Family Health Team

Annual Operating Plan Submission: 2018-2019

FHT Name: North York Family Health Team

Date of Submission: May 28, 2018

Primary Health Care Branch
Ministry of Health and Long-Term Care

Ontario

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Board Approval of Submission

By providing the signature of the Board Chair, the Board of the FHT certifies the following:

- The Board has formally approved the following Annual Operating Plan Submission
- All mandatory parts of the submission have been completed:
  - 2017-2018 Annual Report
  - 2018-2019 Service Plan
  - 2018-2019 Governance and Compliance Attestation
- The completed submission has been returned to the ministry on or before **May 31, 2018.**

Signature of FHT Board Chair or alternate Board authority:  Justin Gould, NYFHT Board Chair Print FHT Name: North York Family Health Team *I have the authority to bind the corporation*	**Date: 05/16/2018**

Introduction

The Family Health Team (FHT) Annual Operating Plan Submission is part of each FHT's accountability requirements to the Ministry of Health and Long-Term Care. The submission is comprised of three sections:

PART A: 2017-2018 Annual Report – **mandatory**
PART B: 2018-2019 Service Plan – **mandatory**
PART C: 2018-2019 Governance and Compliance Attestation – **mandatory**

The healthcare sector has undergone significant transformation and improvement in key areas of accessibility, integration, quality and accountability. FHTs play an integral role in enhancing primary care by organizing services around the following principles:

- ***Enhancing patient access*** through reducing the number of unattached patients, increasing house calls and community outreach, offering timely appointments, etc.

- ***Local integration and collaboration*** with health care providers, community partners and Local Health Integration Networks (LHINs) in person-centred planning, care coordination and program/service delivery.

- ***Improved quality*** through the implementation of improvement activities identified in Quality Improvement Plans and through the design and delivery of person-centred primary care services and programs.

The Annual Operating Plan Submission must be submitted electronically to the FHT's Senior Program Consultant no later than **May 31, 2018.**

Note:

Opportunities for increases to FHT operating budgets in 2018-2019 are limited. FHTs are encouraged to base their 2018-2019 budgets on their existing allocation and to work closely with their ministry representative to address any unforeseen operational pressures using the in-year reallocation process. If a FHT is seeking funding for any additional resources in 2018-2019, the request must be justified by the submission of a detailed business case. **(See Attachement: Request for Additional Resources)**

Part A: 2017-2018 Annual Report

1.0 Access

Increasing access to comprehensive primary care has been a key priority of Ontario's interprofessional programs. Considerable progress has been made in attaching patients to a family health care provider. Access is about providing the right care, at the right time, in the right place and by the right provider, through activities such as offering timely appointments, providing services close to home, after-hours availability, and a compassionate approach to bringing on new patients.

1.1 Patient Enrolment

State your patient enrolment target for 2017-18, as indicated in Schedule A, Appendix 3 of your current agreement. Please also state the number of patients you have enrolled by March 31, 2018.

Patient enrolment	Target March 31, 2018	Actual March 31, 2018	
Number of enrolled patients	85,000 Active 73,000 Rostered	89,420 Active 68,060 Rostered	
Are physicians enrolling new patients?		Yes ☒	No ☐
Please explain:			
If the target was not met, please explain why and outline your plan to meet this target:			

1.2 Patient Enrolment – Access for New Patients in 2017-2018

Please explain how new patients were referred to FHT services.

	Yes	No
Were patients who contacted the FHT directly (self-referrals) enrolled?	☒	☐
Were any new patients referred by Health Care Connect (HCC)?	☒	☐
Were patients from other sources enrolled? (e.g., hospital, home care, other physicians/specialists)	☒	☐
Were any new patients referred by Health Links?	☒	☐

1.3 Non-Enrolled Patients

Where resources are available, FHTs are encouraged to offer interprofessional programs and services to both enrolled and non-enrolled patients. If the FHT serves a specific non-enrolled patient population, describe the target population, services required, method used to estimate the number of patients served by the organization, and why the patients are not enrolled. Please provide an estimate of the number of non-enrolled patients served.

