Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 27, 2025

Ontario Health

OVERVIEW

The Toronto Western Family Health Team (TWFHT) is dedicated to enhancing access to care and patient flow while minimizing administrative burden. We are working to achieve this through:

• Improved Appointment Booking: Online booking allows patients to schedule appointments with all healthcare providers at their convenience, even outside regular hours.

• Streamlined Processes: Standardized forms and digital systems like CHIME and Telus PS Suite increase efficiency for both patients and staff.

• Expanded Specialist Access: Partnerships with specialists offer on-site clinics in dermatology, neurology, and more, reducing wait times for referrals.

Patient engagement remains central to our approach. We utilize patient experience surveys to inform improvements and involve patient partners in recruitment and strategic planning. We also prioritize provider experience through workload assessments, flexible hours, and professional development opportunities.

Safety is paramount. Regular safety huddles, incident reporting, and quality improvement projects contribute to a strong safety culture.

Finally, the TWFHT takes a population health approach, offering proactive patient education and collaborating with other health system providers to promote health and prevent disease within our community.

ACCESS AND FLOW

The TWFHT is committed to continuously improving access to care and patient flow. To achieve this, we have implemented several key initiatives. We have increased specialist access through partnerships that offer on-site clinics in dermatology, neurology, and more, reducing wait times and improving collaboration. We have also enhanced appointment booking by making online booking available for all healthcare providers, allowing patients greater flexibility and convenience. To ensure timely care for urgent needs, we have implemented same-day access through Clinical Associates and a designated "Doctor of the Day," ensuring patients are seen promptly even when their primary care provider is unavailable. Recognizing the importance of efficient communication, we implemented a new call-centre software system in March 2024 to improve phone access, with features like call queuing and data-driven resource planning. These improvements build on our existing focus on patient engagement, provider experience, and safety. We continue to utilize patient feedback, offer professional development opportunities, and maintain a strong safety culture through regular huddles and quality improvement projects.

EQUITY AND INDIGENOUS HEALTH

The TWFHT is committed to providing equitable and compassionate care to all individuals, including those from marginalized populations. In 2021, we appointed physician and non-physician co-leads for Equity, Diversity, and Inclusion (EDI) to guide our efforts. These efforts were further strengthened in 2022 with the establishment of the interdisciplinary Social Accountability and EDI Committee.

Moving forward, we will continue to focus on advancing these initiatives through staff training and education. This includes previous initiatives, such as the 8-hour Anti-Oppression Training program offered by Urban Alliance on Race Relations and 90-minute bystander training sessions, equipping our team with the skills and knowledge to foster a more inclusive environment.

To better understand the needs of our patient population, we are continuing to work on identifying their social demographics through a standardized method. This data will inform future quality improvement initiatives and help us identify groups with unmet needs.

Finally, 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.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Patient engagement and experience are foundational to how the TWFHT designs and delivers health services. For over seven years, we have used a robust patient experience survey process, with quarterly dashboards reviewed by leadership and clinical teams. This data allows us to track trends and inform new initiatives. We incorporate patient experience metrics into formal programs like our Intensive Counselling Program pilot, which utilizes the CAMH's Ontario Perception of Care Tool, and into health education workshops. To further enhance patient engagement, we are increasing our number of trained Patient Partners, who are actively involved in recruitment, strategic planning, and co-designing programs with our team. We recently piloted a health workshop created and delivered with a patient partner, which is currently being evaluated. The TWFHT has a Patient Engagement Framework that is aligned with our current Strategic Plan and guides our efforts to ensure that the patient voice is central to all that we do.

PROVIDER EXPERIENCE

Healthcare providers at the TWFHT have faced the same human resource challenges impacting the healthcare sector. The pandemic response, evolving healthcare landscape, and changing patient expectations have contributed to increased stress for our staff. To address this, we have implemented several initiatives to improve provider experience. These include maintaining appropriate staffing levels with relief coverage, conducting workload assessments and standardization, offering flexibility with time off and work hours, and encouraging social events for team building and connection. We support professional development for our interprofessional healthcare providers (IHPs) through funded training opportunities and paid time off for participation in primary care activities like research and teaching. To further support full scope of practice, Nurse Practitioners at both sites have continued to expand their roles as primary care providers by expanding their patient panels, leading to increased professional satisfaction and improved access for new patients. Additionally, we leverage resources available through UHN, including access to a physician wellness lead who works to address workplace burnout.

