Let's Make Healthy Change Happen.

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

Aurora-Newmarket Family Health Team

3/19/2025

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.

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 of improving our set goals and objectives and help meet the quality initiatives and targets put in place on an annual basis. All Board members and employees receive minutes of all meetings via email.

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.

We review Ontario Health (OH) requirements and align our FHT obligations based on Schedule A of our Annual Operating Plan submission. We continue to review, re-establish and enhance internal initiatives that have been set to meet our Quality Improvement Plan (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 the 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 continues to have 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 can 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 we determine what the needs of our demographic are and plan for our teams to offer efficient well-balanced programs and services. Our team has continued to focus on our programs and services success 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 2025-2026:

- Work with the Northern York South Simcoe (NYSS) Ontario Health Team (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 Electronic Medical Records (EMR), we 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, Inter-Professional Health Professionals (IHP) and administrative team can support each other and support the patient in coordinated, comprehensive care.

Access and Flow

The ANFHT continues to focus on maintaining and improving access, activities and ensuring patients are satisfied with provider availability and seen in a timely manner. This includes post discharge follow up 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 we have strategically integrated inter-professional health professionals (IHP) into our follow-up care model. This ongoing Plan-Do-Study-Act (PDSA) cycle aims to evaluate the impact of incorporating IHP team members into the discharge follow-up process, optimizing both access to care and the capacity of our physicians.

This past year we increased access through our EMR with our new online booking platform and same-day bookings. We sent communications to our patients, detailing options to assist them in securing a timely appointment. We updated our phone prompt system to give the patients easier access and an understanding of the changes, which included updating prescription and referral processes.

This year we will be starting a new initiative to decrease our use of manual faxes in favour of e-solutions.

In partnership with our Registered Dietitian and Registered Nurses, we will be aiming to increase the percentage of individuals that have been diagnosed with Type 2 Diabetes, with up to date with HA1C testing, by analyzing our current follow up booking process.

Our Occupational Therapist (OT) works with patients (and their families/caregivers) to ensure that they 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 to meet their needs.

Our team continues to act as an involved liaison with Home and Community Care (HCC), to improve coordination of community services for our patients. Both an 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 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.

Equity and Indigenous Health

Our team works within 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. Improving our data collection methods through our EMR during intake assessments will support our queries to identify patient populations. Our QIDDS is working to combine data from external reports such as the OH My Practice reports, OHT geo-analytic data and our own survey and EMR data.

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 into 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. Within this goal it is important that everyone on our team listens to the needs of our patients individually.

Our Social Worker (SW) maintains a Single Session Counselling Clinic for those patients with immediate needs, to support clinicians with addressing the social determinants of health by supporting patients leveraging community resources. This will advance our DEIB initiatives by providing an easy-to-access single session clinic with no screening or referral required. This mitigates access to service barriers for mental health support.

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 administration 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 their behalf to pharmaceutical companies. We also assist patients in connecting to community 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. Our EMR allows for the indication of a patient's preferred pronouns.

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 accurate data will drive our programs and service indicators.

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

Our program delivery process evolves and improves as each program is rolled out or conducted. Feedback from our patients and participants is analysed with lessons learned, to develop improvement ideas. We have brought back in-person delivery of programs and services, 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 monthly, with feedback through our scorecard. Issues/concerns are reviewed at our daily huddle and/or team meetings, with action plans put into 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. We will continue to analyze results from the patient experience survey and determine ways to improve based on this feedback.

When our team reviews our goals and objectives for the next fiscal year, we will start the conversation regarding patient involvement in our Quality Improvement (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 Northern York-South Simcoe (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.

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 team of Clinicians have incorporated online booking and messaging through the Oceans platform and our EMR, as well as email options for our patients. 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 for both patients and employees. 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.

The Nurse Practitioner is responsible for the implementation, management and updating of medical directives. These directives are based on the needs of the FHT and have been developed to assist with patient care and collaboration between the RD, RN’s, NP and Physicians.

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 and 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 Occupational Therapist actively screens appropriate patients over the age of 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 to reduce future risk of falling.

The ANFHT offers a program where our Occupational Therapist reviews the concept of "Aging in Place", educating patients on modifications and supports available inside the home and will offer information on financial and community supports to help people live safely in their homes. A 1:1 home assessment will also be available as a follow-up. Patients gain increased knowledge and resources to feel confident about "Aging in Place". This program is linked to our Advance Care Planning program.