Non-enrolled patients: 21,360 (over 3% increase from last year)

Diabetes Education Centre Patients:

- NYFHT DEP is a community-based service as per the Ministry/FHT Agreement
- Rostered patients (FHT physician members only)
- Non rostered patients (community physicians that are non members of the FHT) are tracked on EMRs

Cancer Survivorship Program Patients (Stages I to III):

- There is a five (5) year surveillance for cancer recurrence following end of active treatment at North York General Hospital; visits occur every 6 months and as needed according to patient symptoms.
- NYFHT received permission from MOHLTC to care for all colorectal cancer survivors (stages I-III) who have finished their active treatment at NYGH, in order to: increase access to oncologists by newly diagnosed cancer patients; increase access to follow-up care by cancer survivors with symptoms; reduce duplication of diagnostic imaging and thereby improve system efficiency and patient safety, improve adherence to Cancer Care Ontario guidelines for surveillance care, increase the degree of patient-centeredness by virtue of nurse-practitioner and case worker provision of care

FHO physicians within the FHT support non-enrolled patients by seeing:

Obstetrical Patients:

- Caring for pregnant patients rostered to other family physicians but referred to NYFHT physicians due to their expertise in perinatal care and delivery
- NYFHT received permission from MOHLTC to provide FHT services to these patients, as pregnant patients are understood to be in a critical period for health behavior change, especially around nutrition, exercise and relationship skills (all services provided by our FHT)
- The number of patients is based on number of deliveries done by the OB group at NYGH

Palliative Care Patients:

- Caring for palliative patients rostered to other family physicians but referred to NYFHT physicians due to their expertise in palliative care

Affiliated Physician Office Patients:

- Physicians see patients that prefer not to roster. These patients are considered active patients and receive care.

Are FHT programs available to members of the broader community? Please explain.

The Diabetes Education Program and the Colorectal Cancer Survivorship programs service patients other than those affiliated with member physicians as per the MOHLTC directive.

1.4 French Language Services

Does the FHT provide programs and/or services in French for patients whose mother tongue is French, or patients who are more comfortable speaking French?	Yes ☒	No ☐
If yes, provide an estimate of how many patients	N/A Data not collected by AHPs but provides French speaking services as the need	

	arises.

1.5 Accessibility to Cultural and Language Services

Does the FHT address the linguistic and cultural needs of the population being served, where possible? Please explain.
The NYFHT aims to accommodate the linguistic and cultural preferences of our patients. We utilize translation services for patients of the NYFHT who require care in a different language. The NYFHT also has a diverse community of employees who helps to address the unique linguistic and cultural needs of patients when they arise. For the upcoming year, NYFHT will incorporate cultural sensitivity and inclusiveness training as part of employee and new hire training.

1.6 Regular and Extended Hours

What are your regular hours of operation when patients can access IHP services? *Ex.: Mon: 9-5, Tues: 8-4, etc.*	Hours of operation: Mon: 8:30 – 6:00 Tues: 8:30 – 6:00 Wed: 8:30 – 6:00 Thurs: 8:30 – 6:00 Fri: 8:30 – 6:00 Sat: Closed Sun:Closed

	Group Sessions extended into evenings to accommodate patients
When are FHT services available after hours?	Extended hours: Mon- Fri: 6:00- 8:00pm (Group Sessions extended into evenings to accommodate patients)
Identify which programs are offered after hours:	**Diabetes Education Programs** **Mental Health Group Programs** **Nutrition Group Programs**
Additional information:	

1.7 Timely Access to Care

Please provide information on how appointments were scheduled in 2017-2018.

Timely Access to Care		
Does the FHT currently schedule appointments on the same day or next day (within 24 to 48 hours)?	Yes ☒	No ☐
If yes, what percentage of total enrolled patients is able to see a practitioner on the same day or next day, when needed? (Please indicate with an asterisk "*" if the value entered is an estimate)	-currently not tracked % -patients are triaged depending upon their urgency	

1.8 Other Access Measures

Please provide information on other types of access measures provided in 2017-2018.

Other Access Measures	

Percentage of FHT practitioners who currently provide home visits?	5% Homebound patient program, led by a nurse practitioner beginning in 2018/2019
Which types of IHPs perform home visits?	Physician Assistant Registered Nurse Homebound patient program, led by a nurse practitioner beginning in 2018/2019
Number of home visits performed by IHPs in 2017-2018	-as needed (20 plus) -turnover due to maternity leaves

