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



Aurora Newmarket
Family Health Team

03/05/2026 FINAL

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 have 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, if they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

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Overview

The Aurora–Newmarket Family Health Team (ANFHT) is committed to continuous quality improvement, patient safety, and the delivery of coordinated, patient-centred care. Since the establishment of the Quality, Health and Patient Safety Committee (QHPSC) in 2013, the committee has provided governance, oversight, and leadership for quality initiatives across the team. This inter-professional committee meets quarterly (more frequently and as required), to review performance, promote new initiatives, and address emerging quality and safety priorities.

Transparency and accountability are supported through regular communication and distribution of meeting minutes to all Board members and team members.

For the 2026–2027 Quality Improvement Plan (QIP), the ANFHT will maintain the same indicators as outlined in 2025–2026, with a continued focus on advancing implementation, addressing workflow barriers, and improving efficiency to support sustainable quality improvement.

Efforts to improve timely follow-up after hospital discharge will continue, with a focus on optimizing the roles of our Registered Nurses and Occupational Therapist, while reducing administrative burden for physicians/NP's. Consideration will be given to targeting high-risk patient populations to improve outcomes and reduce readmissions.

Improving timely access to urgent care remains a priority. Ongoing refinements to the online appointment booking system aim to enhance accessibility, clarify appointment types, and preserve urgent care capacity for appropriate use.

Cancer screening rates will continue to be addressed, particularly through increasing cervical screening capacity by training an additional Registered Nurse and streamlining booking processes. Our team completes “blitzes” throughout the year for targeted cancer screening.

We remain committed to advancing equity, diversity, inclusion, and anti-racism education. Administrative training is nearing completion, and broader team education initiatives are planned for 2026–2027 to further embed these principles into practice.

Standardization of referral processes for Social Work, Dietitian, and Occupational Therapy services will support improved documentation of social determinants of health, including housing and food security.

Falls prevention efforts will focus on improving identification of high-risk patients and exploring opportunities to automate screening processes to reduce administrative burden.

Patient experience initiatives will continue, with planned team training to promote supportive, respectful, and welcoming interactions within the primary care setting.

Diabetes management remains a priority, with strategies including chart reviews to identify care gaps, enhanced patient reminders for laboratory testing, and internal flagging mechanisms to support timely HbA1c monitoring.

Finally, efforts to reduce misdirected faxes will continue through provider education and expanded use of secure digital solutions.

Overall, the 2026–2027 QIP will focus on strengthening existing initiatives, improving workflow efficiency, and enhancing patient access, safety, and equity across services.

The ANFHT has demonstrated achievement in aligning internal priorities with Ontario Health requirements and Schedule A of the Annual Operating Plan. The Quality Improvement Plan (QIP) has always been part of operational planning and used as a living document to guide performance measurement, timelines, and accountability.

Quality initiatives are aligned with provincially recognized primary care indicators, including timely access to care (third next available appointment), cancer screening participation (cervical, breast, and colorectal), chronic disease management (such as diabetes and COPD monitoring), appropriate use of our services, and patient experience.

The ANFHT continues to improve access to care by working as a team and strengthening partnerships with community providers to better support our patients.

By reviewing our programs and listening to patient feedback, we have been able to continue offering virtual and hybrid services where they make the most sense. Programs such as Post-Partum Education (“Baby and Me”) have demonstrated increased participation through virtual delivery, while Advance Care Planning is offered using a hybrid model to support patients and caregivers.

The ANFHT leverages its Electronic Medical Record (EMR) to support data capture, performance measurement, and reporting for quality indicators. EMR-enabled tools are used to identify care gaps, monitor outcomes, and support proactive patient outreach.

The ANFHT uses its EMR to capture data, set performance measures, track quality indicators, and identify gaps in care or identify on a needs basis what programs and services may need to be expanded or included. The team actively participates in the Ontario Health / ICES Primary Care Practice Report initiative and uses this data to inform quality priorities, indicator selection, and continuous improvement activities.