SAFETY

Safety is a longstanding priority at the TWFHT. All team members complete mandatory safety e-learnings covering safety behaviours and error prevention tools. Both sites conduct daily safety huddles before morning clinics, using a "looking back/looking forward" approach to review safety concerns and operational updates. These huddles are followed by a summary email to the entire team, ensuring transparency and shared awareness. We utilize UHN's Incident Reporting and management system, with all staff trained on proper usage. Clinic managers investigate all reported incidents, and identified areas for improvement are addressed through ad-hoc working groups or at the committee level. Themes are also discussed at the Executive Committee level to ensure appropriate action. Currently, a working group focused on maintaining accurate medication lists in patient charts has been recognized by the CPSO QI initiative and presented at TASN forums. We are also actively working to update our preventative care visits to utilize the opportunity to ensure charts at up to date.

PALLIATIVE CARE

The TWFHT is committed to providing high-quality palliative care for certain patients at or near end of life with a strong emphasis on a patient-centered approach that prioritizes the holistic well-being of individuals and their families navigating serious/terminal illness. This commitment is demonstrated through key activities, including interdisciplinary collaboration, where physicians, nurses, social workers, and other specialists work together to develop personalized care plans that address a patient's physical, emotional, and spiritual needs, ensuring comprehensive and coordinated care. Palliative care is also an important element of our home-based primary care program. Furthermore, for patient’s for whom we work collaboratively to deliver palliative care, the TWFHT engages community partnerships, leveraging resources within the community and for home care, to ensure patients have access to a wide range of support services. This includes collaborations with organizations that offer specialized care, equipment, and emotional support. These activities reflect the TWFHT's dedication to person-centered care, coordinated services, and continuous improvement, which are key principles of the Quality Standard for Palliative Care and the Ontario Palliative Care Network model of care.

POPULATION HEALTH MANAGEMENT

The TWFHT is dedicated to advancing population health through proactive patient education and enhanced access to medical resources. We have expanded our educational programs to cover a wide range of health topics, empowering patients with the knowledge and tools to make informed decisions about their well-being. These programs, delivered through workshops, seminars, and online resources, address common medical concerns, chronic disease management, and healthy lifestyle habits. Our revamped website provides patients with reliable and up-to-date medical information at their fingertips.

As part of our commitment to Ontario Health Teams, we collaborate with other healthcare providers to implement 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. Through these collaborative efforts and our focus on patient education, we aim to enhance the overall health and well-being of our patients and community.

ADMINISTRATIVE BURDEN

The TWFHT prioritizes addressing and reducing administrative burden for both our staff and patients. We have focused on standardizing processes for patient forms, referral management, and new patient intake, with clear clinic policies articulated on our website. Introducing online booking has significantly reduced phone call volume for administrative staff, providing patients with a convenient alternative for scheduling appointments. To further maximize efficiency, we utilize digital systems like CHIME, an AI-powered clinic management software that automates patient wayfinding and supports collaboration. We are also progressively integrating new tools, including Ocean eReferrals and eConsults, to contribute to a more streamlined and efficient workflow, thereby allowing our team to focus on providing high-quality patient care.

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

_____

Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #1	**663.00**	**795**	**2443.00**	**268.48%**	**NA**
Number of new patients/clients/enrolments (UHN Toronto Western FHT)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)
OHT Population: Number of new patients/clients/enrolments					

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Process measure

- 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

Target for process measure

- We will continue tracking the mechanism by which new unattached patients self-identify or are referred through our intake form.

Lessons Learned

The ongoing push towards online processes help streamline the process for both the clinic and the community members. Ensuring a paper-based application option remained important to facilitate access for individuals with access challenges otherwise.

Access and Flow | Timely | Optional Indicator

Indicator #2

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 (UHN Toronto Western FHT)

Last Year		This Year		
34.00	45	50.40	48.24%	55
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

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

Process measure

- We will track the number of triage call conducted by our nursing team over the next year.

