Access and Flow | Timely | Custom Indicator

Indicator #3

Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed. (Southlake FHT)

Last Year		This Year	
48	**55**	**54**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Supply individual providers with access related data on a regular basis for decision making and practice management

Process measure

- 1. Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment (TNA) for a new patient physical, routine exam, or return visit exam. 2. Percentage of providers with an appropriate panel size (defined as the number of unique patients seen by a specific provider within the last 18 months and number of total clinician hours devoted to appointments on a monthly basis)

Target for process measure

- 1.Collecting baseline 2. Collecting baseline

Lessons Learned

We developed quarterly reports for providers, featuring key access-related metrics such as practice supply and demand, panel sizes, third-next available appointments, no-show rates, online appointment usage, and outside usage. Additionally, these reports included updates on FHT programs, upcoming clinics (e.g., flu and pap clinics), new community initiatives, and EMR tools.

The reception to these reports has been positive, with several providers expressing eagerness to leverage the data and analytics to improve patient access in their practices. These reports have effectively engaged providers in enhancing access and have fostered greater receptiveness to change compared to previous initiatives.

Ensuring sustainability for these reports could pose a challenge due to the intensive resources needed to extract and generate the data.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Increase efficiencies of workflows involving digital assets such as electronic communications, online booking and electronic referrals.

Process measure

- 1. Percentage of patients with email and documented email consent on file 2. Percentage of patients with email on file but do not have documented email consent 3. Percentage of appointments that are booked online for individual providers 4. Number of e-referrals sent by primary care providers

Target for process measure

- 1. 70% of all patients in the organization will have email and appropriate indication of consent for electronic communication on file by March 31, 2024 2. No patients will have an email address on file without documented consent for electronic communication (i.e. 0%) 3. 35% of appointments will be booked online across all sites (where applicable) by March 31, 2024 4. Collecting baseline for number of e-referrals sent by primary care providers.

Lessons Learned

Our team implemented a new electronic communication consent tracking system that is capable of identifying consent status regardless of whether it was obtained through our self-check-in kiosk, online patient portal, or in-person.

We meticulously retrofitted over 3000 patient charts with this new digital tracking mechanism. Collectively, we have updated over 6,700 patient charts with the latest electronic consent form.

Comment

According to our latest patient experience survey, 54% of patients and clients were able to consult with a doctor or nurse practitioner on the same day or the next day when necessary. Additionally, 53% of patients found the wait time for urgent appointments reasonable. Although we didn't meet our target this year, we maintained a rate higher than the previous years' median.

From our patient experience surveys, we found that 27% of patients reached a live operator within 3-5 minutes when calling to book an appointment, while 17% were on hold for over 10 minutes. Our team remains dedicated to reducing phone wait times and improving alternative access methods such as online booking.

Indicator #4	Last Year		This Year	
Percentage of patients with a cervix aged 25 to 69 years who had a Pap test within the previous three years. (Southlake FHT)	**65** Performance (2023/24)	**70** Target (2023/24)	**68.90** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Provide easily accessible communication and education for patients who are overdue for a pap test

Process measure

- 1. Number of emails sent 2. Number of page views for cancer screening on patient portal 3. Number of page views for cancer screening on website

Target for process measure

- 1. 100% of patients overdue for a pap test within the measured period, with indication of electronic consent on file, will receive an email with education materials and instructions on how to book an appointment every 6 months. 2. Collecting baseline 3. Collecting baseline

Lessons Learned

We offered nurse-led pap clinics across all of our sites. We emailed over 1000 patients overdue for screening with links to educational material and links to book an appointment with our clinical team.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Provide clinicians with timely and up to date information pertaining to their screening rates and overdue patients

Process measure

- Number of reports given to providers

Target for process measure

- 100% of provider will receive one report with their overdue patients every 6 months.

Lessons Learned

We developed quarterly reports for providers, featuring key access-related metrics such as practice supply and demand, panel sizes, third-next available appointments, no-show rates, online appointment usage, and outside usage. Additionally, these reports included updates on FHT programs, upcoming clinics (e.g., flu and pap clinics), new community initiatives, and EMR tools.

These quarterly reports also contained a list of patients overdue for cancer screening. Each report was customized according to each physician practice across all sites.

Change Idea #3 ☐ Implemented ☑ Not Implemented

Conduct Pap clinics regularly

Process measure

- Number of pap clinics; number of patients booked in pap clinics

Target for process measure

- A minimum of 12 pap clinics will be scheduled by the end of March 31, 2023

Lessons Learned

Instead of restricting our nursing clinics solely to pap smear tests, we found it more beneficial to establish regular clinics at our satellite sites offering a comprehensive range of nursing services, including injections, well-baby checks, and pap tests. In the past year, our nursing team administered over 140 pap smear tests.

