CAREFIRST FAMILY HEALTH TEAM
STRATEGIC PLAN 2016 - 2019

- **Enhanced Safety and Quality of Care**
  Commit to enhancing the safety and quality of care by:
  1. Improve communication and coordination across programs/services
  2. Maintain the integrity of patient information according to privacy and related legislation
  3. Enhance patient's capacity for self-management of chronic diseases
  4. Improve awareness among patients and families about programs and services
  5. Enhance staff competency in providing safe and quality related supports to patients and using evidence-based approach

- **Strategic Partnerships & Alliances**
  Invest in strategic partnerships and alliances as to respond to the needs of complex clients by:
  1. Provide comprehensive and integrated care for patients with complex care needs
  2. Support and facilitate patient knowledge related to programs and services accessibility
  3. Enhance service and scope of care for patients through community partnerships
  4. Provide comprehensive falls prevention programs for patients using an integrated approach
  5. Utilize standardized tools to assess needs of complex clients, that is uniformly used among external service providers

- **Improved Client Experience and Outcomes**
  Improve experience and outcomes for our clients by:
  1. Improve use of EMR
  2. Implement strategies to facilitate urgent patient needs
  3. Respond to patient needs in underserved geographic areas
  4. Provide outreach and mobile health promotion services to patients in underserviced areas
  5. Ensure patients receive timely and adequate follow up

Carefirst Family Health Team
Strategic Plan: Operational Implementation Plan (2016-2019)
Progress Update December 2018 – Q3

Color Codes:

Physicians Workgroup	
Admin Support Workgroup	
DEP Workgroup	
IHP Workgroup (RNs, NP, PT)	
IHP Workgroup (SW Team)	

STRATEGIC ISSUE #1: COMMIT TO ENHANCING THE SAFETY AND QUALITY OF CARE WE CURRENTLY PROVIDE

Objectives	**Activities**	**Responsibilities**	**Resources/ Input**	**Timelines** *S-T = April – July 2018* *M-T = April – Dec. 2018* *L-T = April 2018 – March 2019*	**Outcomes/Outputs**	**Indicators**
Improve communication across programs/services	Notify Family physicians when consults notes from internal specialists are available in EMR Improve communication with internal specialists through regular lunch and learns Improve communication with TCC when FHT patients are admitted (allow them to have restricted access to charts to document progress notes). Developing a mutually agreed upon workflow and communication forms between TCC and FHT MDs	Specialist Clinic TA Office Manager, Admin Lead Admin Lead, TCC Director, Ivan	Staff Specialist support Standardized work flow sheets and communication forms	ST and ongoing	-# of notifications generated -# of lunch and learns conducted (Target: 5 lunch and learns by MDs/Specialist) -# of participants attending lunch and learns (Target: 15 per session) -Development of standardized work flow sheet / communication forms -# of meetings with TCC and FHT (Target: 2 per year) **Progress Update:** Getting notifications for specialists who work at the specialist clinic, but not for those who see patients within FHT Have had 4 lunch and learns by specialists (usually well attended by staff) TCC has been sending standardized communications (i.e. admission or discharge notes). Haven't had a meeting with TCC	-% of MD's satisfied (Target: 90%)

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					yet though.	
Maintain the integrity of patient/client information according to privacy and other legislation.	-Review and implement client identifier policy and procedure to reduce error. -Explore electronic reporting capacity EMR to reduce paper documentation, increase efficiency and decrease error. -Develop orientation guideline/manual to include medication management and privacy information. -Review incident and complaint reporting system including incident types, example privacy breach. -Conduct chart audit.	Administrative staffs, HR, IT	-E-Fax system -EMR support -Incident Report system (Comply Track) -Chart Audit form	S-T L-T M-T S-T S-T	-No privacy breaches -MedDialog in place -Manual Developed -# of Training conducted (Target: 3) -# of chart audits conducted (Target: 5 per quarter)	-% of privacy breach incident reported (Target: 0%) -% of staff training provided (Target: 90%) -% of staff reported feeling competent in the use (Target: 95%) -% of staff reported satisfied with orientation manual (Target: 90%) -% of staff trained (Target: 90%) -% of staff reported satisfied with training offered (90%) -% of chart audit compliance (Target: 100%)
Enhance patient's self-management on diabetes and chronic disease management through programs/services	Provide education sessions in various forms related to diabetes and chronic disease management i.e. foot care workshops, cooking classes, grocery tours, exercise etc.	DEP team members	-DEP meetings -space available at Silver Star site (e.g. teaching kitchen)	S-T and ongoing	# of workshops organized (dining out 4 per annum, 3-4 cooking classes and grocery tours per quarter, 2-3 foot care workshops per year)	% of participants reported increased knowledge in self-management (Target: 80%)
Improve awareness among FHT patients and families about programs and services offered	-Develop consent form for the collection of patient emails for database -Incorporate into routine practice the collection of patient's email for database (i.e. as part of new	-Admin Lead -Front Desk -IHPs -All clinicians -IT	-Email consent form -All Staff meeting for discussion -Front desk enrollment process (current and expanded)	S-T	- # of Patients with email in database - # of mass emailing sent	- % of patients with email in database (Target: 65%) -% of patients aware of FHT services and programs