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

Palliative Care

One of the NYSS OHT recommended priorities is to develop palliative care pathways. With our team being supported by the OHT, we hope to be part of the priority to develop palliative pathways.

Our Advance Care Program (ACP) supports our patients at any age by initiating discussions to increase awareness of the valuable technical resources that are available to patients and increase confidence in accessing creditable resources. We provide education to increase patient knowledge about automatic substitute decision maker(s) and the option of choosing a Power of Attorney for Personal Care. Our team works to connect patients and caregivers with the appropriate resources. Our goal is to start discussions around this topic early before a health crisis.

Caring For the Caregiver is a program that connects caregivers with community resources for support and provides strategies to manage stress and improve self-care. Our OT and SW counsel caregivers that support our patients on an ongoing basis, through individual sessions or when visiting patients in their homes. This is an important resource for caregivers that are supporting palliative patients who are residing in their home. We offer this to both patient and non-patient caregivers.

Two Physicians are active in long-term care (LTC).
One Physician is the Medical Director of a Nursing Home in our region. He attends the Long-Term Care facility (LTCF) twice weekly for 3 hours per day to conduct rounds, and he offers 24/7 coverage. Monthly, he conducts Interdisciplinary rounds with Pharmacy, Dietary and Nursing involvement.
From a quality perspective many audits are conducted at the LTCF; these include audits that monitor all transfers to the ER. Patient centeredness remains one of the cornerstones of care in the LTCF.
Another Physician is an Associate at a LTCF.

Population Health Management

In conjunction with a community Allergist, our office offers timely allergy testing (usually within 4 weeks) to our patients and the community. We have integrated eReferrals, through the Oceans platform, into our process to help facilitate quick referrals by community clinicians.

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 Nurse Practitioner Led Clinic (NPLC) located in Georgina.

Our team collaborates on diabetes, cardiovascular and women’s health management as well as 15 other programs and 11 services that consider the needs of our patient population. Our programs are also designed around Preventative Health, for example our partnership with CAMH allows us to offer a Smoking Cessation (STOP) Program to our patients.

Our Immunization and Vaccine service runs in collaboration with York Region Public Health to ensure immunization for all patients in a timely and accessible manner. We maintain two cold-chain fridges for the specific purpose of storing these vaccines. We communicate often with Public Health Nurses, with vaccine questions and/or questions regarding any public health update(s).

The FHT and the Family Health Organization (FHO) have signed off on the updated Collaborative Decision-Making Arrangement (CDMA) with the NYSS OHT. Our Executive Director is involved in the development of the OHT initiative for the Inter-professional Primary Care Clinic and Urgent Pediatric Clinic, that are now in the early stages of operation, supporting the Georgina area.

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.

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 Appointment Booking (OAB) is available to our patients through Oceans, which is integrated into our EMR. OAB has been implemented, and we have increased appointment availability through this forum. The utilization of Oceans, assists with form completion, notes, letters and streamlines these processes electronically. As a team we will look at the costs associated with including all IHP's on the platform, giving our patients the opportunity to schedule follow ups independently.

The demands from patients and the expectations from stakeholders placed on physicians and healthcare providers continue to be excessive, compounded by an overwhelming administrative burden and lack of health human resource support for primary care.

Finding ways to reduce the administrative burden, like streamlining processes with technology or adjusting workloads, is crucial to improving both the well-being of healthcare workers and the quality of care for patients.

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 Human Papillomavirus (HPV) Tests, with the mentoring of our Nurse Practitioner, and assists in clearing our screening lists. As a result, we continue to improve our current performance rate to within 10% of our target. Our team members review this process to work through any backlog and complete blitzes for cervical, breast, and colorectal cancer screening.

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 assessment 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.

Contact Information/Designated Lead

Aurora-Newmarket Family Health Team - Mary-Jane Rodgers, Executive Director mjrodgers@auroranewmarketfht.ca

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

ANFHT Board Chair/QHPSC Co-Chair, Dr. Mary Beth Bourne _____ (signature)

ANFHT Executive Director/ QHPSC Co-Chair, Mary-Jane Rodgers _____ (signature)

ANFHT Board Member/Lead Physician, Dr. Indra Roopnarian _____ (signature)