Emergency Department (ED) Diversion		
Does the FHT have a strategy to divert enrolled patients from the ED (a**side from physician contractual requirements for after hours**)?	Yes ☒	No ☐
Please describe the strategy: (Examples: NP after-hour clinics, ED Reports (CTAS 4, 5), triaging, patient awareness procedures (phone calls, posters, website, reminders), hospital discharge follow-up, outside use reports follow up)		
➢ Continuously working with North York General Hospital on efforts to improve integration between hospital and community care i.e. to improve transitions after hospital discharge in order to decrease readmission rates (7 Day follow up initiative, reviewing ED reports and reason for admissions, etc) ➢ Part-time NP Homebound patient program currently being implemented. Due to lack of NP resources, it is only part-time. Request for more funding in this service. ➢ Active partner in Health Links ➢ Active collaboration in Assess and Restore initiative, partnered with NYGH and CCAC which is aimed at Falls Risk prevention and early detection ➢ Cancer Survivorship Program- led by our Nurse Practitioners, CSP provides ongoing surveillance and detection of colorectal cancer survivors, diverting care		

from NYGH.

- Shared data warehouse between the FHT and NYGH assists us to work together to review patient admissions and strategize implementation activities to support enhanced community-based care vs. acute episodic care

How are patients made aware of hours of operation? (Examples: visible clinic signage, voicemail, patient pamphlets, FHT website or other means)
Patients are made aware of NYFHT Central Services via personal contact, voicemail, patient pamphlets, and the FHT website. Physicians are responsible for making patients aware of office hours at each of their community office sites.

2.0 Integration and Collaboration

Collaboration with community partners is a key priority for FHTs. As the entry point to the health care system for many Ontarians, primary health care providers need to partner with other health and social service organizations in the communities they serve.

These partnerships can improve patient navigation, expand the suite of supports available to patients, and facilitate seamless transitions in all steps of the patient's journey. Meanwhile, care providers benefit from more efficient and coordinated service delivery.

2.1 Service Integration and Collaboration with Other Agencies

For those agencies that you are either collaborating or integrated with, please check the appropriate box if you have coordinated care plans, memorandums of understanding, shared programs and services, or shared governance.

	Coordinated Care Plan	Memorandums of Understanding	Shared Programs and Services	Shared Governance	Other	Comments:
Children's Services	☐	☐	☒	☐	☐	Physicians only - eCHIN, a member organization that allows HICs to access pediatric hospital data and on-line referral systems Information sharing with Children's Aid Society regarding referrals. Partnerships with children's mental health agency Skylark Youth and families. Case management-produced Children's service resource for physician offices.
LHIN - Home and Community Care	☒	☐	☒	☐	☐	Health Link partnerships In progress of working with CCAC to improve streamlining of services to meet primary care patient needs CCAC coordinator assigned to each physician office, assigned contact person/liason. Telehomecare collaborative with CCAC for CHF patients
Community Health Centre	☐	☐	☒	☐	☐	Share best practices and knowledge between agencies in mental health service CHC's are part of LHIN meetings in strategizing population health initiatives "patients first-action plan for health care" discussions Patient and Staff information sessions
Community Support Services	☐	☐	☒	☐	☐	See "CCAC" Section In the process of collaborating with local community support services (ie: Ontario Works, Mental Health) to integrate and share community resources, led by NYFHT Case Worker. Collaborating with NYGH on leading community Advance Care Planning workshops

						Connecting maternal newborn patients to Toronto Public Health Particiaption in community service meetings when possible such as Fairview Interagency Network
Developmental Services	☐	☐	☐	☐	☒	RN's identify patients and connect as appropriate. Case worker supports system navigation for the patient and family
Diabetes Education Centre	☒	☐	☒	☐	☒	Collaborative care between NYFHT and NYGH diabetes complex care centre Collaborative care with community physicians and other agencies
Local Hospital	☒	☐	☒	☒	☐	Shared Board Governance from hospital to FHT Hospital FHO now a member of FHT North York Central Health Link Programs: Colorectal Cancer Survivorship Program; DEP; CHF Optimization Program Numerous Committees and Initiatives: Primary Care Integration Committee, Connecting Care Initiative, shared data warehouse initiative, Breast Cancer Integrated Care Collaborative, etc. Other Hospitals Research collaborative(s) Close partnership with DFCM Integrated Funding Model for CHF and COPD Shared partnerships in leading projects such as Advance Care Planning workshops.
Mental Health and Addiction Services	☐	☐	☒	☐	☐	Partnered with CAMH for STOP Smoking Cessation Program Update sessions for staff
Public Health Unit	☐	☐	☐	☒	☐	LHIN Primary Care Transformation Plan
Senior Centre/Service	☐	☐	☒	☐	☐	Active physician participation in Geriatric Working Group with NYGH

