Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 14, 2024

Aurora·Newmarket Family Health Team

Ontario Health

OVERVIEW

The Aurora-Newmarket Family Health (ANFHT) Quality, Health and Patient Safety Committee (QHPSC) was established in 2013. The committee consists of an inter-professional team, including a retired Physician and active Coroner, who supports the FHT as Board Chair. We meet quarterly and at the call of the chairperson (s) for new initiatives, ideas, concerns and when reporting approvals are needed. These team based meetings, support our initiative to improving the set goals and objectives to meet our quality initiatives and targets that are set on an annual basis.

Each member works to establish their timelines and activities to meet the goals and objectives that are assigned to them, based on our annual QIP.

In the past, we reviewed MOH requirements and aligned our FHT obligations based on Schedule A of our Annual Operating Plan submission. Our portfolio was transferred from the Ministry of Health (MOH) to Ontario Health (OH) in October 2023. With new direction, we will continue to review, re-establish and enhance internal initiatives that have been set to meet our QIP. Our focus is to build on our previous year of goal setting and re-examine our timelines and plans to meet and/or exceed our overall goals.

Our team has continued to provide timely access to our services and programs and worked to integrate with our community partners to give our patients enhanced quality care.

Through evaluation, we decided that some of our groups and services we offer virtually would continue in this format, due to space capacity and the continued interest and participation from

patients to do so. For example our "Post-Partum Education (Baby and Me)" program has seen an increase in attendance through our virtual set-up, because new moms are comfortable with being able to participate from home. The team will be facilitating our Advanced Care Planning group based on a hybrid model to support both patients and caregivers and allow them the option to attend in-person or virtually.

We have always been "early adopters" on quality initiatives, such as timely access and integration. This allows comprehensive care with all health care providers and a demographic that has access to quality health care. Our team actively participates in OH/ICES Primary Care Practice Report (PCP) initiative. This data, feedback and information assists us in goal setting, strategic planning and communication with our key stakeholders.

As a team, we focus on utilizing our QIP and Schedule A as "living" documents. We have aligned the two quality tools to develop, enhance and capture the requirements of our internal initiatives.

By utilizing a Program Planning and Evaluation tool, we are able to re-examine our existing programs and services and re-establish targets and outcomes. During this exercise, our team captures new (and existing) programs and services that will complete and complement our vision and quality requirements. Throughout this annual mandate will determine what the needs of our demographic are and plan for our teams to offer efficient well-balanced programs and services. This year the focus was on revamping our programs and services to be successful for in-person, but also fit our new virtual landscape, while continuing to deliver meaningful, effective preventative health options to our patients.

Our goals and objectives for 2024-2025:

- Work with the Northern York South Simcoe (NYSS) OHT and community partners to engage in patient centered care and assist in navigation of the healthcare system to support population health management.
- Review and choose primary care indicators to track, that are mandated, useful and feasible. By utilizing the support from our Ontario Health Team, we will be able to identify community needs, supports and resources.
- Identify, evaluate, educate, train and make recommendations to support occupational health and safety, workplace violence and harassment awareness, with a focus on diversity and inclusion.
- Through our EMR, continue to identify and test platforms that can support the changing needs of our team and patients.
- By utilizing the "Choosing Wisely Canada" initiative, educate, inform and have conversations with our patients that lead to effective care choices that is best suited to their individual needs.
- Submit our annual Quality Improvement Plan (QIP) to Ontario Health, as part of our annual operating plan submission.

Through our work in quality, our Clinicians, IHP's and administrative team are able to support each other and support the patient in coordinated, comprehensive care.

ACCESS AND FLOW

The ANFHT continues to focus on maintaining and improving access and activities and to ensure patients are satisfied with provider availability and they are seen in a timely manner. This includes post discharge within 7 days "when appropriate", newborns within 48 hours, same day access and post ER visits for those patients who

require ongoing assessment.

Our team has been pro-active in seeing our patients post ER visit – those which were managed in the ER for 24-36 hours, and not admitted to hospital and require ongoing evaluation/re-evaluation. We are working on improving the tools, searches and leveraging our IHPs to help with follow up on a case-by-case basis.