In alignment with the Choosing Wisely Canada initiative, the ANFHT promotes evidence-based decision-making by supporting clinician-patient conversations that encourage appropriate testing, treatment, and care choices.

Through these combined efforts, the ANFHT continues to strengthen a culture of quality, accountability, and reliable care while delivering accessible, quality services to its patient population.

Access and Flow

The Aurora–Newmarket Family Health Team (ANFHT) remains focused on ensuring patients receive the right care, in the right place, at the right time. Timely access and smooth flow across the health system are priorities, particularly in supporting patients to stay safely in the community and avoid unnecessary emergency department visits or hospital admissions.

We continue to provide timely follow-up care post-discharge, including newborn visits within 48 hours and in-patient discharge follow-up within 7 days, when appropriate. Our team actively manages patients discharged from the ER without hospital admission, offering ongoing assessment through integrated inter-professional health professionals (IHPs).

This Plan-Do-Study-Act (PDSA) cycle evaluates how involving inter-professional health professionals (IHPs) in follow-up care improves timely access and optimizes clinician capacity. Services include wound care, diabetes management, COPD, and other respiratory conditions. We have worked closely with our Registered Nurses (RNs) to support them in practicing to their full scope. One example is the implementation of Ocean online appointment booking (OAB) for RN appointments, which enables patients to schedule services such as HPV/PAP screenings directly online. Our goal with this tool is to achieve full integration of both RNs into our FHT’s virtual and in-person booking system, improving access and streamlining patient care.

We continue to focus on improving enhanced access through the Ocean online appointment booking (OAB) platform integrated with our EMR, increasing same-day appointment availability. Updated phone prompts and patient communications clarify booking options and streamline prescription and referral processes.

Our team continues to reduce manual faxing use by adopting electronic solutions to improve communication efficiency. We have improved this function but will continue to adopt options that will enable us to only use e-faxing.

In collaboration with our Registered Dietitian and Registered Nurses, we plan to increase monitoring of patients with Type 2 Diabetes by analyzing and improving our follow-up booking processes to ensure timely HbA1C testing.

Our Occupational Therapist supports patients and families with care plans, including home visits for home safety assessments, future care planning, and connects them to community resources.

We work closely with Ontario Health at Home (OHaH) and other partners to coordinate services and improve care transitions, strengthening relationships within the Ontario Health Team and local healthcare providers to better support our patients.

Over the past year, our Occupational Therapist collaborated with Central Ontario Health at Home to strengthen Occupational Therapy referral pathways at the Aurora–Newmarket Family Health Team and support their service waitlists. She initiated contact with the Central Ontario Health at Home manager to establish a structured collaboration focused on receiving referrals aligned with her scope of practice, helping to reduce caseload pressures. Following a meeting with the broader agency team, she developed a standardized referral form to streamline referral processes. This approach has been successfully implemented and continues to support clear communication, efficient referrals, and strong professional relationships with community care coordinators.

Equity and Indigenous Health

Our team continues to use our EMR to capture social determinants of health (SDoH) and update caregiver information, improving our understanding of patients' needs. We enhance data collection during intake and leverage external reports—including OH My Practice, OHT geo-analytic data, and our own survey and EMR data—to identify priority populations and inform targeted programs.

We are prioritizing team education in social determinants of health (SDoH) and introductory diversity, equity, inclusion and belonging (DEIB) strategies to provide equitable care and develop initiatives addressing systemic barriers. We acknowledge that advancing equity and Indigenous health is an area where our team is still building skills and resources, and we are committed to ongoing learning and improvement.

Our Social Worker runs a Single Session Counselling Clinic, offering immediate support for social and mental health needs without referrals or screening, reducing access barriers.

Our IHP team and clinicians assist patients in accessing community programs for financial support, housing, and medications not covered by OHIP. We also advocate on their behalf with pharmaceutical companies and may provide medication samples when available. Additionally, we offer onsite STI medication administration for patients without support.

