



Quality Improvement & Innovation Partnership

Advancing Improvement in Primary Healthcare in Ontario

New FHT & NPLC Workshop

Mar 28, 2010





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Population Approach Proactive Care Patient-Centered Care Applying These Ideas to Developing Programs

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Objective

How to apply a population focus, with an emphasis on pro-active, patient centered care when planning programs.



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Defining

Population Approach

- Improve health of the entire population in an equitable way
- Looks at & acts upon broad range of factors/conditions that influence health
- Considers multiple determinants of health in program planning
 - *Public Health Agency of Canada*

Patient Centered Care

- Highlights patient concerns and need for information
- Seeks to understand pts perspective, the whole person (emotional needs & social issues)
- Finds common ground and aligns with the patient, enhancing the pt/clinician relationship and obtaining input to direct visits and programming
- *Patient-centered medicine: transforming the clinical method, Moira Stewart, Radcliffe Publishing, 2003*

Proactive Care

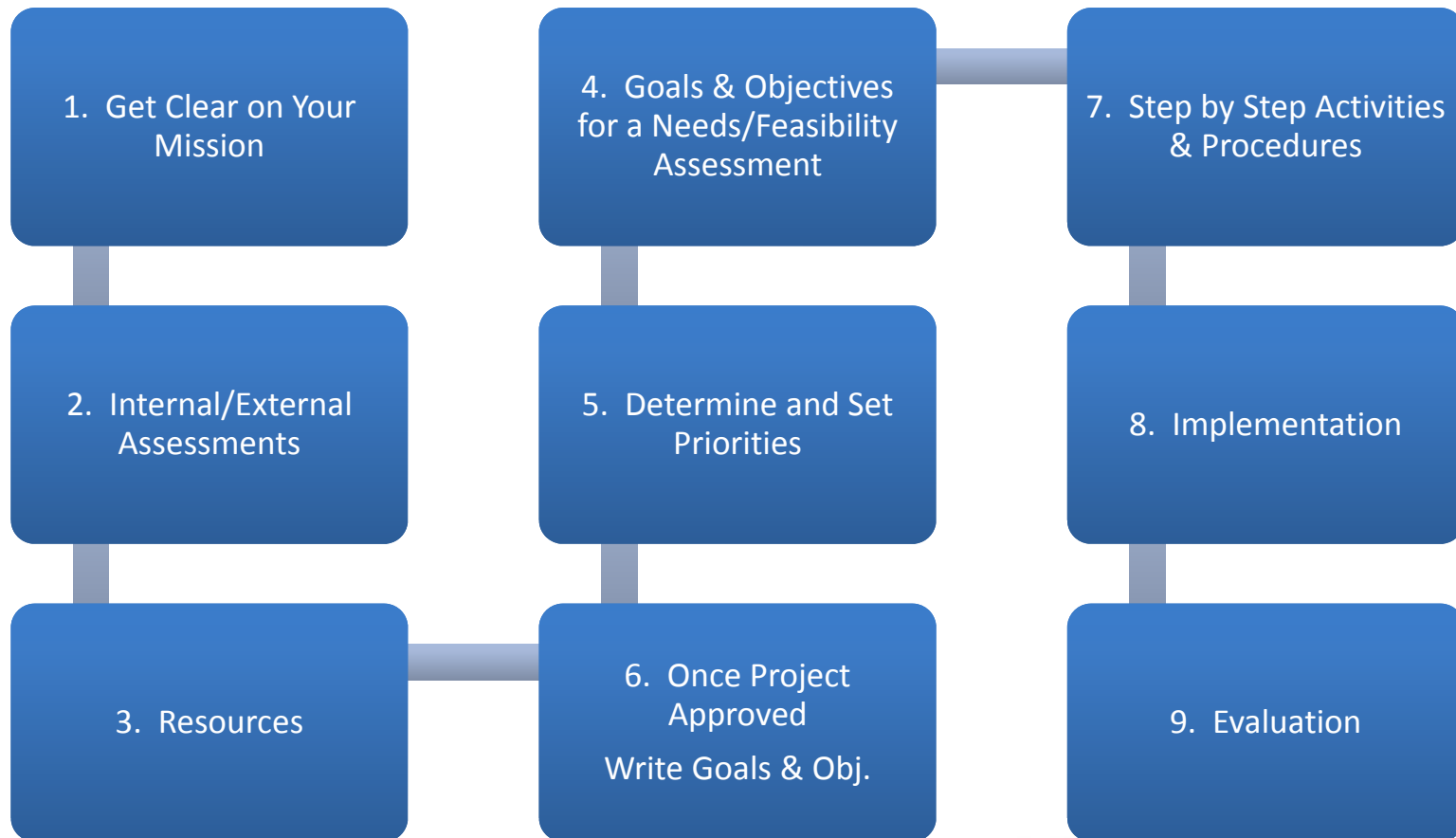
- Uses data to create automated, personalized pt interactions
- Initiates care before there is a need
- Manages chronic conditions in a more timely, effective manner, including patients as self-managers
- Strengthens the relationship by providing options & personalized interactions on their terms (email, phone, text)