FHT: (specify)	☐	☒	☒	☐	☒	QIDDS leader for 3 other FHT's; DPT data sharing project with 2 other cluster FHT groups across southern Ontario; QI support processes; chronic disease collaborative project with 2 other FHTs; ED collaboration; ED support of other FHTs
Long-Term Care Homes	☐	☐	☐	☐	☒	Integration via CCAC Case worker linking patients to housing options and CCAC. Host information sessions for patients
Other: (specify)	☐	☐	☐	☐	☐	Collaborate with community services offering supports for various communities I.e. Taibu and black communities of the GTA, Pilipino senior community, transgender community

Please describe any involvement in LHIN-led initiatives (e.g. sub-region work)

- Medical Director continues to liaise with Primary Care Lead at the LHIN
- Ongoing communication and community meetings with the LHIN on primary care transformation and Patients First Action Plan for Health Care
- Turnover at Central LHIN - Primary Care Lead and Primary Care Medical Lead X 2.

2.2 System Navigation and Care Coordination

Is the FHT involved in Health Links? Indicate if Lead (i.e. funding recipient) or Partner	Yes ☒	No ☐	Partner/Lead Partner

How does the FHT help navigate patients through the health care system? Please provide up to three examples, i.e. referral protocols to link patients with other appropriate providers or organizations; coordination with hospital for post-discharge primary care; LHIN collaboration for home care supports, other follow-up care, etc.

1. Collaborating with hospitals to ensure 7 day discharge follow-up for high risk patients being discharged from hospital. Our recently implemented NP homebound program will be key in supporting this work as well as continuing to

liase and encourage CCAC to have their care coordinators follow up with community based needs.
2. Affiliated physicians continue to accept patients that are referred from Health Links that require a physician or are being referred from other LHINs and Health Links.
3. Continuing to work closely with NYGH and other community agencies to receive patients requiring diabetes education and/or colorectal cancer support
4. Coordination of care by NYFHT Case Worker to connect patients to appropriate providers and services to facilitate tailored systems navigation, supporting patients in need such as those in low income situations, complex care needs.

2.3 Digital Health Resources

Clinical Management System/Electronic Medical Records

Please provide information on your EMR

Which EMR vendor/version is being used?
Practice Solutions 5.2 Accuro 2015.01

	Level of integration 1) None 2) Read-only 3) Full integration	If no EMR integration, are other data-sharing arrangements in place (e.g., case conferencing)? Please provide any other comments
LHIN – Home and Community Care	None	Yes
Emergency Department	None	Yes
Hospital	None	Yes
Laboratory Service	Full integration	*Physicians have full integration, FHT Clinical services do not.
Other (specify):	None	

Are you able to electronically exchange patient clinical	Yes	No

summaries and/or laboratory and diagnostic test results with other doctors outside of the practice?	☒	☐

Are you able to generate the following patient information with the current medical records system:	Yes	No
Lists of patients by diagnosis (e.g., diabetes, cancer)	☒	☐
Lists of patients by laboratory results (e.g., HbA1C<9.0)	☒	☐
Lists of patients who are due or overdue for tests or preventative care (e.g., flu vaccine, colonoscopy)	☒	☐
Lists of all medications taken by an individual patient (including those ordered by other doctors)	☒	☐
Lists of all patients taking a particular medication	☒	☐
Lists of all laboratory results for an individual patient (including those ordered by other doctors)	☒	☐
Provide patients with clinical summaries for each visits	☒	☐

Do FHT patients have access to the following patient-facing online services?	Yes	No
Direct email communication with the FHT	☒	☐
View patient test results	☐	☒
Request prescription refills/renewals	☐	☒
Book appointments with Family Health Team providers	☐	☒

Does the FHT have a data sharing agreement with the affiliated physician group(s)?	Yes ☒	No ☐

Please explain how the EMR is used for tabulating patient statistics, identifying and anticipating patient needs, planning programs and services, etc.

In general, The NYFHT uses EMR systems to collect data and perform statistical analysis on the following:

- patient demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, weight, BMI and billing information, patient and population for program planning, preventive cancer screenings including cervical, breast and colorectal cancer screening, chronic disease management and follow ups, and possible trends and long term changes in patients.
- data collection and analysis to inform the quality improvement initiatives, program planning and evaluations.
- examine the current performances of our programs and services, establish baselines, and set targets.