To promote culturally safe care, we provide multi-language materials, multicultural postpartum resources, and gender-affirming care, including preferred pronoun documentation in our EMR. Our Nurse Practitioner is hosting an upcoming presentation in collaboration with Southlake Health on how black women experience menopause differently.

Within the Northern York South Simcoe Ontario Health Team (NYSS OHT) our team is an anchor partner and there are opportunities to be involved in learnings to better serve First Nations, Inuit, Métis, and Urban Indigenous patients, through local Indigenous consultation and culturally safe practice education. This is something our team hopes to become familiar with through DEIB training and implementation and participation in programs and services that will be made available.

These initiatives reflect our commitment to advancing equity, Indigenous health, and inclusive, patient-centered care, while recognizing that continued growth in skills and resources is essential to achieving these goals.

Patient/Client/Resident Experience

Our team prioritizes patient experience by ensuring patients are actively engaged at the center of their care. We collect feedback through surveys, one-on-one encounters, program evaluations, and our website to guide quality improvement initiatives and program planning.

All programs solicit feedback at completion, which informs program adjustments and helps ensure that services meet patient needs. Patient surveys are sent quarterly, and results are reviewed during daily huddles or team meetings and through our QHPSC. Action plans are developed for any concerns or opportunities identified, creating a responsive, patient-centered approach. We review survey results to ensure they represent our patients and provide useful insights for making improvements. It is important to note we do not wait to have concerns addressed, we manage these in real-time to give our patients and team members a sense that we are being pro-active.

We maintain clear and accessible communication through multiple channels, including our website, quarterly newsletter, monthly health initiatives boards, and waiting room information stations. QR codes link patients to surveys and feedback opportunities, and flyers highlight programs, services, and community resources. Hybrid delivery models allow patients to participate virtually or in-person, increasing accessibility and choice.

Patient input is increasingly incorporated into Quality Improvement initiatives, with discussions beginning during annual goal setting and program planning. Through our participation as an anchor partner with the Northern York-South Simcoe (NYSS) OHT, we collaborate on care coordination, patient navigation, and models of care that align with provincial direction.

By systematically collecting, analyzing, and acting on patient feedback, we ensure that our programs and services remain relevant, effective, and responsive to patient needs, fostering a culture of continuous improvement and patient-centered care.

Provider Experience

The ANFHT team remains committed to maintaining a professional, compassionate, and respectful environment for both colleagues and patients. We recognize that supporting providers' well-being is essential to recruitment, retention, and quality care.

Our clinicians and administrative team use digital tools such as online booking, secure messaging through Ocean and our EMR, and email communication to streamline workflow and reduce administrative burden.

Quality improvement initiatives are supported by our QIDSS expert, improvement strategies, and best practices to guide clinical and administrative operations.

Our Administrators also plan and execute a weekly newsletter, monthly scorecards, all meeting minutes, liaise with the team on improvements, changes and updates. We all work as a team to keep our Schedule A and QIP working active tools throughout the year and incorporate into our daily schedules.

We maintain an open and collaborative workplace through daily huddles, team meetings, and an open-door policy, ensuring all team members can share ideas, address concerns, and participate in decision-making. Administrators continuously review and update programs, policies, and procedures, implementing new initiatives to improve workplace efficiency and patient care.

To support recruitment, we offer mentorship, professional development opportunities, and a supportive team environment to help new employees integrate successfully and thrive within our organization. We encourage and maintain ongoing training and onboarding for all team members and encourage them to keep active within their own networks. We work with high schools, colleges and universities to encourage and support co-op, training and clinical placements or practicums.

