**SMITHS FALLS NURSE PRACTITIONER-LED CLINIC**

**ANNUAL REPORT**

**October 01 2012 – August 31 2013**

Pursuing health promotion, illness prevention and chronic disease management through exemplary comprehensive patient-focused primary health care services.

**Message from Nancy Unsworth, NP-PHC**
**Executive Director**

This report covers the period Oct 1, 2012 to August 31, 2013.

The Smiths Falls Nurse Practitioner-Led Clinic provides comprehensive, accessible, and coordinated primary health care services to populations who have difficulty accessing a primary care provider (i.e. unattached patients) as mandated by the Ministry of Health. We continue in the pursuit of health promotion, illness prevention and chronic disease management through exemplary integrated holistic patient-focused care. Our clinic delivers interdisciplinary collaborative care with this year's focus centered on the patient experience within a seamless system of care. Patients are easily able to access all our care providers (nurse practitioners, nurses, dietitian, social worker and pharmacist). This allows us to care for each individual as an integrated community with much expertise and experience. To elaborate on this, we have networked within our system to create patient care pathways to ensure the right care is given at the right time by the most appropriate provider be it in house or within our community (i.e. in-house programming, Rideau Valley Diabetes Services, Tri-County Mental Health and Addiction Services, Ontario Works, Ontario Disability Program and the Perth And Smiths Falls District Hospital). Most importantly, the patients themselves have participated and become vested in this transformation as they experience our model of care with Nurse Practitioners being the primary care providers.

**Primary Health Care Model of Collaboration**

At the Smiths Falls Nurse Practitioner-Led Clinic, we have experienced a melding of professional practices as we have developed into a cohesive holistic health care team. The patient experience is paramount and we have put emphasis on patient empowerment as collaborative care partners vested in their own optimal health care outcomes. Interestingly enough, 15% of our patients' self-report poor general health, 67% surveyed indicated fair health status and 18% felt their health was excellent. From the providers' point of view, the chronic diseases of diabetes, hypertension, dyslipidemia and COPD are prevalent among our patient population. Many of these complex patients have been without a primary care professional for some time. We have successfully hosted our first Chronic Disease Self-Management Program, with very positive patient feedback. We will be offering this program again in January and anticipate a high level of patient interest. Also of note from our patient surveys is the accessibility of care with our advanced access for the purposes of scheduling and efficiency. The patient experience of being seen in a timely fashion noting same day visits as exceptional service is proving to be very successful.

**Strategic Plan & QIP**

The past year has been exciting as we have moved through client intake and managed demand variation proactively. The patient experience is paramount and continues as the main driver in all that we do. We continue with daily huddles, contingency planning and cross-training and

are now collecting data on caregiver panel size equation, 3rd next available appointment, post vacation strategies and cycle time. Our patient number has now reached 1582, in house and settled.

Our employee experience is also considered to be very important as we endeavor to share information and develop pathways of communication as patient care is integrated. We continue to create awareness regarding overall work processes, our Quality Improvement Plan, the patient satisfaction surveys, education, best practice guidelines and recognition for a job well done. It is a challenge to develop the clinic routines and advanced access recognizing the extended scope of practice of our registered nurses/registered practical nurses. Strong opinions and past experiences dictate a delicate weave as new practices are incorporated and our programming matures. We have just filled the last NP position as the clinic demand now dictates.

Program development has continued with fine tuning of our smoking cessation program as outcomes are benchmarked. This is in conjunction with our Quality Improvement Plan. We have also instituted our hypertension program, well-baby program, INR program, immunization program and are currently working on our prenatal program. We have developed many handouts for patient education and health promotion as well as in-house education.

Our Quality Improvement Plan was reviewed by Health Quality Ontario and we are happy to report that it was considered complete and we look forward to further benchmarking as data continues to accrue and undergoes analysis. The development of a robust QIP with ambitious improvement targets is a priority as we move forward with excellence in patient care and the ongoing development our programs.

***In Overview:***

March 31, 2013 was our first year end – everything has been submitted to the Primary Health Care Branch.

As of April 1, 2013 the Smiths Falls NPLC was moved to the Primary Health Care Branch from the Nursing Secretariat.

The clinic has been inundated with patient intake due to the closing of 3 physician practices. We are now working with our QIP coach to facilitate a group intake for those patients suitable and interested.

The clinic financials/expenditures 2012/2013 have been within the budgetary parameters as per our Evergreen Agreement.

The Ministry of Labor visited the clinic a few months ago noting an emphasis on education and accident prevention from July to September for new and young employees. Our representative

was pleasantly surprised at how much development had taken place during our first year – all our obligations were met in regards to Health & Safety.

We are happy to report we have renewed our policy for our employee benefit plan and have remained just under budget. We have purchased a bike rack for our cyclists which will be installed in the spring.

We have offered and participated in many ongoing educational events. We are a host to students from various disciplines, i.e. pharmacy, nursing and nurse practitioners.

We continue to work hand in hand with the Steering Committee of the Rideau-Tay Health Links.

**Acknowledgements**

We gratefully acknowledge the support given from Marilyn Butcher, founder of the first Nurse Practitioner-Led Clinic who continues to counsel us with wisdom and experience.