Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 26, 2024

Ontario Health

OVERVIEW

The Toronto Western Family Health Team (TWFHT) is dedicated to enhancing access and flow within its healthcare services while simultaneously addressing administrative burden. Initiatives over the past year have significantly improved access to care and patient flow. These include closer partnerships with specialists, offering on-site clinics in dermatology, neurology, sports medicine, psychiatry, paediatrics, and spine surgery. Online appointment booking, implemented over 18 months ago, now extends to all healthcare providers, granting patients the flexibility to book appointments outside regular hours.

To address administrative burden, the TWFHT has standardized processes for patient forms, referral management, and new patient intake, with policies clearly articulated on their website. Digital systems like CHIME and Telus PS Suite streamline administrative tasks, while online booking reduces phone call volume.

Patient engagement remains central, with ongoing patient experience surveys informing initiatives and programs. The involvement of patient partners in recruitment interviews and strategic planning enhances patient-centred care.

Provider experience is prioritized through workload assessments, flexibility with hours, and professional development opportunities. The introduction of Nurse Practitioners as Primary Care Providers has expanded access and improved professional satisfaction.

Safety is paramount, with regular safety huddles, incident reporting, and ongoing quality improvement projects. A focus on maintaining a safety culture aligns with accreditation preparations.

Lastly, the TWFHT adopts a population health approach, offering proactive patient education and improved access to medical resources. Collaborating with other health system providers, they actively engage in population health-based approaches to promote health, prevent disease, and support community well-being. Through these efforts, TWFHT remains committed to enhancing overall healthcare delivery and community health outcomes.

ACCESS AND FLOW

The TW FHT is committed to continuously improving access and flow. There have been a broad range of initiatives over the past year that have successfully improved access to care and patient flow. In order to promote timely access to specialist care, we have engaged in closer partnerships with specific specialists, who hold clinics on-site at the TW FHT which reduces wait-times and improve collaboration/patient experience (dermatology, neurology, sports medicine, psychiatry, paediatrics and neuro-spine). On-line appointment booking was implemented over 18 months ago and has expanded so that all healthcare providers offer on-line appointment booking (PCPs, allied health, nursing). Providing and expanding these options allow patients choice on how to book and the freedom of booking outside “normal” business hours. There has been a continued focus on same day/urgent access: the implementation of Clinical Associates for urgent & semi urgent issues when the PCP is not available and a new clinical role called “Doctor of the Day” (DOD) where a designated physician is identified to be approached by clinical or administrative staff for acute clinical concerns requiring physician intervention. Identifying a defined point of contact when the PCP is not available has provided clarity for the team, more efficient responsiveness of the clinical concern and faster response times to the patient. Same Day Appointment availability is announced at each morning’s safety huddle (averaging 25 – 30 spots per day) which allows the team to pivot early if there are any challenges.

In March 2024, we implemented a new call-centre software which will significantly improve our phone access, which has been identified as a problem for many years. Our previous technology was antiquated, without even the ability for the caller to wait in queue for a call. The new system will exponentially improve our ability to “live-answer” calls as well as provide key metrics which are essential for resource planning and alignment.

ADMINISTRATIVE BURDEN

Addressing and reducing administrative burden continues to be a priority here at the TW FHT. We have been engaged in standardizing processes – this past year focusing on processes for patient forms, referral management, new patient intake and clinic policies being clearly articulated on the website . Introducing online booking has reduced the volume of phone calls administrative staff receive as patients have a new avenue to book appointments with their provider.

The TW FHT has been actively involved in introducing and implementing digital systems to maximize efficiency and reduce administrative burden. We continue to use the CHIME system, an AI-powered clinic management software that automates patient wayfinding and supports collaboration between staff and clinicians. We also continue to maximize the capabilities of our electronic medical record software, Telus PS Suite, by creating new custom forms and shortcuts for clinicians to reduce the length of documentation time.

EQUITY AND INDIGENOUS HEALTH

The TWFHT continues its commitment to addressing the needs of marginalized populations within our practices. In 2021, we appointed a physician and non-physician co-lead for Equity, Diversity, and Inclusion (EDI), who have since been guiding our efforts. In 2022, they established the interdisciplinary Social Accountability and EDI Committee.