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Program Planning Model



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Planning, Program Development & Evaluation: A Handbook for Health
Promotion, Aging, and Health Services, Thomas C. Timmreck



Determining Appropriateness

Is this program aligned with our mission?

Do we know the population/catchment area this will serve?

Do we have the ability to do this?

Who cares if program is done (who will approve development)?

Does the community support the project?

Are there any existing community resources?

Do we have the space, equipment, money, expertise?

Is the team motivated, committed and do they have the necessary competencies?

Has support been rec'd from Board, Employees, Community to explore?

Can anyone help us (partnerships, e.g. CCAC, Arthritis Society and Alzheimer's Society)?

Get Clear on
Your Mission



Internal/External
Assessment



Resources



Phase 2

Assessment & Approval

Perform a needs assessment to identify primary care & patient needs.

What would be the goal of a needs assessment or feasibility study
(e.g. to identify gaps)?

What type of assessment (e.g. survey, focus group)

How will instrument be developed?

Who will analyze and report on results?

Who will want to know the results (approval body)?

What are our priorities, link back to population health (biggest bang
for buck)?

Has program been approved for development (if yes, write program
goals & objectives with being patient centered as a goal)?

Goals & Objectives for
a Needs/Feasibility
Assessment



Determine and Set
Priorities



Once Project
Approved
Write Goals & Obj



Phase 3

Planning & Implementation & Evaluation

What needs to be done first (start small and build on successes)?

What processes need to be in place before others?

Should we develop a project plan (e.g. creating program charter)?

What are the tasks (purchasing, office space, hiring, budgets, policies/procedure, marketing)?

How can we meet our goals for care (e.g. to be patient centered)?

What needs to be done to implement the program (staffing – hire for specific skills/coordination)?

When do we plan to go live (e.g. open program to patients)?

How will we get immediate and ongoing evaluation and feedback on our program to ensure our objectives are being met?

Step by Step
Activities &
Procedures



Implementation



Evaluation



Applying a Population Approach When Program Planning

As part of your internal assessment,

- Familiarize yourself with prevalence of chronic conditions in Ontario
- Build your FHT Patient Profile
 - Chronic disease case mix
 - Specialty areas
 - Demographics (e.g. homogenous or heterogeneous, gender, age, socio economic/education status, etc.)
 - Assess ethnic/cultural groups served
- See if Ontario prevalence similar or different (may provide clues on programming planning focus)
- Direct your Needs Assessment toward different populations to identify gaps

eMR is KEY

- **Create Health Information Committee early**
- Be innovative in your methods to classify patients with chronic conditions
- Aim for consensus Re: data entry and measurement of indicators
- Create registries for pts with asthma, COPD, diabetes and hypertension
- Program Charters (everyone aware of program entry, tx and discharge)
- QIIP or CIHI for measures/benchmarks
- Pharmacist medication searches