The quality team is analyzing access through our phone system, identifying bottlenecks and ways to improve. This includes having our registered nurses complete triaging to support our clinicians. We have also implemented Online Booking for the providers through Oceans and our EMR.

Our OT works with Home and Community Care (HCC) and the patient (and their families/caregivers) to ensure that patients have appropriate care plans in place at home, including advanced care directives. Patients are also given resources and support in connecting with private care and respite in order to meet their needs.

Our team continues to act as an involved liaison with HCC, to improve coordination of community services for our patients. Both a HCC member and ANFHT member (OT) act as contacts for questions and concerns regarding the HCC process. Other strategies include updates on the patients currently on service with HCC, education on use of appropriate forms and referrals to HCC and also information on new services provided by HCC. We continue to work toward improving care transitions for our patients as they move across the health care system.

Strengthening partnerships within the OHT, local hospital, other care providers, home and community care and community agencies helps to facilitate better communication and support for our patients.

ADMINISTRATIVE BURDEN

Through the Oceans platform and Telus Health, we utilize the e-referral process, to alleviate the manual process of faxing and follow up. Our team has standardized and automated forms within our EMR to allow for easier access and utilization.

Online Booking for the providers through Oceans and our EMR has been implemented. As this service increases, we will include IHP's, so our patients have the ability to schedule follow ups and forms, notes and letters will be included to streamlining these processes electronically.

The demand from patients and expectations from stakeholders that Physicians and Health Care Providers are expected to maintain and provide is at an all-time high, including an overwhelming administrative burden. Our associated FHO has recruited a fifth Physician to their complement of 4 Physicians and have hired a 5th full-time Medical Receptionist to support the Physicians that are associated with our FHT, in order to keep up with growing patient demand and saturation of administrative requirements.

EQUITY AND INDIGENOUS HEALTH

Our team is planning improvements to our EMR to utilize PSS tools to capture social determinants of health (SDOH) and work on updating caregiver information. We agree that utilizing our Occupational Therapist to connect with patients will assist the clinicians with equitable care. A key goal for the ANFHT will be to complete team education and/or training to ensure we focus on SDOH and to collect the data we will need to develop programs and services. As a group, we are looking in to what alternative initiatives we will need to enhance this care. This will be a priority for the ANFHT and one of our goals and objectives for the upcoming year.

PATIENT/CLIENT/RESIDENT EXPERIENCE

By balancing the work we do on improving healthcare quality and patient safety, we work to distinguish between the physical needs of the patient in a safe environment and the external environment that can be an influence. By focusing on improving efficiency and productivity and ensuring that that they are involved in decision making, our goal must remain “patients who are engaged and at the centre of the circle of care”.

Our team works on patient engagement, through surveys, our website, groups and programs and one on one encounters. Data collection is a key initiative to ensure that effective data will drive our programs and service indicators. We will continue to measure patient feedback in regard to their involvement in decisions regarding their care.

Our website is kept up to date and our Quarterly Newsletter contains current information on new projects. Our goal is to release an informative document that can be shared with our patients on our progress as their primary care provider. Our annual QIP (once approved by our QHPSC and Board of Directors) is available on our website.

Our “Monthly Health Initiatives” Board has flyers that have information featuring our programs and services for the month. Each exam room has a flyer with relevant information on what our FHT offers.

Our “Information Station” in our waiting room displays our achievements and relevant policies and procedures, with a QR code that links to our patient survey.

Another information board in our waiting room is dedicated to community resources, information and activities.

All of our programs initiate a survey for patient feedback at the completion of the program. This is useful in evaluating our programs and enable change if warranted.

Our program delivery process that evolves and improves as each program is rolled out or conducted, is analysed with lessons learned and improvement ideas from our patients and participants. We have brought back programs and services in-person, with an option to utilize a hybrid model, where both virtual and in-person participants can be involved.

Through patient feedback and data, we were able to ensure our patients are benefitting and knowledgeable about the resources

that are available to them. Patient surveys are sent out on a monthly basis, with feedback through our scorecard. Issues/concerns are reviewed at our daily huddle and/or team meetings, with action plans put into to place if required.

Surveys are based on a sample of the patient population we serve. The statistics help provide metrics and targets that demonstrate how accurate our survey sample is. The confidence interval will help ANFHT interpret the data from our patient experience survey to ensure we are capturing information that we will utilize to make improvements and implement change.