Moving into the 2024-2025 year, our focus remains on advancing these initiatives. We have initiated training and education for all staff, with plans to expand it to include all disciplines and statuses. Staff will participate in an 8-hour Anti-Oppression Training program offered by Urban Alliance on Race Relations, supplemented by 90-minute bystander training. These sessions aim to equip our team with the necessary skills and knowledge to foster a more inclusive environment. Additional training programs are being explored.

Moreover, we are actively working on identifying our patient population's social demographics through a standardized method. This data will serve as a cornerstone for future quality improvement initiatives and will help us identify groups with unmet needs.

Simultaneously, the EDI committee is reviewing our Terms of References and policies to ensure they reflect an equity perspective, further embedding inclusivity into our organizational framework.
As we move forward, TWFHT remains dedicated to fostering an environment where all individuals receive equitable and compassionate care.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Patient engagement and experience is a foundational element which the TW FHT incorporates into health services design and delivery. We have a robust patient experience survey process for over 7 years, with quarterly dashboards presented at Executive Committee and Board quarterly and with clinical leadership reviews. We are able to see trends over time as we implement new initiatives based on these results. Patient experience metrics are incorporated into formal programs (i.e. Intensive Counselling Program pilot – CAMH's Ontario Perception of Care Tool) and health education workshop sessions. There has been one pilot trial of patient co-design, where a health workshop was created and delivered with a patient partner (presently in evaluation phase). The TW FHT is working with the UHN Patient Partner program to increase the number of trained TW FHT Patient Partners (currently 4). Patient partners are involved in recruitment interviews (i.e. for new physicians) and part of the strategic planning process. The TW FHT has a Patient Engagement Framework which is aligned with our current Strategic Plan.

PROVIDER EXPERIENCE

Healthcare providers at the TW FHT have not been immune to the human resource challenges that are happening across the healthcare spectrum. All staff, regulated and unregulated, have experienced stress related to the pandemic response, the constantly changing healthcare landscape and the changes in patient's expectations from their health care team. There have been a number of approaches to improve provider experience. Core to this is maintaining staffing levels/including relief factor, workload assessments and standardization, flexibility with time off/hours of work requests and encouraging social events for team members to re-connect. Professional development requests for IHP's have been funded with paid time off as well as time to participate in a number of primary care related activities (including research and teaching). The TW FHT partnered with CACHE to offer two BOOST! Workshops that focused on role optimization and purposeful collaboration.

The focus on supporting full scope of practice for IHPs has continued with the launch of Nurse Practitioners across both sites becoming Primary Care Providers/MRP, with their own full patient panel. This has significantly improved their professional satisfaction as well as improving access for new patients.

UHN as an organization that has a myriad of resources for staff and there is also a site physician wellness lead to works with the hospital's physician wellness group to identify and address issues of workplace burnout.

SAFETY

Safety has been a focus for many years at the TW FHT. All team members have completed Safety e-learnings which review safety behaviours and error prevention tools. Both sites hold safety huddles before each morning clinic, with a looking back/looking forward approach highlighting safety issues as well as operational updates, followed by a summary email to the whole team. The TW FHT uses UHN's Incident Reporting and management system and all staff are educated on use. Clinic managers investigate all reports, and opportunities for improvement are identified and address in ad-hoc working groups or on a committee level, depending on the underlying factors. Themes are discussed at Executive Committee level. There is currently one working group working on a project focusing on maintaining an accurate med list in the patient chart – this project has been recognized by the CPSO QI initiative for MDs, and has been presented at TASN forums. In preparation for Accreditation (May 2024), one of the Safety Leads is participating in a number of team meetings with a "safety road-show" with a focus on how to maintain a safety culture.

POPULATION HEALTH APPROACH

The Toronto Western Family Health Team is committed to advancing population health through proactive patient education and enhanced access to medical resources. Recognizing the importance of preventive care and empowering patients with knowledge, we have expanded our educational programs to cover a variety of common medical concerns. Through workshops, seminars, and informational sessions, we aim to equip our patients with the tools they need to make informed decisions about their health and well-being.