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	patient intake) -IT to help email patients regarding program/service promotion -Establish a social media committee for planning and exploration of the use of social media for program/ service promotion		- Satisfaction survey -Staff support -Social Media		- # of patient participation and satisfaction -Committee is established -# of posts on social media **Progress Update:** - over 690 consents collected for subscribing to email database - in progress for mass emailing with consideration of sending reminder letters on preventive care screenings and future flu shot clinic dates/hours - in progress for utilizing social media (such as FHT website)	available (from satisfaction survey) (Target: 70%)
Provide education and to promote awareness on Mental Health	Compile collection of mental health related handouts and brochures, and make available for Patients at waiting area, including a handout/flyer regarding FHT SW services. Further expanding and development of new Mental Health related group programming including: - Mindfulness/ Relaxation drop-in program -Interpersonal communication skills enhancement group.	-SW Team, led by Rui -SW student -SW Team, led by Grace	-SW Team's existing resources -External relevant resources -SW Team's existing resources -Books and training materials on specific topic areas (e.g. Mindfulness, Communication Skills, etc.)	S-T	-# of handouts distributed -# of Group sessions conducted (Target: 20-30) -# of Participants (Target: 10 participants per session) **Progress Update:** -over 260 mental health handouts distributed from September till now -43 group session conducted -227 participants	-% of patients reported feeling more aware of services offered through FHT (Target: 70%) -% of Patients reported self-improvement in mental health /stress related symptoms after group session (Target: 80%)
Increase patient's accessibility to social work services	SW team to schedule one morning each month (at each site) to provide SW drop-in sessions for patients with no prebooked appointments and for self-referring patients	-SW Team	-SW Availability -Room availability -Promotional flyers to encourage self-referrals	S-T	-# of drop-in sessions offered (Target: 2 per month) -# of patients accessing drop-in sessions (Target: 2-3) **Progress Update:** -offered sw drop-in from May to August, low attendance because team already provide same day/next day access to sw services	-% of Patients reported self-improvement in mental health /stress related symptoms after accessing drop-in session (Target: 80%)
Enhance staff competency in providing mental health related supports to patients using	SW Team to set up resource library for staff to accessing training books/materials on mental health related topics	-SW Team, led by Amanda -Admin Lead to assist with purchasing of	-Financial supports for staff training and professional development	S-T	-# and inventory of books/materials collected -# of staff utilizing / borrowing	-% of staff reported feeling satisfactory with the resource library in helping to

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evidence-based approach		books/materials	-Relevant books/materials		from resource library **Progress Update:**	promoting competency in mental health related issues (Target: 90%)

STRATEGIC ISSUE #2: INVEST IN STRATEGIC PARTNERSHIPS AND ALLIANCES TO RESPOND TO THE NEEDS OF COMPLEX CLIENTS

Objectives	Activities	Responsibilities	Resources/ Inputs	Timelines *S-T = April – July 2018* *M-T = April – Dec. 2018* *L-T = April 2018 – March 2019*	Outcomes/Outputs	Indicators
Provide comprehensive and integrated care for patients with Dementia through the implementation of a dementia strategy	Screening of patients over 65 when memory concerns are expressed Build a registry for those with cognitive impairment Explore the possibility of setting up a memory clinic for patients once per month by collaborating with external partners and providing training to internal staff Connect with Alzheimer's Society for resources/training	All Ivan MD, SW, RN/NP, Admin Lead SW	-Internal staff -Alzheimer's Society -Partnerships with Seniors Care Network and trainers	Medium-long term	-# of patients screened -# of patients on Dementia Registry -# of Memory Clinics offered (Target: 1 per month) **Progress Update:** Unknown # of patients screened, but those with memory concerns are usually referred to appropriate resources. No dementia registry built yet. Our own memory clinic is in development – some IHP's are receiving training and 1 MD is currently seeing patients in an external memory clinic.	-% of patients over 65 and who have memory concerns screened (Target: 100%) -% of patients diagnosed with cognitive impairment (of those screened) (Target: 70%) -% of patients with dementia referred to appropriate resource (i.e. memory clinic or geriatrician) (Target: 90%)
Support and facilitate patient and client knowledge related to programs and services Examples: chronic diseases and INTEGRATE	-Review/ provide staff training related to programs and services to increase staff awareness of programs and services eg. CDMP/ INTEGRATE /GAIN clinic -Facilitate the knowledge transfer to patients and clients of available programs and services through the dissemination of the welcome package.	Administrative staffs, IHPs, HR, IT	-Patient Welcome Package -Service Department brochures and promotional materials	M-T S-T	-# of Training conducted (Target: 5) -# of staff attended training (Target: 10-30 each session) -# of Patient Welcome packages distributed	-% of staff trained (Target: 90%) -% of staff reported satisfied with training offered (Target: 90%) -% of patients received welcome package (Target: 80%)