When our team reviews our goals and objectives for the next fiscal year, we will start the conversation regarding patient involvement in our QI initiatives. Our team will investigate approaches to define the requirements that will encompass feedback and engagement of our patient population.

By participating as an anchor partner with the NYSS OHT, our team is involved in the planning and integration of the model(s) of care that will fulfill the mandate of Ontario Health. We work collaboratively with our partners on care coordination and patient navigation and care management. The OHT continues work on planning and deliverables, with a focus on aligning with the provincial direction, to meet the needs of the OHT populations. The recommended priorities are:

- Improve integrated care for seniors and those with complex needs
- Integrated clinical pathway for Heart Failure (CHF)
- Improve integrated care for those with mental health and addictions concerns
- Home Care Modernization/ Naturally Occurring Retirement Communities
- Develop palliative care pathway

PROVIDER EXPERIENCE

The entire ANFHT Team has maintained a professional, compassionate, respectful attitude toward each other and most of all to our patients/clients. Our associated FHO have hired a 5th full-time Medical Receptionist to support the Physicians that are associated with our FHT, in order to keep up with growing patient demand and saturation of administrative requirements.

Our team of Clinicians have incorporated online booking and messaging through the Oceans platform and our EMR. Our team works on our quality initiatives with the support from a QIDSS expert, who supports our administration with a monthly scorecard, ideas for improvement and best practices. Our Administrators work to ensure our programs and services, policies, procedures and improvements are kept up to date and new initiatives are implemented. We hold daily huddles, team meetings and an open-door policy for both clinical and administration for our team to come together on improvements and new ideas.

Although the demand on all clinicians, IHPs and our administrative team has increased, and at times is overwhelming, our team continues to meet expectations and produce excellent work and positive outcomes for the patients/clients.

We are looking for creative ways to reduce administration burden on Physicians and Health Care Providers and support their own health as they navigate the ever-changing health care environment.

SAFETY

The ANFHT has a written investigation protocol and an incident reporting policy. Our team has a risk management matrix that includes policies on conflict of interest, disruptive behaviour and a detailed harassment policy. We have defined “Emergency Codes” that outline which code represents an emergency that is called over the intercom system, and 2 mobile panic buttons that notifies our security company and police if necessary. All phone calls that become accelerated are referred to our Executive Director.

Our physical space is protected by shatterproof glass, with exit doors having the locking mechanism on the inside of the doors. One panic button is located at the front reception and the second in the Social Worker’s office.

Our exit doors are kept locked if there are less than 2 people in the office.

Our team has open frank discussions with regards to patient management. Our EMR is equipped with an emergency message notifier that alerts all active EMR users. Home visits are logged into our EMR, with patient information and who is attending the house call. The team is aware when a Health Care Provider is leaving/returning from a visit to ensure their safety.

Our team members are certified in Mental Health First Aid instructed by the Mental Health Commission of Canada.

Our QHPSC oversees our health and safety program, with a written policy that mandates our team comply with the requirements of the Ontario Occupational Health and Safety Act. Our Health and Safety manual outlines all appropriate health and safety standards, mandates implementation and is reviewed, and approved on an annual basis, or as required by the Ontario Occupational Health and Safety Act. We have a fire and evacuation plan that is tested annually.

Our entire team completes an annual review of our Workplace Violence and Harassment Prevention Policy. Everyone is trained on our Internal Responsibility System (Bill 132 and 168), WHMIS and each team member is First Aid and CPR/BLS certified. Each team member has also completed the Ontario Health and Safety Awareness training.

Our Health and Safety representatives complete detailed monthly checks that include equipment, office infection prevention and control. There is also a Health and Safety agenda item on our monthly team meetings.

We hold daily huddles, monthly team meetings, clinical meetings to support all team members. The Lead Physician and Executive Director meet weekly to discuss and review all operational requirements. Each employee receives a performance review and the Executive Director maintains an open door policy and one-on-one discussions at the request of any team member.

Our Board of Directors foster a safe environment for our employees and patients, with open door communication between all members.