Additionally, we have revamped our website to provide improved access to medical content, ensuring that our patients have reliable and up-to-date information at their fingertips. Whether it's understanding a new diagnosis, managing a chronic condition, or adopting healthier lifestyle habits, our online platform serves as a valuable resource for patients seeking guidance and support.

In collaboration with other health system providers and as part of our commitment to Ontario Health Teams, TWFHT actively engages in population health-based approaches to care. By proactively addressing the unique needs of our community, we strive to promote health, prevent disease, and support individuals in living well with their conditions. Through partnership and innovation, we are dedicated to enhancing the overall health and well-being of our patients and community.

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

_____

Board Chair

Quality Committee Chair or delegate

Executive Director/Administrative Lead

Other leadership as appropriate

Experience | Patient-centred | Priority Indicator

Indicator #1

Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) involve them as much as they want to be in decisions about their care and treatment (UHN Toronto Western FHT)

Last Year		This Year	
83.48	**85**	**87.83**	**88**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

25% of patient interactions at our FHT are with resident physicians. We will employ our Partners in Care Program to encourage residents to allow more patient involvement in their decision making

Process measure

- The Partners in Care program is a long-running program aimed at promoting CanMED attributes beyond Clinical Expert, including Communicator, Collaborator, Professional, Leader, Health Advocate, and Professional. It is meant to support trainees in their ability to provide high quality patient-centred care. As the impacts of the pandemic on education ramp down, this program will be able to function to its maximal impact in advancing these qualities in their participants.

Target for process measure

- 100% of resident physicians in the Family Medicine program should participate in the Partners in Care program during the 1 year period

Lessons Learned

The improved performance is based on the results from a quarterly patient experience survey. They reflect a marginal increase per our expectations and hopes.
Implementing curricular changes with sustained practice impacts is challenging. We will continue to modify the program to better support our trainees in offering the care our patients deserve.

Safety | Safe | Priority Indicator

Indicator #4	Last Year		This Year	
Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system. (UHN Toronto Western FHT)	**2.90** Performance (2023/24)	**2.90** Target (2023/24)	**2.90** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

As 92.6% of newly dispensed opioids are prescribed by external providers, we will focus instead on reducing the number of non-palliative patients prescribed >90 mg MEQ

Process measure

- We will track the response rate from the provider's of these patients

Target for process measure

- 70% of the identified patients are reviewed and provided a response by their family physician within 2 months of being contacted

Lessons Learned

We identified 62 patients at FHT who were prescribed 90 MEQ or greater. Prescribers were messaged and asked to determine the next steps, whether none, contacting the patient, or correcting the medication list. The PCP responses reflected 35 patients requiring no action required and 7 patients with outdated medication lists (i.e. no longer taking). 6 patients were contacted to book an appointment to discuss reducing their opioids.
These results reflect the intricacies of opioid prescribing and of maintaining up-to-date medication lists.

Safety | Safe | Custom Indicator

Indicator #7

Percentage of patients with diabetes age 18 or over who have had a diabetic foot ulcer risk assessment using a standard, validated tool within the past 12 months. (UHN Toronto Western FHT)

Last Year		This Year	
7.60	**20**	**40**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Increase number of diabetic foot assessments using the standardized validated Inlow's 60 Second Diabetes Foot Screen tool

Process measure

- We will track number of nursing chronic disease diabetes visits conducted to ensure utilization by the primary care providers

Target for process measure

- Given the timeline for routine diabetes care and the referral lag for new services, we will aim for 5% of our patients with diabetes to undergo a nursing-led diabetes review visit by the end of a 6 month period

Lessons Learned

Only 6 nursing visits were booked for diabetes.
Instead, the Inlow's foot screen was incorporated into an updated diabetes documentation tool and conducted by both PCPs and the nursing team during routine scheduled diabetes visits.
We used billing data (specifically K030 and Q040) to identify patients seen for diabetes visits. Of these patients, we were able to track those with the Inlow's tool in the chart over the past year.