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Enhance service and scope of care for patient through partnerships	Partnership between FHT and optometrist to enhance client care and track annual eye exams Partnership between FHT and chiropodist to offer foot care workshop, and/or free for service chiropodist care Partnership with Carefirst Seniors Wellness/ CDMP and refer patients to CVR, EFPP, line dance, Tai Chi groups, etc. Partnership with communities pharmacists and refer patients for MedsCheck Continue OTN support with nephrologist	-DEP RN -DEP RD -Specialist clinic -Pharmacy	-DM custom form -New tracking form for initial visit -Tracking form for client follow up visits -survey -passport program -Client MedsCheck report	S-T and ongoing	# of patients who have annual eye exams completed # of Patients referred for foot care services # of DEP clients attending CVR, EFPP, line dance, Tai Chi # of patients who have annual MedsCheck completed # of counseling session offered via OTN	% of annual eye exams completed (Target: 80%) % of clients who were referred and received chiropodist care (Target: 70%) % of clients who were referred and attended group programs (Target: 80%) % of client who completed MedsCheck annually (Target: 80%) % of client reported satisfied with counseling support (Target: 90%)
Provide comprehensive falls prevention programs for Patients using an integrated approach.	-Conduct EMR search for patients of high-risk for falls -NP to provide assessment, counseling, and intervention for patients with high-risk for falls. -Physician(s) and IHP to develop clinical pathway for falls prevention -Develop and implement Home Safety and Risk Assessment Tool -Compile education materials on falls awareness and prevention for patients -Establish regular fall prevention education and bone health exercises classes for patients at risk -Develop tracking mechanism to track number of falls among patients over time. -Provide ongoing training and communication among physicians and IHPs in fall risk identification, and fall incidents reports	-Physicians -NP -IHPs -IT -all staff	-EMR -Incidents reports on comply track -Patient satisfaction survey	M-T	-# of training and communications provided on the integrated plan/pathways for fall prevention -# of patients receiving one-on-one counseling re: falls -# of patient attending group programs re: falls -# of patients identified on the falls risk database -# of fall incidents documented -# of patients self-reported improved bone health (BMD)/balance after intervention (group and/or one-on-one counseling) **Progress Update:** -Physiotherapist has received 225 referrals for individual consultation and treatment; - provided 8 falls prevention	-% of patients identified with high fall risk having falls within fiscal year (Target: >10%) -% of patients identified with high fall risk receiving counseling on falls risk (Target: 90%) -% of patients identified with high fall risk attending group programs on falls (Target: 70%) -% of Patients reported improved bone health / balance after intervention (group and/or one-on-one counseling) (Target: 90%)

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					education sessions in community CVR and fall preventions groups; - Conducted 17 home safety assessments and provided home exercises programs and in-home fall prevention interventions including assistive devices assessments; - Provided /organized 2 staff training sessions on Falls Prevention Strategies and Osteoporosis and Fragility Fracture -An integrated program: Osteoporosis, Fracture &Fall Prevention Program (OFFPP) has been established and implemented. The first group of 7 participants has finished 5 weeks of education and exercises training this fall . Otherwise, Nurses are conducting screening on patients for the following during their visits for complete physical: - diagnosis of Osteoporosis; - falls or balance issue within past 12 months (65 and over); - Any BMD done (65 and over) Patients with the diagnosis of Osteoporosis are offered with individual counselling by nurses (Ivan can provide Stats on # of Osteoporosis counselling done so far) Patients who are agreeable are referred to PT for the comprehensive fall prevention program (Xiao Ping can provide feedback on this)	
Utilize standardized tools to assess needs of complex clients, that is uniformly used among external service providers.	-Create IAR accounts for all SW members to be able to access InterRAI CHA scores conducted by external service providers. -Provide CIMS training for SW Team to populate InterRAI CHA assessment and generate scoring -SW Team is to ensure all INTEGRATE patients have INTERRAI completed by: a. check IAR/CIMS to see if InterRAI CHA already completed.	-Admin Lead to ensure SW Team has IAR accounts set up, and CIMS training provided -IT to develop custom form for documenting MAPLe score in EMR -SW Team ensure InterRAI CHA completed for all INTEGRATE Patients, and document in EMR	-IAR -IT department -CIMS -EMR	S-T	-IAR accounts set for all SW team members (Target: 3) -CIMS training provided (Target: 1) -# of INTEGRATE Patients with MAPLe (or InterRAI PS) score documented in EMR (Target: 50) **Progress Update:** -All SW have IAR accounts and all took CIMS training -5 MAPle scores documented,	% of INTEGRATE Patients with MAPLe (or InterRAI PS) score documented in chart (Target: 90%)