Recognizing the increasing demands on clinicians and team members in the evolving health care environment, we continue to explore creative approaches to reduce administrative burden, support provider wellness, and enhance job satisfaction. We do this by fostering a supportive environment, promoting collaboration, and providing the tools and resources team members need to succeed. We aim to enhance provider experience, improve retention, and ensure our team can deliver excellent care while maintaining their own well-being. Although we strive to support team members requests and ideas, we recognize that not every outcome will meet everyone's expectations. We embrace lessons learned and remain committed to open discussions and ongoing communication, ensuring that all team members feel heard and included in decision-making.

Safety

At the ANFHT, safety is viewed as more than preventing harm; we focus on proactive, real-time monitoring and building resilience within our team. Our EMR supports safety alerts, including emergency message notifications and tracking of home visits, ensuring team members are aware of colleagues' locations during patient interactions. Daily huddles, monthly team meetings, QHPSC Meetings and clinical discussions provide forums to identify potential safety risks early and respond promptly.

Our Health and Safety program, overseen by the QHPSC, is guided by policies compliant with the Ontario Occupational Health and Safety Act. All team members are trained in Workplace Violence and Harassment Prevention, Mental Health First Aid, First Aid/CPR/BLS, WHMIS, and Ontario Health and Safety Awareness, reinforcing a culture of shared responsibility. For this coming year we will be investigating group training on how to manage the daily stress of working in health care. All policies reviews are completed annually with an electronic signoff. Health and Safety representatives perform monthly checks of equipment, infection control measures, and physical space hazards, allowing us to address risks before they result in harm.

Proactive initiatives include our Falls Prevention and Aging in Place programs, led by our Occupational Therapist, which identify at-risk patients and provide education and interventions to prevent injury. Emergency preparedness is supported by defined codes, mobile panic buttons, fire and evacuation plans, and open lines of communication with leadership.

We have built a strong and safe workplace by encouraging open conversations, learning from what happens day to day, and keeping communication clear between clinical and administrative teams. By following guidelines, staying aware of what's happening in real time, stepping in early when needed, and working together as a team, we create a safety-focused environment that supports both patients and staff while helping us continually improve how we work.

Palliative Care

The ANFHT supports palliative care throughout the course of illness, with a focus on comfort, choice, and quality of life for patients and their families. Palliative care will continue to be a key priority within the Northern York South Simcoe Ontario Health Team (NYSS OHT), including work toward developing clearer and more coordinated palliative care pathways across the region.

One way we support patients is through our Advance Care Planning (ACP) Program, which helps individuals of all ages begin conversations early about their values, wishes, and future care preferences—ideally before a health crisis occurs. Our team provides education on substitute decision-making, Powers of Attorney for Personal Care, and reliable planning resources. These conversations take place during appointments with Occupational Therapists and Registered Nurses, as well as through in-person and virtual education sessions, helping to normalize advance care planning and support shared decision-making that reflects what matters most to patients.

The ACP Program is closely linked with our Aging in Place / Strong and Steady Program, and patients are encouraged to participate in both concurrently. Aging in Place / Strong and Steady is a two-hour, in-person workshop offered approximately six times per year. Led by an Occupational Therapist, the session focuses on helping patients live safely and confidently at home by reviewing home modifications and available supports, exercises to improve balance, strength, endurance, and mobility, and information on financial and community resources. Community physiotherapy resources are also provided.

When appropriate, one-on-one in-home assessments are offered to further support individual needs. Together, these programs increase patient knowledge, encourage early planning, and support independence and quality of life over time.

We also recognize the important role of caregivers. Our Caring for the Caregiver Workshop connects caregivers with community supports and offers practical strategies to manage stress and maintain well-being. Our Occupational Therapist (OT) and Social Worker provide counselling and education through home visits (OT) and individual sessions, supporting both patient and non-patient caregivers caring for individuals with life-limiting illness.

One of our physicians serves as an Associate Physician in a long-term care facility, supporting resident care through regular rounds, on-site coverage, and 24/7 on-call availability. The physician works collaboratively through interdisciplinary meetings with pharmacy, dietary, and nursing staff.

