients age 50-74 with diabetes will begin chronic dialysis in the past 12 months. 4) 0% of patients 50-74 with diabetes will be diagnosed with retinopathy in the past 12 months. 5) 0% pf patients age 50-74 with diabetes will have one of the following: acute MI, amputation, begin dialysis, retinopathy, in the past 12 months. 6) 75% of patients 20 or older with diabetes will report having an eye exam in the past 24 months. 7) 80% of patients 20 or older with diabetes will have at least two HbA1C in the past 12 months. 8) 80% of patients age 20 or older with diabetes will have cholesterol screening in the past 36 mnths. 9) 80% of patients 20 or older with diabetes will have a foot exam in the past 12 months. Geriatric Dementia 1) 15% of patients between 75 and 80 will be screened using MMSE. 2) 20% patients in the geriatric dementia program will be reviewed through the interdisciplinary care management clinic.	Ensure that information gathered is used to inform service and program planning and to make improvements to clinical and organizational practices.	# of program discussions held that incorporated feedback from patient feedback questionnaires	QM & Mgmt Minutes

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				Hypertension 1) 50% of patients 18 or older will have BP measured in past 15 months 2) 90% of patients 18 or older with hypertension will have BP recorded in the past 12 months. 3) 50% of non-diabetic patients 20 or older with hypertension, will have a BP less than 140/90. Anticoagulation 1) 100% of RNs will implement the anticoagulation program who have attended training; in adherence to medical directive Mental Health/Child Psych 1) 250 patients referred by PCP will receive psychometric and psychological testing through NEOFACS. 2) 75% of patients referred to MH program will receive a SW visit within 1 month of referral. 3) No more than 10% of patients will be no-shows.			
		Review health promotion programs, processes and outcome measures.		Periodic Health Exams/Cancer Screening 1) 80% of female patients 18 to 69 who have not had a hysterectomy will have a Pap test in the past 36 months. 2) 75% of female patients 50 to 75 who have not had a mastectomy will have a mammogram in the past 24 months. 3) 70% of patients 50 to 74 will have FOBT testing in the past 24 months	Assess patient needs on an ongoing basis.	# of patient feedback questionnaires completed # of patients attending healthy lifestyle sessions	Pt Feedback Summary Staff Portal
					Provide patients with self-management support.	# of patient encounters with Health Promoter for self-management coaching	Staff Portal
					Identify program objectives and outcome measures.	# of TFHT program protocols revised # of TFHT program protocols implemented	QM Meeting Minutes

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				OR a colonoscopy/sigmoidoscopy in the past 10 years. Healthy Lifestyles Sessions 1) 90% of patients will indicate a high level of satisfaction with healthy lifestyle sessions. 2) 10 daytime healthy lifestyles sessions will be offered 3) 10 evening sessions will be offered. Immunization 1) 70% of patients 65 or older will have flu shot in past 12 months. 2) 70% of patients 65 or older will have pneumococcal immunization.	Work with IT to ensure that data can be inputted/extracted/analyzed/summarized using EMR.	# of EMR tracking tools developed through QIDSS # of EMR tracking tools implemented	QM Reports
					Develop and implement tools or a mechanism to assess the patient's experience.	# of patient feedback questionnaires completed # of patient feedback questionnaires completed at each TFHT site # of questionnaires completed on paper and on-line # of Patient Discovery Interviews completed	Pt Summary Report TBD
					Ensure that information gathered is used to inform service and program planning and to make improvements to clinical and organizational practices.	# of program discussions held that incorporated feedback from patient feedback questionnaires	QM & Mgmt Minutes

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				Nutritional Counselling' 1) Less than 60% of patients 18 and older will be overweight or obese according to BMI. 2) 60% of patients seen for weight management will have a decrease in BMI. 3) 60% of patients 12 or older, seen by the RD will report consuming fruits & vegetables five or more times daily. 4) 60% of patients 12 or older, seen by the RD will report moderate activity level. 5) 85% of patients 12 or older, seen by the RD will have self-management goals identified. Smoking 1) 100% of patients over 18 will have smoking status documented in the EMR. 2) 50% of patients will have self-management goals documented in the EMR. Well Baby, Well Child 1) 100% of patients age 7 will have received recommended primary childhood immunizations. 2) 100% of patients 6 or younger will have a completed Nipissing Development Screen. 3) 100% of patients age 6 or younger will have completed Rourke Baby Record.	Extend wellness efforts to include partners in care, community agencies, and the private sector.	# of patients participating in health lifestyles sessions who are non-TFHT patients	Staff Portal