	Last Year		This Year	
Indicator #6	**34**	**55**	**83**	**NA**
Percentage of patients ages 65-70 who have a documented 2 dose series of Shingrix vaccines in our EMR (UHN Toronto Western FHT)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Increase the number of eligible patients to receive the Shingrix vaccines during the publicly available time period

Process measure

- We will track the number of completed custom forms in the chart to reflect use of our tool

Target for process measure

- 70% completion of custom forms by the primary care providers within 2 months of being contacted

Lessons Learned

Contacted over 1100 patients and identified 960 who had received both doses. Documentation of patient receipt of vaccine in EMR was inaccurate. Many patients had received the vaccine at another location and did not inform FHT of receipt.

	Last Year		This Year	
Indicator #5	**43**	**65**	**64**	**NA**
Percentage of patients ages 65 and above who have a dose of Pneumovax 23 documented in our EMR (UHN Toronto Western FHT)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Increase the number of eligible patients to receive the Pneumovax 23 vaccine during the publicly available time period

Process measure

- We will track the number of completed custom forms in the chart to reflect use of our tool

Target for process measure

- 100% completion of the custom form within 2 months of the initiation of the program

Lessons Learned

Upon contacting the overdue patients, many reported already having a dose in the past. This reflects inaccurate or missing documentation of the vaccine in the EMR, primarily as many patients obtained their vaccine elsewhere and did not notify our FHT.

	Last Year		This Year	
Indicator #2 Percentage of patients age 18-36 months who have received recommended childhood immunizations (UHN Toronto Western FHT)	**78** Performance (2023/24)	**95** Target (2023/24)	**86** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Increase the number of children age 18-36 months who received the complete age-appropriate primary immunization series.

Process measure

- We will track the parental/guardian response rate to the nursing inquiries through a custom form in the chart

Target for process measure

- We will aim for a response rate of 90% within 2 months of being contacted

Lessons Learned

We experienced several logistical barriers to implementing a custom form to identify parental/guardian response rates. Accordingly we are unable to determine the proportion of those who declined or those who seek care elsewhere and are simply not updated in our records. This challenge remains despite parents/guardians being regularly contacted by our nursing team.

	Last Year		This Year	
Indicator #3				
Percentage of patients age 7 years who have received recommended childhood immunizations (UHN Toronto Western FHT)	**36** Performance (2023/24)	**95** Target (2023/24)	**51** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Increase the number of children age 7 who received the complete age-appropriate primary immunization series.

Process measure

- We will track the parental/guardian response rate to the nursing inquiries through a custom form in the chart

Target for process measure

- We will aim for a response rate of 90% within 2 months of being contacted

Lessons Learned

We experienced several logistical barriers to implementing a custom form to identify parental/guardian response rates. Accordingly we are unable to determine the proportion of those who declined or those who seek care elsewhere and are simply not updated in our records. This challenge remains despite parents/guardians being regularly contacted by our nursing team.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Increase the number of children age 7 who received the complete age-appropriate primary immunization series.

Process measure

- We will track the parental/guardian response rate to the nursing inquiries through a custom form in the chart

Target for process measure

- We will aim for a response rate of 90% within 2 months of being contacted

Lessons Learned

See above

Access and Flow

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of new patients/clients/enrolments	O	Number / PC patients/clients Number of new patients/clients/enrolments	EMR/Chart Review / Most recent consecutive 12-month period	663.00	795.00	We have added new physicians to our team and re-oriented the role of our nurse practitioners to allow them to take on a primary care provider for patients.	

Change Ideas

Change Idea #1 Increase the number of unattached patients living within our catchment area who are booked in as new patients over the same July to December time frame in 2024.

Methods	Process measures	Target for process measure	Comments
" TWFHT has 4 providers who are accepting new patients into their practice in addition to 3 nurse practitioners. The remaining physicians will continue to roster patients as well, though in much more moderate numbers. New unattached patients will be identified through a link on our clinic website. We will advertise this link via multiple means. We will additionally accept direct referrals from UHN for individuals with significant medical comorbidities who require a primary care provider."	We will track the number of patients who apply, meet our criteria (in catchment and unattached), offered a new patient appointment, and complete the rostering process over the designated time period	We will continue tracking the mechanism by which new unattached patients self-identify or are referred through our intake form.	

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Patient/client perception of timely access to care: percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	34.00	45.00	This indicator is challenging as it is focused on patient perception of an appointment on the date they wanted	

Change Ideas

Change Idea #1 Improve patient's perception of timely access to care by taking advantage of our interdisciplinary care team responsbile for their care.