Applying Patient Centered Care When Program Planning

For step by step activities or implementation tasks consider how to,

1. Respect patients' values & needs by including them in planning for appts
2. Identify activities to empower patients
1. Consider socio-cultural competence
2. Coordination and integration of care
1. Patient communication methods
1. Clinicians discuss with patient their preferences, goal setting & action planning
2. Peer Support Group, waiting Rm Pt medication reviews, mental health education toolkits, diabetes passports
3. Languages spoken by staff, Google for translation, diversity program discussed
4. Clinical problem solving and interdisciplinary case consultation as part of regular team and clinical meetings, OTN for remote site, PRO Access, psychiatry in suites
5. Website, patient survey, newsletters, flyers, patient information boards

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Applying Patient Centered Care When Program Planning

For step by step activities/implementation consider how to,

- | | | | |
|---|---|-----|--|
| 6 | Feedback and measurement processes | 6. | Involvement of team in QIIP, patient satisfaction surveys, wellness surveys |
| 7 | Patient/family involvement | 7. | CMCC (moving towards collaborative model with pts/family involvement), family therapy |
| 8 | Staff development | 8. | Infusing chronic disease self mgt philosophy into FHT/Motivational Interviewing |
| 6 | Involvement in pilots promoting collaboration | 9. | FHT RN COP – defining/discussing role, IMPACT for pharmacist integration and complex elderly care, BETTER Research Project, etc. |
| 6 | Integration into FHT operational structures | 10. | Incorporate into daily operational practices (e.g. performance, safety, planning) |



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Applying Proactive Care When Program Planning

1. Enable patients to take a more active role in their care. E.g. surveys, focus group for seniors programming
 1. Strive to have treatment tailored to their needs; easier to do with multidisciplinary team
 1. Develop relationships that are coordinated, ongoing partnership
 1. Leverage eMR to achieve proactive care goals.
1. Teach patients how to do this (e.g. understanding what tests they should have regularly, learning to keep track and ask right questions)
 2. By researching/discussing and networking about the variety of tx options and allowing staff to try different tx options
 3. Allow a variety of communication mechanisms (e.g. email, telephone, one-on-one)
 4. Automated pt appt reminders/eMR sending emails, merging pt population lists with letters



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Small 'P' – Programs

Program that are integrated into office routine

- Smoking cessation counseling (RNs)
- INR point of care anticoagulation (pharmacist)
- Well woman care (RNs)
- 'Ouchless' Immunization (RNs)
- Advanced Access



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Group Programs

- Stanford Chronic Disease Self Management
- Bereavement Support Group
- Psychotherapy
- Craving Change
- Diabetes Do It Yourself
- Cognitive Therapy
- Meditation Wellness
- Multiple Family Therapy



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Multi-Disciplinary

- Diabetes Clinic
- Hypertension Clinic
- Asthma Clinic
- Endocrinology Clinic
- Complex Medical Care Clinic



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Large Scale 'P' – Programs

<http://taddlecreekfht.on.ca>

Taddle Creek
Family Health Team

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1-866-553-7205

AFTER HOURS CLINIC

Date: Wednesday, Sep 15 2010
Time: 5:00 pm to 8:00 pm
Location: [Office of Drs. Hirsz, Valentinis, Shaw & Biancucci](#)
Telephone: 416-591-1222
Clinic Dr.: Abraham Hirsz

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TADDLE CREEK FAMILY HEALTH TEAM

Taddle Creek Family Health Team is an innovative, collaborative way of providing primary health care to residents of Toronto and surrounding area. This team approach brings together family physicians, nurse practitioners, registered nurses, a pharmacist, dietitians and social workers in order to coordinate the best patient care possible. Click on one of the programs below to learn more.

CARDIOVASCULAR PROGRAM

Learn More

RESPIRATORY CARE PROGRAM

Learn More

DIABETES EDUCATION PROGRAM

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MENTAL HEALTH PROGRAM

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HIV

HIV PROGRAM

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HOMECARE PROGRAM

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METHADONE MAINTENANCE PROGRAM

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PEDIATRIC HEALTH MAINTENANCE PROGRAM

Learn More

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In Summary: Program Tools

1. Program Goals
2. Annual Goals – review your strategic plan
3. Program Charter
4. Referral Form –important to get consensus on plan
5. eMR Documentation
6. Pt Satisfaction Survey
7. Wait List Mgt – what to do about success
8. Group Ed./Tx – Considerations & Best Practices
9. External Resources/Toolkits
10. Website



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