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3. Organizational Capacity	**Ensure that the organization has the infrastructure and resources in place to fully implement and evolve the collaborative model of care.**	**Advocate for (secure) funds to hire a human resource professional.** ***Note that the following are HR tasks/functions that need to be addressed whether an HR professional is in place or not.***			Implement HR best practices.	# of components if HR Downloads utilized # of consultation sessions with HR lawyer # of HR outcome measures developed # of vacancies in TFHT positions # of staff hired # of staff left Annual rate of turnover % of staff who can provided services in French # of staff who claimed STD # of staff who claimed LTD # of staff with WSIB claims # of staff on maternity leaves	ED/HR/Finance
					Define roles and responsibilities.	# of job descriptions reviewed and revised	ED
					Assess salary equity issues across sites and within the local health care system.	# of positions for which salary was reviewed # of activities undertaken in order to advocate for salary equity	ED/HR
					Address workload balance among staff/sites.	# of positions for which hours and/or workload was adjusted	ED
					Complete a human resource plan/succession plan.	Date of completion of human resource plan that includes succession planning	ED
					Develop a professional development plan/appraisal process for staff.	Date of completion of professional development plan # of performance appraisals completed	ED

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					Link performance appraisals/professional development to the achievement of the strategic plan.	# of performance appraisals for which the contribution of individual staff members to the achievement of the strategic plan is identified	ED
					Develop and implement tools to monitor employee experience and design supportive strategies to address issues identified.	% of staff who submitted their orientation evaluation % of students who submitted their orientation evaluation	HR
					Conduct employee 'exit' surveys to inform retention strategies.	% of staff who have been invited to complete an exit interview or form # of exit forms received	HR
		Improve internal communication and processes to ensure the timely flow of information and follow-up of identified actions/activities among care team members and across sites.			Revise committee structures and communicate objectives and progress (follow-up) across the organization.	# of functioning committees/groups # of functioning committees with terms of reference reviewed within the past year # of staff newsletters circulated # of staff meetings held # of FHT Days held	ED
		Review and plan for incremental IT enhancements.			Establish EMR organizational standards (all sites).	# of sites represented at IT Committee by an IT lead	Minutes
					Address connectivity (speed) issues that impact the exchange of electronic information.	# of PSS upgrades completed	IT Manager
					Identify technology-related education and training needs.	# if IT training sessions held	IT Manager

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					Review alternate means of booking appointments (i.e., on-line) and assess potential legal ramifications. Recommend a plan of action.		
					Implement one mail encryption (not a high priority).	# of staff registered for one-mail	TBD
		Address site specific privacy concerns			Develop a plan to address site specific privacy concerns relating to processes and office layout (issues identified for 101 mall site and 3rd avenue site).	Document changes made to address privacy at all sites	ED
4. Education & Excellence	**Support the professional development of the care team and future health care professionals. Lead the adoption of innovative practices and research initiatives that contribute to primary care excellence.**	**Identify professional development needs and provide opportunities for training and education.**			Identify individual needs via the performance appraisal process and ensure that they correspond to the needs of the care team/organization.	# of students supported through the TFHT; identify disciplines # of education sessions attended by IHPs % of staff who participate in professional development	HR Staff Portal
		Be an early adopter of innovative clinical practices and participate in quality improvement and transformation initiatives.			Identify key innovative practices and quality improvement initiatives for consideration.	# of patients seen through Health Link Initiative # of HL patients seen by TFHT staff	HL
					Encourage standardization of processes based on best practices and learning across sites.	# of referrals received from TADH of high user patients # of these patients who received in-depth assessment and case management by TFHT staff	HL
					Provide opportunities for staff to visit various sites to learn about different programs and processes and enhance inter-site collaboration.	# of meetings that included review of the practices implemented at different sites	Meeting Minutes
					Explore means of reducing PCPs' paperwork to ensure organizational capacity to take on a more significant role as system navigator.	# of initiatives that will reduce PCP paperwork # of patients for whom system navigation was provided by IHPs	IT Minutes Staff Portal

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					Promote excellence by disseminating information on key learnings and successes internally and externally.	# of issues of Monthly Measure distributed # of reports produced and distributed to staff # of repots produced and distributed externally to health partners	QIDSS
					Develop a Board Workplan to address progress with strategic plan, Board self-evaluation, Board Fiduciary functions, Governance policies and to progress organizational maturity through adherence to the MOHLTC's compliance Assessment	Board Workplan to be completed and presented to the Board in September 2014	All Reports and Minutes
5. Collaboration and Advocacy	**Facilitate the organization of primary care providers to enhance their ability to advocate as a sector and contribute to health system transformation.**	**Lead the development and implementation of the Timmins Health Link Partnership**			Details outlined in the business case.	# of meetings held of HL partners # of primary care education days held # of participants at primary care education days # of committees/groups attended on behalf of primary care	Health Link Reports, Minutes ED Board Report

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