Population Health Management

The ANFHT works with community partners to understand the health and social needs of the people we serve and to improve how care is delivered. Through our participation in the NYSS OHT, we collaborate with community partners, other primary care, public health and Southlake Health partners to identify common needs and work together on solutions that support patients across the community.

We are always looking for ways to work with community specialists and other primary care teams to improve access and reduce wait times for services. For example, in collaboration with a community allergist, we offer timely allergy testing for both our patients and the broader community. The use of eReferrals through the Ocean platform supports efficient coordination and timely access to care.

Our team also works with other primary care teams to share and deliver programs that respond to identified population needs. This includes partnerships with a Nurse Practitioner–Led Clinic to offer health promotion programs such as our lifestyle program Eating the Mediterranean Way. We have also supported the NYSS OHT by providing services to their Health and Wellness Education series. Our IHP team presented workshops on Caring for Caregiver, and CBT-I (Insomnia).

Recognizing a widespread lack of knowledge about menopause, our Nurse Practitioner developed a Group Workshop to introduce the basics to women of all ages. Multiple partnerships have been established to share this information beyond our immediate patient population. Our Nurse Practitioner has partnered with the YRDSB to present on menopause and its impact in the workplace. She also presented to residents of Georgina through a collaboration with the NYSS OHT and the Town of Georgina (mentioned above). Additionally, representatives from the Government of Nova Scotia's Department of Health and Wellness - who are currently developing the province's first-of-its-kind Menopause Centre of Excellence (MCoE) reached out for guidance and we have met and discussed the approach we have taken with this program. Our Nurse Practitioner is conducting a presentation to Southlake Health's cardiovascular and rehab program on peri menopause/menopause and how it effects cardiovascular risk.

Preventive care is a key focus of our population health approach. Through partnerships with CAMH, we offer the Smoking Cessation (STOP) Program, and in collaboration with York Region Public Health, we provide accessible immunization services. Regular communication with public health partners ensures alignment with current guidance and emerging population needs.

Ongoing collaboration with Southlake Regional Health Centre and participation in OHT initiatives, including interprofessional primary care, support a coordinated "circle of care" that improves access, continuity, and outcomes across the care continuum.

Contact Information/Designated Lead

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

Other

The Aurora-Newmarket Family Health Team uses the Primary Care Practice Report provided by Ontario Health to help guide our quality improvement work. This report gives us clear information on how we are doing across several areas, including cancer screening, diabetes management, and other key indicators required by Ontario Health. We use this data to understand our performance, track progress over time, and identify areas where we can improve.

Our Annual Operating Plan, including Schedule A, helps us focus on programs and services that best meet the needs of the population we serve. This planning process ensures our work is aligned with the demographics and priorities of our community.

Preventive cancer screening remains an important focus for our team. We regularly review our patient roster to identify individuals who are eligible for screening and follow up with them as needed. We use Screening Activity Reports from Ontario Health and Cancer Care Ontario to keep our records up to date and to ensure screening is completed according to guidelines. Our Registered Nurse (RN), who is certified to perform HPV testing with support from our Nurse Practitioner, plays a key role in addressing screening gaps. We will soon be adding another trained RN to this process. As a team, we review our processes, address backlogs, and run focused screening efforts for cervical, breast, and colorectal cancer. These efforts have helped us continue to move closer to our screening targets.

We also have a pediatric service that focuses on early identification of developmental concerns, including motor, behavioural, speech, and social development. Children identified through this process are referred to our Occupational Therapist. When delays are identified, families may be connected with early intervention services or other appropriate programs. Caregivers are also provided with practical strategies to support their child's development, along with help navigating pediatric services. Our Occupational Therapist also provides patients, caregivers and schools support around ADHD and concussion management.

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

ANFHT Executive Director/ QHPSC Co-Chair, Mary-Jane Rodgers

ANFHT Board Member/Lead Physician, Dr. Indra Roopnarian