In addition since 2008, NYFHT has been part of the Canadian Primary Care Sentinel Surveillance Network (CPCSSN) project, Canada's first multi-disease electronic record surveillance system that contains digital health information of patients with chronic disease for surveillance and primary care research. Through CPCSSN, our EMR data have been collected, cleaned and standardized on selected chronic health conditions facilitating production of reports for physicians about their practice and in comparison to others within the region, province, and across the country.

Furthermore, the NYFHT was the first site that implemented the Data Presentation Tool (DPT), a software application that was developed by CPCSSN. The software has enabled us to produce statistical reports using cleaned and standardized data extracted and merged from our EMRs. Production of these reports have led our physicians and the FHT to making informed decisions based on actual data.

The use of DPT has helped our FHT to overcome the limitations of our EMR systems and help physicians transform their data into useful information providing a path toward the meaningful use of EMRs.

2.4 Data Management Support

Please provide information on any data-management support activities in 2017-2018.

Does your organization use the services of a QIDS Specialist or any other data management specialist?	Yes	No

	☒	☐

If yes, how has this role helped your organization with quality improvement, program planning, and performance measurement? Please describe any challenges and successes.

1- QIDSS Services:

We share our QIDSS with three other FHTs in the area.

- In collaboration with the team and physicians, identifies, develops and monitors the Health Quality Ontario formal QI plan (QIP).
- Supports senior leadership and clinicians in quality improvement and decision support needs.
- Provides methodological support, data extraction, collection, and analysis for the FHTs QI initiatives, program evaluations, and research projects.
- Is a member of and supports the work of the Information Management/Information Technology Committee in implementation of quality improvement projects both relevant to EMR data optimization and health care services improvement.
- Chairs and supports the work of formal QI committee to review performance data, identify areas in need of improvement, and carry out and monitor the mandated Health Quality Ontario QI Plan and additional improvement efforts.
- Chairs the Electronic Medical Record (EMR) data standardization committee to support and promote standardization of EMR data entry to improve consistency of patient care, data sharing and reporting. .
- Performs statistical analysis and develops reports related to priority measures for various levels of the organization.
- Prepares reports and presents results to the NYFHT leadership team, physicians, allied health care professionals and staff to identify gaps and improve performance.
- Performs benchmarking to evaluate various aspects of the health services processes through comparison with industry's best practice.
- Provides QI orientation for new FHT employees.

2- Data Manager Services:

- Supports the implementation of NYFHT data optimization initiatives to identify, track, and correct poor quality data in two EMR systems (ie. Rostered patients, smoking status, diabetes, CHF, COPD to name a few).
- Designs, tests, and deploys tools (templates, stamps, and flow sheets) and processes for standardizing care, managing performance data in two different EMR systems.

- Supports and develops standard operating procedures for data cleaning, and communicates resolutions for data quality issues to NYFHT leadership.
- Supports the improvement of EMR data by identifying gaps in the EMR data and provides solutions.
- Create reports using EMR and FHT stats quarterly on stats of the FHT centralized programs and individual stats for ministry reporting.
- Creates reminders and searches/queries for various FHT QI projects and analyses the progress of FHT projects on a timely basis.
- Provides EMR orientation for new FHT employees.
- Responsible for the data extraction for various QI projects and summer student programs.
- Responsible for assisting family medicine residents with their QI project data needs.

3.0 Other

3.1 Other Information and Comments

Public Engagement Strategy: Does the FHT have a formal mechanism to include patient and community input into FHT planning and priorities?

Virtual Patient Advisory Collaborative

Patient experience surveys

Focus groups

Workshops/Meetings

Does the FHT have a formal process to include input from the Local Health Integration Network (LHIN) and other system and community partners?

Process included meetings and feedback as needed i.e. shared projects, research, Committees, other FHT's etc.

The Ministry of Health and Long-Term Care likes to promote the work done by FHTs. Please describe any awards, acknowledgements or achievements from 2017-2018.