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	b. if no InterRAI completed, conduct InterRAI PS using CIMS; if identified as high risk on PS, then proceed with InterRAI CHA c. Input MAPLe scoring into EMR				another 15 more will be entered by January,2019	

STRATEGIC ISSUE #3: IMPROVE FUTURE EXPERIENCE OUTCOMES FOR OUR CLIENTS

Objectives	Activities	Responsibilities	Resources	Timelines *S-T = April – July 2018* *M-T = April – Dec. 2018* *L-T = April 2018 – March 2019*	Outcomes/Outputs	Indicators
Improve use of EMR	Set up e-faxing for referrals E-Faxing prescriptions to pharmacies Conduct regular privacy audits to detect breach Better EMR training for all staff	Ivan, front desk Ivan, front desk Privacy Committee, led by Dr. K. Lee, Admin Lead and other staff representatives) Ivan	Telus, IT, Finance	Medium-long tem	-# of incoming and outgoing fax generated -# of prescriptions faxed -Set up of Privacy Committee and # of meetings held -# of audits conducted (Target: 5 per quarter) -# of Training sessions provided (Target: 2 per year) -# of staff attending training session (Target: 30) **Progress Update:** E-fax has been implemented since Nov 2018 and most physicians are using it to fax prescriptions and referrals. Privacy committee was formed and has had 2? meetings. Ivan currently in process of doing privacy audits. We've had 2 EMR training sessions provided by IT.	-% front desk staff reported satisfied with the amount of time freed up from managing faxes (Target: 90%) -% of privacy breaches detected (Target: 0%) -% of staff satisfied with EMR training (Target: 90%)
Implement strategies such as "on call/ triage system" to facilitate urgent client needs	Facilitate appropriate and timely appointments with collaborations with physicians for same day appointments / next day appointments for urgent case	Administrative staffs, physicians, nurses	-On Call / Triage system -EMR schedules	M-T	- Clear on call schedule and flow chart developed.	-% of staff satisfaction (Target: 95%)

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Respond to clients' needs at underserved geographical areas	Increase quantity of English-based programs at Richmond Hill site via OTN Offer screening services and small group session via mobile health unit at multiple geographical areas	RN, RD, SW, team assistant	Mobile unit	S-T and ongoing	Conduct mobile outreach once every quarter	-% of patients reported satisfied with being able to access health related services in outreach location (Target: 90%)
Provide outreach and mobile health promotion services to patient in underserviced areas	-Identify services to be served on the unit such as primary care, screenings of COPD, preventive care and diseases, CDMP promotions and flu shot clinic) -Identify areas of need such as outreach to underserved areas (demographic and target populations)	-Admin lead -Team Leads -Clinicians	-Medical Mobile Unit -Clinical staff -Satisfaction survey	M-T	-# of outreach conducted using medical mobile unit -# of patients/clients served using medical mobile unit. **Progress Update:** - Nurses are involved in 2 occasions for event/outreach using the medial mobile unit (the Charity Walk and outreach to the Mapleglen Residences) - Activities conducted include blood pressure clinic/screening and measuring body height, weight , waist circumference and BMI - over 60 patients/clients are serviced during the Charity Walk event and 12 clients are served at the Mapleglen Residences	-% of patients reported satisfied with being able to access health related services in outreach location (Target: 90%) -% of patients at outreaching event reported increase in knowledge on health self-management (Target: 80%)
Ensure all Patients referred for SW services have adequate follow-up	-IT to conduct quarterly searches on EMR and generate list of patients' with last SW intervention note inputted 6 months ago; SW to then follow up with own cases.	-Admin Lead -IT -SW team	-IT search on SW Intervention Custom Form	S-T	-# of patients identified with follow up past 6 months -# of Patients followed up conducted **Progress Update:** -165 patients identified with no contact for the past 6 months.100% followed up as needed or discharged	-% of patients followed up within 6 months (Target: 85%)