POPULATION HEALTH APPROACH

Our Senior Administrator identified the excessive wait time for a local Allergist, and in consultation with the FHO group of Physicians, put in to place a service for an on-site Allergist to clear our existing backlog and to offer this service to the community, by integrating a process that community clinicians can refer and have their patients seen in an acceptable time frame (usually within 4 weeks). This referral process is available through the Oceans platform.

We have partnered with other primary care teams to merge or offer our programs to their patients, for example our "Eating the Mediterranean Diet Way" program is in partnership with a NPLC located in Georgina.

Our team collaborates on diabetes, cardiovascular, women's health management as well as 15 programs and 11 services that consider the needs of our patient population. Our programs are also designed around Preventative Health, for example, our STOP (Smoking Cessation) Program, which we partner with CAMH. We continue to collect and analyze data based on those targets.

We work with outside partners to achieve a "circle of care" for our patients. We utilize Southlake Regional Health Centre for partnerships in mental health care and palliative care programs and services.

CONTACT INFORMATION/DESIGNATED LEAD

Mary-Jane Rodgers
Executive Director
Aurora-Newmarket Family Health Team
531 Davis Drive, Suite 405
Newmarket, Ontario L3Y 6P5
Tel: (905) 898-2240 ext. 226
Fax: (905) 898-2253
Mobile: (289) 338-4497
Email: mjrodgers@auroranewmarketfht.ca
http://www.auroranewmarketfht.com/

OTHER

The ANFHT is registered to receive the Primary Care Practice Report, in which Ontario Health provides us with quality indicators related to our Family Health Team and our ranking. The report measures a range of indicators, including those related to our cancer screening, diabetes management and indicators required by Ontario Health.

Through our Annual Operating Plan, specifically our Schedule A document, we identify those programs and services that address the needs of our demographic population.

We identify a population for the purpose of Preventative Cancer Screening. We work through our patient population to identify, notify and follow up with those who are eligible based on their cancer screening needs. We are using the Screening Activity Reports, generated by Ontario Health and Cancer Care Ontario to ensure accurate records and testing accountability within the Cancer Care Ontario guidelines. Our Registered Nurse is certified to perform Papanicolaou Tests (PAPS) and with the mentoring of our Nurse Practitioner, assists in clearing our screening lists. As a result, we continue to improve our current performance rate to within 10% that we set as a target. Our team members reviews this process to work through any backlog, to establish blitzes for screening for Mammograms, PAPs and FIT testing .

Our Occupational Therapist actively screens appropriate patients over 50, to encourage awareness of Falls Prevention and to encourage safety during winter months. Our Falls Prevention program identifies patients at risk for falls and provides appropriate intervention in order to reduce future risk of falling.

We have a program that identifies pediatric patients with gross motor/fine motor, behavioral, speech or social developmental concerns. These patients are referred to the OT, who completes a developmental screen with the patient and their caregiver to determine if the infant or child has a developmental delay. If a delay is present the patient may be referred to early intervention services or another appropriate program. The OT also provides strategies to the caregiver to assist with meeting developmental milestones as well as system navigation assistance with pediatric services.

Our Immunization and Vaccine service runs in collaboration with York Region Public Health to ensure immunization for all patients in a timely, accessible manner. We maintain two cold-chain fridges

for the specific purpose of storing these vaccines. We communicate often with PHN's with vaccine questions and/or questions regarding any public health update.

With the support of one of our pharmaceutical partners, we offer a compassionate IUD program for patients who do not have a source of funding due to their lower income status or absence of benefits. We also offer onsite STI medication as part of our Sexual Health program.

Our clinicians support our patients who may not be able to afford medications and services not covered by OHIP and will advocate on behalf of them to pharmaceutical companies. We also assist patients in connecting to programs and services that will provide them financial support and housing.

We offer alternate language pamphlets for information on programs and services, such as cancer screening. Our postpartum packages contain multi-cultural resources and handouts.

Our team of clinicians are sensitive to gender identity within our patient base. In the past, we hosted an 2SLGBTQ+ community awareness and information session for our team to better understand how we can support and make our space a welcoming one.

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 on **March 13, 2024**

Dr. MaryBeth Bourne, Board Chair

Mary-Jane Rodgers, Quality Committee Chair or delegate

Mary-Jane Rodgers, Executive Director/Administrative Lead

Dr. Indra Roopnarian, Other leadership as appropriate