- NYFHT's Insomnia program, lead by our pharmacists and social work team and involving our registered dietician and medical director, won the AFHTO Bright Lights award.
- NYFHT's award winning Insomnia program was a featured HQO article in Quorum
- The NYFHT's work supporting sedative hypnotic De-prescribing was accepted as at the DFCM Conference 2017, a presentation *titled "An Interdisciplinary Approach to De-Prescribing Sedative-Hypnotics in the Elderly*"
- The NYFHT DEP is an accredited program through Diabetes Canada Standards Recognition Program.
- NYFHT allied health staff presented at this year's AFTHO conference, including the following:
    - *Introduction of a Multidisciplinary Program to Deprescribe Sedative Hypnotics (SH) in Patients ≥65 years of age in a large multi-site Family Health Team (FHT)* – Pharmacist & Social Work Team
    - *Improving Patient Outcomes One FHT Pharmacist at a Time* – Pharmacist
    - *An innovative smoking cessation program for cancer survivors within a primary care setting* – Nurse Practitioner
    - *Determining Prevalence of Malnutrition in North York Family Health Team Geriatric Population at High Risk* – Registered Dietician Team
- NYFHT RN and QI specialist presented at Quality Improvement and Patient Safety Forum 2017 in a poster titled: *Screening Program for Patients at Risk of Falls –Pilot Phase*
- NYFHT QI specialist presented at in a poster titled: *Improving Patient Care Through Formation of a Data Standardization Committee*
- NYFHT pharmacist lead, Eric Lui, presented at the *Conference on Sedative-Hypnotics De-prescribing* in a Medication Management Workshop Day .
- NYFHT acquired funding to incorporate a Psychiatrist and Addictions Counsellor into its team
- Implementation of a Virtual Patient Advisory Collaborative
- Implementation of a Privacy committee, of which all members are in the process

of acquiring privacy certification

Is there anything else that the organization would like to communicate to the ministry regarding its activities in 2017-2018? Any challenges, opportunities and recommendations for the ministry can also be detailed in this space.

Challenges:

- Decision-makers/funders with expectations that FHT's can implement strategies with member physicians that are outside of FHT control i.e. advanced access, emails, patient complaints involving physicians and their staff,etc.)
- Ensuring PHIPA legislation is followed i.e. email processes between providers and patients, EMR/database sharing agreements between agencies
- Accountability performance indicators that are not aligned between the Ministry/ HQO/AFHTO
- Different FHT structures creates confusion for a one contract or agreement fits all i.e. some ED's are managing physician private offices
- Conflict of Interest situations for Charitable/Non Profit FHTs and Boards

Recommendations:

- Equity in FHT AHP and administrative salary and benefits compared to other community health services including other FHTs
- Accountability framework expectations for FHT's that are aligned between the Ministry/LHIN/HQO partners
- Proactive Ministry/LHIN support to FHT's in physician relationships i.e. agreements
- Proactive PHIPA legislation awareness/support to FHT's and member physician offices

Part B: 2018-2019 Service Plan

The objective of Part B is to capture your organization's vision and strategic priorities as well as program and service commitments in 2018-2019. The five-year longitudinal evaluation of FHTs showed that organizational factors such as articulating a clear vision and establishing clear priorities were often associated with higher performance. Part B therefore provides you with the opportunity to describe the results of visioning and priority-setting exercises for your organization, and how these translate into program and service commitments and associated measures. Part B is comprised of two components:

1. **Section 1.0: Strategic Priorities and Vision**: in this section, FHTs are provided with the opportunity to identify their strategic priorities and broader vision for 2018-2019, with an emphasis on the activities planned in the areas of access and integration, collaboration and quality improvement.

2. **Section 2.0: Operations, Programs and Services** are to be detailed in the attached Schedule A, Appendix 3 template. FHTs are strongly encouraged to reflect their vision and strategic priorities in the programs and services offered. Performance measures for programs and services should be detailed in Schedule A, Appendix 3 which will be incorporated into your budget, forming the basis for performance monitoring and evaluation throughout the fiscal year.

1.0: Strategic Priorities and Vision

1. *If available, please describe the vision of the Family Health Team. Please indicate if this has been clearly articulated to staff, patients and partners.*

The North York Family Health Team's (NYFHT) vision is to enhance quality primary healthcare, interdisciplinary learning, and clinical research to improve the health of the diverse patient population within our community. Our mission is to provide accessible, patient-focused, and family-centered primary healthcare through an interdisciplinary team committed to transforming health knowledge into best practices. The values of the NYFHT are: patient and family centered care, teamwork, continuous learning, and communication. The NYFHT is committed to maintaining a culture of mutual respect, accountability, confidentiality and collaboration, and will make a determined effort to ensure effective communication and build positive relationships with patients, staff and partners. The NYFHT's vision, mission, and values are clearly articulated to all staff, patients and community partners through our

ongoing discussions, meetings, website and various communication materials.