Methods	Process measures	Target for process measure	Comments
Our reception team employs a triaging process for acute patient concerns, including booking an urgent same day or next day appointment with a physician or NP or offering a triage call with the nursing team. We will track the number of triage calls done by our nursing team to better understand their involvement in addressing these acute concerns. We will combine this with examining our current communication tools with our patients to highlight that care may be provided by any member of our FHT team, including our nurses, in addition to their PCP.	We will track the number of triage call conducted by our nursing team over the next year.	As the initial step, our aim is to identify a baseline. We will adjust our intervetnion accordingly.	

Equity

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	56.00	75.00	University Health Network is aiming to implement mandatory EDI training for all their employees and physicians. However, given turnover and leaves, achieving a 100% target is not feasible at any single time point.	

Change Ideas

Change Idea #1 We will increase the percentage of staff who completed EDI education by offering multiple course options for their completion and following the mandatory deadlines set by the University Health Network leadership

Methods	Process measures	Target for process measure	Comments
As courses become available, we will notify the team. We will attempt to provide funding for any courses that charge a fee.	We will track the number of team members who completed a certified course in relation to the number of spots available in the course. We will track the relative interest in each course and offer a breakdown based on site and team role (i.e. physician, allied health, and admin)	We hope to offer a minimum of 4 opportunities to the team over the next year offering more than a single opportunity to complete a course for each staff.	

Experience

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) involve them as much as they want to be in decisions about their care and treatment	O	% / PC organization population (surveyed sample) All patients with an appointment in fiscal year are surveyed once	In-house survey / Most recent consecutive 12-month period	87.83	88.00	Patient involvement in decision making is an important element of high quality patient care	

Change Ideas

Change Idea #1 25% of patient interactions at our FHT are with resident physicians. We will employ our Partners in Care Program to encourage residents to allow more patient involvement in their decision making

Methods	Process measures	Target for process measure	Comments
The Partners in Care program is a long-running program aimed at promoting CanMED attributes beyond Clinical Expert, including Communicator, Collaborator, Professional, Leader, Health Advocate, and Professional. It is meant to support trainees in their ability to provide high quality patient-centred care. We will run the program in its full form to all PGY-1 trainees and obtain feedback for its improvement	We will obtain formal resident feedback regarding the impact of the Partners in Care program on their care delivery	We hope to see a 75% response rate by the residents on the quality and impact of this program over the following year.	Total Surveys Initiated: 1241

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients age 18-36 months who have received recommended childhood immunizations	C	% / Patients	EMR/Chart Review / 2024/2025	86.00	100.00	All children should receive the primary immunization series by the 18-36 month age range.	

Change Ideas

Change Idea #1 Increase the number of children age 18-36 months who received the complete age-appropriate primary immunization series.

Methods	Process measures	Target for process measure	Comments
"1) A chart review will be conducted to identify patients ages 18-36 months who do not have a complete immunization series documented in our EMR 2) The list will be provided to our nursing team with instructions to contact the parents/guardians to either provide the missing vaccination record or schedule an appointment for the vaccination"	We will track the parental/guardian response rate to the nursing inquiries through a custom form in the chart	We will aim for a response rate of 90% within 4 months of being contacted	

Measure - Dimension: Effective

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients age 7 years who have received recommended childhood immunizations	C	% / Patients	EMR/Chart Review / 2024/2025	51.00	95.00	All children should receive the primary immunization series by the age of 7. The target below 100% reflects children whose parents decline immunizations.	

Change Ideas

Change Idea #1 Increase the number of children age 7 who received the complete age-appropriate primary immunization series.

Methods	Process measures	Target for process measure	Comments
"1) A chart review will be conducted to identify patients aged 7 who do not have a complete immunization series documented in our EMR 2) The list will be provided to our nursing team with instructions to contact the parents/guardians to either provide the missing vaccination record or schedule an appointment for the vaccination 3) Children who are no longer patients at our clinic will be marked inactive"	We will track the parental/guardian response rate to the nursing inquiries through a custom form in the chart	We will aim for a response rate of 90% within 4 months of being contacted	