Indicator #8

Percentage of screen eligible patients aged 50 to 74 years who had a mammogram within the past two years. (Southlake FHT)

Last Year		This Year	
55	**60**	**66.50**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Provide easily accessible communication and education for patients who are overdue for a mammogram

Process measure

- 1. Number of emails sent 2. Number of page views for cancer screening on patient portal 3. Number of page views for cancer screening on website

Target for process measure

- 1. 100% of patients overdue for a pap test within the measured period, with indication of electronic consent on file, will receive an email with education materials and instructions on how to book an appointment every 6 months. 2. Collecting baseline 3. Collecting baseline

Lessons Learned

We employed a multifaceted approach, including social media campaigns, signage and website updates, to disseminate information about cancer screening.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Provide clinicians with timely and up to date information pertaining to their screening rates and overdue patients

Process measure

- Number of reports given to providers

Target for process measure

- 100% of provider will receive one report with their overdue patients every 6 months.

Lessons Learned

We developed quarterly reports for providers, featuring key access-related metrics such as practice supply and demand, panel sizes, third-next available appointments, no-show rates, online appointment usage, and outside usage. Additionally, these reports included updates on FHT programs, upcoming clinics (e.g., flu and pap clinics), new community initiatives, and EMR tools.

These quarterly reports also contained a list of patients overdue for cancer screening. Each report was customized according to each physician practice across all sites.

Equity | Equitable | Custom Indicator

	Last Year		This Year	
Indicator #9	**CB**	**CB**	**30**	**NA**
The percentage of providers that are satisfied with current resources available for referring and managing patients from the LGBT2SQ+ population. (Southlake FHT)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Have easily accessible and centralized resources to support providers that manage patients from the LGBT2QS+ population

Process measure

- 1. Number of providers that consider these resources as useful

Target for process measure

- 1. 100% of providers will find the centralized resources in the EMR useful

Lessons Learned

Our Case Manager developed a document in our electronic medical records system that contains helpful resources to help manage patients that are part of the LGBTQ2S+ population.

Comment

While only 30% of providers expressed satisfaction with current resources for referring and managing patients from the LGBT2SQ+ community, 50% remained neutral. This data suggests a potential scarcity of adequate community resources rather than dissatisfaction with the content of the provided handout. Equity, diversity, and inclusion remain a priority for our organization, and we are committed to enhancing the quality of care in this area through our 2024-2025 Quality Improvement Plan.

Experience | Patient-centred | Custom Indicator

Indicator #7	Last Year		This Year	
Percentage of providers that state they are aware of all FHT programs and services (including group programs), and know how to refer to each program. (Southlake FHT)	**CB** Performance (2023/24)	**CB** Target (2023/24)	**81.30** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Develop a centralized, updated and intuitive system for providers to know what FHT programs are offered and how frequently these programs will be offered

Process measure

- Percentage of referrals to group programs from providers

Target for process measure

- Collecting Baseline

Lessons Learned

We've effectively rolled out a "FHT Navigation Toolbar," a digital solution streamlining and automating program referrals across all our sites. This tool eliminates the need for providers to recall program details, criteria, and referral procedures, thus enhancing efficiency. Moving forward, it will facilitate further enhancements, particularly in measuring program wait times with our allied health providers.

Comment

In our initial 2023 survey, 32% of providers reported being familiar with all FHT programs and services, including group programs, and knew how to refer patients to each one.

Following the implementation of our change ideas, a 2024 follow-up survey showed a significant improvement, with 81.3% of providers finding it easy to refer patients to FHT programs and services, including group programs. However, only 50% indicated awareness of when group programs are offered at the SAFHT, suggesting a potential area for further improvement in the upcoming years.

	Last Year		This Year	
Indicator #6 Percentage of providers that state it is easy to refer patients to FHT programs and services (including group programs) (Southlake FHT)	**CB** **Performance (2023/24)**	**CB** **Target (2023/24)**	**73** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve referral paths by streamlining processes and resources

Process measure

- Average wait time for IHP providers

Target for process measure

- Collecting Baseline

Lessons Learned

A survey targeting our primary care providers revealed that 45% of the challenges in referring to FHT programs and services stemmed from administrative processes, such as completing forms, understanding program criteria, and identifying proper request channels. 27% of the challenges were related to communication and keeping track of active programs.

Identifying these barriers enabled us to develop tailored interventions aimed at alleviating these challenges and lessening the administrative workload for our providers.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Develop a centralized, updated and intuitive system for providers to know what FHT programs are offered and how frequently these programs will be offered

Process measure

- Average wait time for IHP providers

Target for process measure

- Collecting Baseline

Lessons Learned

We've effectively rolled out a "FHT Navigation Toolbar," a digital solution streamlining and automating program referrals across all our sites. This tool eliminates the need for providers to recall program details, criteria, and referral procedures, thus enhancing efficiency. Moving forward, it will facilitate further enhancements, particularly in measuring program wait times with our allied health providers.