2. *Identify the strategic priorities for the FHT that will apply to the 2018-2019 fiscal year.*

1. *O*rganizational capacity building:
   - ✓ support the development of a primary health care model that incorporates equity of care for our subLHIN population by working with partners to enhance current primary care as well as improved integrated care "Patients First Action Plan for Health Care"
   - ✓ create FHT FHO/Physician services and data/privacy contractual agreements both for current physician members and for future physician relationships
   - ✓ ensure ongoing Board governance development and education.
2. Health system innovation:
   - ✓ develop and maintain a focus on quality improvement, data management improvement, and innovation in evidence based use of resources and technology.
3. Health system sustainability:
   - ✓ develop, implement and manage various strategies aimed at supporting and sustaining the infrastructure of the FHT such as EMR transition, data standardization, flexible budget, and coordination and integration of services with partners.
4. Improved service access and delivery:
   - ✓ continue partnership integration and collaborative strategies that will broaden the planning and delivery of services to FHT patients.
5. Improved health status and reduced health disparities
   - ✓ develop, implement and spread programs targeted for high risk populations, thus aligning priority health care to the needs of our community.
6. Enhancement of communication programs and strategies:
   - ✓ include targeted plans that meets the intended audience segment by using preferred communication tools.
7. Human Resources
   - ✓ advocate for comparable and equitable salaries to other Ministry funded community agencies for all FHT employees

3. *Please explain how the strategic priorities identified in Question 2 support the objectives of advancing access, integration/collaboration and quality improvement, as applicable.*

All of the above strategies will support patients in our community by advancing access to quality-based care that is population and partnership (integration/collaboration) focused.

The NYFHT Board has currently received further education in strategic planning processes and will be drafting and implementing a new plan for 2019 if not sooner.

4. *Does the FHT plan on undertaking a capital project (major renovation/construction/lease-hold improvement/re-location to a new or existing space) within the next two to three years? If yes, please provide us with a brief project description, including anticipated timelines and budget (if known).*

The current 10 year NYFHT lease will expire on October 30, 2018. The NYFHT plans to continue to lease space in this building if possible with the new owner and providing the terms are reasonable.

This FHT began with 28 employees and 11,559 square feet. We currently have 45.4 employees and the current space is not sufficient to our expanding needs for patient services. We also have specialist consultants such as psychiatry to support our mental health services. This FHT is an academic primary care organization and hence, is asked to support student training needs for AHP's and physician residents. We are asking for an additional 3,441 square feet for a total of 15,000 square feet in our new lease to support these essential primary care services.

Timeline: lease ends October 30, 2018

Budget: square foot increase of 3,441 for a total of 15,000 square feet at market price in North York.

2.0: Operations, Programs and Services

Using the attached template for Schedule A, Appendix 3, please describe how the organization's IHP resources are being applied across each of the programs and services offered to patients. The template should be completed for new and existing programs and services and should capture the involvement of all ministry-funded IHP FTEs.

Please populate the template, using one row per FHT program and one row for Acute & Episodic Services.

The attached Appendix A "Programs and Services Details" provides further direction on how to complete Schedule A, Appendix 3.

To assist with Schedule A, Appendix 3 completion, FHTs are encouraged to access a wide range of resources on program planning and reporting available through the Association of Family Health Teams of Ontario (AFHTO).

Part C: 2018-2019 Governance and Compliance Attestation

Strengthening accountability in Family Health Teams is a key component of enhancing the quality and performance of the primary care sector. Sound governance

practices play an important role in enhancing accountability, performance and the overall functioning of an organization. As part of the efforts to enhance access, quality and accountability, beginning in the 2015-2016 fiscal year, all Family Health Teams are required to complete and submit the Governance and Compliance attestation annually.

Please complete the Governance and Compliance Attestation (separate document) with accurate information on current board and governance structures and practices.

APPENDIX A – PROGRAMS AND SERVICES DETAILS

When deciding whether an activity should be classified as a program on Schedule A Appendix 3, consider the following:

- Was the program planning process followed to establish specific goals, objectives and admission criteria to the program?
- Are there admission or referral criteria to access the program?
- Will a targeted intervention be delivered?
- Is it a planned patient visit?
- Has the Family Health Team (FHT) assigned specific FHT staff (Full Time Equivalents = FTEs) to deliver the activities of the program?