Target for process measure

- As the initial step, our aim is to identify a baseline. We will adjust our intervetnion accordingly.

Lessons Learned

Multiple efforts were made to improve access including increasing provider availability, adjusting clinic schedules to balance urgent and non-urgent appointments, utilizing online booking, and upgrading our phone lines to reduce wait times.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #6	**56.00**	**75**	**78.85**	**40.80%**	**80**
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (UHN Toronto Western FHT)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

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

Process measure

- 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)

Target for process measure

- 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.

Lessons Learned

A large proportion of our team met the criteria set by this QI project. An area for further exploration is determining what is meaningful EDI education to better determine areas of professional development for our team.

Experience | Patient-centred | Optional Indicator

Indicator #3

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)

OHT Population: All patients with an appointment in fiscal year are surveyed once

Last Year		This Year		
87.83	**88**	**91.30**	**3.95%**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

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

- We will obtain formal resident feedback regarding the impact of the Partners in Care program on their care delivery

Target for process measure

- We hope to see a 75% response rate by the residents on the quality and impact of this program over the following year.

Lessons Learned

Feedback has been positive with self-documented improvement in communication skills that lead to meaningful improvements in this measure.

Safety | Effective | Custom Indicator

	Last Year		This Year		
Indicator #5 Percentage of patients age 18-36 months who have received recommended childhood immunizations (UHN Toronto Western FHT)	**86.00** Performance (2024/25)	**100** Target (2024/25)	**97.90** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

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 4 months of being contacted

Lessons Learned

Ensuring updated tracking of our active patients is critical to determining the strengths of our interventions

	Last Year		This Year		
Indicator #4	**51.00**	**95**	**75.10**	**--**	**NA**
Percentage of patients age 7 years who have received recommended childhood immunizations (UHN Toronto Western FHT)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

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 4 months of being contacted

Lessons Learned

Ensuring updated tracking of our active patients is critical to determining the strengths of our interventions

Access and Flow

Measure - Dimension: Timely

Indicator #4	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	50.40	55.00	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 serves as the first point of contact for patients with acute concerns and directs them to the most appropriate provider based on established protocols. Patients may be offered an urgent same-day or next-day appointment with a physician or nurse practitioner or be referred for a triage call with the nursing team. To better understand the role of our nursing team in managing acute issues, we will track the number of triage calls conducted by nurses. Additionally, we will review and enhance our patient communication tools to emphasize that care may be provided by any member of our Family Health Team, including nurses, in addition by their primary care provider.	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 intervention accordingly.	

Equity

Measure - Dimension: Equitable

Indicator #1	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	78.85	80.00	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 aim to make the process of EDI education more meaningful and impactful for our team, patients, and community partners.

Methods	Process measures	Target for process measure	Comments
We will facilitate forum discussions engaging all relevant stakeholders to identify areas of potential growth for our team. Once collated, we will explore meaningful interventions to address these areas.	We will create a narrative report detailing the work	Completion of the narrative report with specific recommendations for our team.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	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	C	% / Patients	In-house survey / 2025	91.30	95.00	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.	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
eReferral: Percentage of clinicians within the primary care practice utilizing this provincial digital solution	O	% / Staff	Local data collection / Most recent information available	CB	100.00	There are many benefits to the eReferral system and registration for this program is simple.	

Change Ideas

Change Idea #1 As a family health team operating within a hospital network, we frequently utilise the hospital-based imaging services through JDMI. Our tools allow us to make referrals via 3 methods: paper-based faxed referrals, direct ordering through EPIC, and eReferrals. We will aim to transition our team to use eReferrals primarily.

Methods	Process measures	Target for process measure	Comments
We will provide clinician education regarding the method and benefits of ordering hospital-based imaging at UHN via eReferrals to all team members. We will engage the medical administrative assistant team to identify practitioners who are not yet utilising this system and individually inquire regarding barriers.	We will track the number of providers who utilise of eReferrals for medical imaging ordering at UHN at the end of 2025.	We will aim for 80% of providers to meet this target	