Comment

Since implementing these change ideas, a follow-up survey distributed in 2024 revealed there was a 25% increase in providers that stated it was easy to refer patients to FHT programs and services (including group programs).

	Last Year		This Year	
Indicator #1				
Percent of patients in weight management program would recommend this program to others (Southlake FHT)	**CB**	**70**	**100**	**NA**
	Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Work collaboratively with patients and our partnered specialist physician to determine appropriate outcome measures for this program

Process measure

- 1. Percentage of patients who completed the weight management program 2. Percentage of patients who completed evaluation and provide feedback

Target for process measure

- 1. 50% of patients enrolled will complete the program 2. 60% of patients who completed the program will provide feedback

Lessons Learned

33 patients have enrolled in this program since the initial pilot last fiscal year. Based on our evaluation survey, nearly all patients indicated that they were able to apply new tools, skills and strategies to their problematic eating behaviours.

We faced challenges with patient education and awareness of program resources, such as medications, local exercise facilities, and mental health services. In follow-up group sessions, we highlighted available resources and clarified how patients could access them.

Comment

Using some of our learnings from our patient focus groups, our team developed weight management program that takes a holistic approach to weight management. An approach that includes not only dietary and exercise components but provides cognitive-behavioral tools, activities and strategies that address problematic and emotional eating behaviors. This year, our resources were allocated to help expand this program to our satellite sites. Based on provider and patient feedback, we developed key performance indicators for this program which include 5% reduction in weight over 12 months and improvement in quality of life using a self reporting tool.

Safety | Safe | Custom Indicator

	Last Year		This Year	
Indicator #5	**CB**	**CB**	**NA**	**NA**
Percentage of patients with cognitive impairment who have a standardized cognitive impairment custom form in their chart. (Southlake FHT)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Provide a standardized method for coding and documenting patients with cognitive impairment in the EMR

Process measure

- 1. Number of patients with cognitive impairment that have diagnosis code and cognitive impairment form in chart 2. Number of patients with cognitive impairment that have no diagnosis code and/or no cognitive impairment form in chart 3. Length of time from when cognitive impairment form is entered in chart to the next point of care

Target for process measure

- 1. Collecting Baseline 2. Collecting Baseline 3. Collecting Baseline

Lessons Learned

While the tool's adoption fell short of expectations, it has effectively directed our attention towards enhancing geriatric care as part of our quality improvement efforts. Considered a foundational step, this tool will pave the way for future initiatives in our 2024-2025 QIP which aims at better supporting our elderly population.

Comment

In our pursuit of safe and efficient care, we implemented standardized procedures for identifying and documenting cognitive impairment in patient records. This initiative enhances the recognition of individuals who may face heightened risks due to communication difficulties and complex medical requirements. Introducing a uniform workflow for identifying and managing patients with cognitive impairment has been promoted for internal adoption. Notably, at a recent 2024 Quality Improvement retreat, this tool sparked interest in a program aimed at enhancing elder care within our organization.

Safety | Effective | Custom Indicator

	Last Year		This Year	
Indicator #2 Percentage of inappropriate bookings in the urgent care clinic (Newmarket site) (Southlake FHT)	**CB** **Performance (2023/24)**	**CB** **Target (2023/24)**	**NA** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Improve urgent care triaging process with nursing team

Process measure

- 1. Outside usage rates 2. Number of urgent care appointments triaged by the nurse

Target for process measure

- 1. Collecting baseline 2. Collecting baseline

Lessons Learned

Tracking the number of inappropriate appointments booked into the urgent care clinics proved to be a very challenging task for our team.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Improve administrator education for urgent care triaging

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Our team conducted a root analysis by conducting chart reviews of previous urgent care clinics. Although the source of issue was not conclusive, our team was able to implement some mitigation strategies to reduce the likelihood of booking errors in urgent care clinics. These strategies included education to our administrative team, revision of our urgent care booking guidelines, development of script for triaging and easier access to booking guidelines through the electronic medical records (EMR) system.

Comment

Following our 2023 Quality Improvement Retreat, our interdisciplinary team prioritized enhancing urgent care triaging. Booking non-acute, chronic, or other non-urgent issues into urgent care slots can impede access for truly urgent cases. Therefore, we concentrated on educating administrative staff to improve triage accuracy. To supplement our training and education for our administrators, our nursing lead and medical director revised our urgent care booking guidelines into a user-friendly document. This document was then embedded into our EMR system to help sustain these changes through future staff turnover.