Program categories can include:

- Disease specific programs, e.g. heart health or lung health. Often these programs involve multiple provider disciplines in the delivery of care
- Population group focused programs, e.g. seniors' health
- Discipline specific programs, e.g. this could be a program of services delivered by a practitioner, such as chiropody services or occupational therapy services
- Health promotion/prevention programs, e.g. immunization program or cancer screening

The attached Decision Flowchart provides a schematic that outlines the patient's journey through Acute/Episodic Services and/or Programs:

Step 1:

Often, the patient's initial encounter for a health concern is through an acute/episodic service encounter. Exceptions are when the patient can self-refer directly to a program or is triaged through reception directly to a program, based on admission/referral criteria for that program.

Step 2:

After assessment by a Physician/Nurse Practitioner/Physician Assistant/Registered Nurse/Registered Practical Nurse for an acute/episodic service, a determination is made to:

i. Refer to a program that will address the patient's needs. Referral is based on established referral/program admission criteria; or
ii. Follow-up with the patient through another acute/episodic service appointment; or
iii. Refer to external providers or programs/services; or
iv. Issue is resolved and no further follow-up is required.

Performance Measures for Programs and Services:

Programs should include clinical outcome measures as performance measures:

- e.g. Number of patients with Chronic Obstructive Pulmonary Disease (COPD) who have diagnosis confirmed with pulmonary function test/post-bronchodilator spirometry and have an advanced care plan completed or in progress

Acute/episodic services may include performance measures such as:

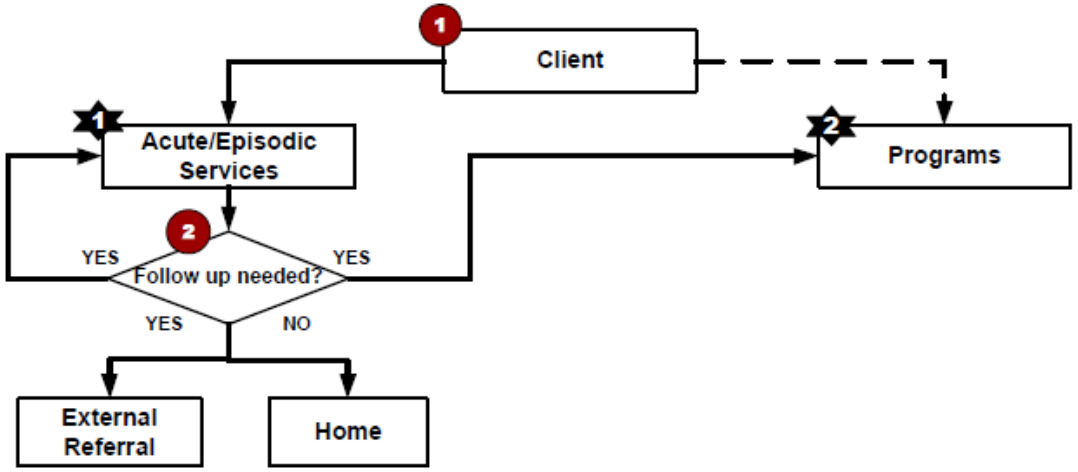
- access (e.g. availability of same day/next day appointments)
- system level indicators such as impact on patients seen within 7 days post hospital discharge, Emergency Room diversion, etc.

Summary:

Overall, Schedule A, Appendix 3 should “tell the story” of the FHT – how are the FHT interdisciplinary provider resources used to meet the needs of the patient population? What are the **outcomes** of the services and programs that are delivered?

For additional information on developing, implementing and evaluating programs and services please visit the AFHTO website.

Schedule "A" Decision Flowchart



Program Category Examples

- Disease Specific
- Population Group
- Discipline Specific
- Health Promotion/ Prevention

Processes		Additional Notes	
1	Initial encounter is for acute/episodic/immediate primary care need, unless self-refer or triage (- - -) directly to programs	1	Examples of acute/episodic services performance measures: • Access (e.g. # of visits, same day/next day) • System level indicators (e.g. ER diversion)
2	After assessment by MD/NP/RN/RPN/PA, determination made to: • refer to programs based on established referral/program admission criteria • follow up with another acute appointment, • external referral, or • "home", i.e. issue resolved	2	Programs: • Program planning process is followed • Admission/referral criteria to program are created • Planned visit • Targeted Intervention • Use of clinical outcome measures expected as a performance measure. Eg. Number of patients with COPD who have had diagnosis confirmed with pulmonary function test/post-bronchodilator spirometry