

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 31, 2026

OVERVIEW

At Southlake Academic Family Health Team (SAFHT), we are committed to improving the care we provide to our patients and community. Quality improvement is part of how we work every day. Over the past year, we have focused on using data, teamwork, and practical solutions to improve access to care, patient and provider experience, equity, and safety across our programs and sites.

We are proud that SAFHT received two Association of Family Health Teams of Ontario (AFHTO) Bright Lights Awards this year, including an award focused on strengthening quality improvement skills. This recognition highlights our team's ability to identify problems, work together across roles, and make real changes that improve how care is delivered. These efforts have helped improve patient safety, reduce administrative challenges, and support staff and providers in their daily work.

We have also made progress in preventive care. Breast, cervical, and colorectal cancer screening rates have improved through better use of data, partnerships with patient advisors, and collaboration with regional cancer programs. By listening to patients and learning more about barriers to screening, we have identified gaps for certain groups, including patients living with obesity, and are using this information to guide future improvements.

In addition, we have strengthened administrative processes through initiatives such as weekly administrator training, clearer workflows, and shared information portals that help staff access consistent and up-to-date information. We are also exploring the future use of artificial intelligence tools to support administrative

work and improve access to care.

This year's Quality Improvement Plan (QIP) will focus on reviewing and enhancing access to mental health services, strengthening physician and provider access, and continuing to improve cancer screening with a particular emphasis on patients living with obesity. In addition, the QIP will advance health equity by extending equity-focused initiatives beyond new patient outreach and embedding them across existing clinical programs; streamline clinician and resident physician access to e-consult services; and deepen collaboration with our hospital partners and the heart function clinic to integrate primary care more effectively into multidisciplinary care pathways for patients living with heart failure.

ACCESS AND FLOW

SAFHT aligned its work with Ontario Health's priority indicators by strengthening cancer screening and improving access to preventive care in primary care settings. Our team continues to exceed provincial averages in colorectal (14.3% higher), cervical (17.2% higher), and breast cancer screening (10% higher). EMR data showed that 44% of patients overdue for breast or colorectal screening fall within obesity class I–III, highlighting a high-risk group requiring targeted support. Partnering with the University of Toronto, we co-designed a patient survey that identified three key needs: more provider-initiated invitations, better education and resources, and reduced systemic barriers. Through our Weight Management Program, overdue patients now receive personalized outreach with screening instructions. Over the next year, we will expand educational tools and introduce digital workflows to enhance access and efficiency.

Based on patient experience survey results, we prioritized improving urgent care access and phone accessibility. We enhanced our phone system data tracking to enable real-time analysis. With an average of 425 calls per weekday at our main site and clearer insight into peak call times, we implemented a call overflow process that allows staff to support the call centre during high-volume periods, reducing wait times.

We also strengthened administrative training through weekly "Admin Elevate" refresher sessions and improved internal communication channels to support knowledge sharing and timely issue resolution.

Last year, we introduced an urgent care triage tool to support administrative decision-making and improve booking efficiency. Since implementation, providers have flagged over 86 cases to help refine the tool. Over the next year, we will continue analyzing utilization of same-day and next-day appointments and further optimize booking workflows to ensure timely access for patients.

EQUITY AND INDIGENOUS HEALTH

Our organization is advancing health equity by systematically collecting and applying sociodemographic data to drive targeted improvement. Through our EMR-based Health Equity Questionnaire (HEQ), we capture key information including age, sex, gender, income, education, race, and language. Over 180 responses have been collected this year through email outreach and self-check-in kiosks.

This information enables us to identify disparities and integrate equity-focused actions into our Quality Improvement Plan. For

example, we recognize that individuals with low income and members of LGBTQ2S+ communities often face greater barriers to accessing care. The data also helps us proactively identify patients who may qualify for fee exemptions for uninsured services or who require special consideration for medications, diagnostics, or other services not covered by insurance. This supports more equitable clinical decision-making and resource allocation.

To further strengthen our approach, our team participated in a University of Toronto Department of Family and Community Medicine (DFCM) community of practice focused on implementing the SPARK Tool, a provincial initiative designed to standardize the collection and use of sociodemographic data in primary care. Through this collaboration, we learned how structured equity data can inform strategic planning, program design, and performance measurement. We also consulted with DeepEnd Canada to enhance leadership engagement, clarify data governance, and build sustainable training processes. We are currently assessing whether adopting the SPARK Tool would further align our organization with provincial best practices and advance long-term equity goals.

PATIENT/CLIENT/RESIDENT EXPERIENCE

We hosted a successful QI retreat this year in Feb 2026. With participation from physicians, interdisciplinary health team members, residents, administrative staff, and representatives from satellite sites, we asked open ended questions and collected information about what is at the forefront of everyone's minds. We provided time for passionate discussions in small groups and sharing opinions with the larger FHT team. Anonymous qualitative data was collected via an online sharing platform accessible through participants' mobile devices. Evaluation of the previous event showed that participants appreciated the opportunity for their ideas to be shared. We reviewed the real time data collected during this session, especially regarding top QI priorities voted by participants. After the QI retreat, we summarized this information and constructed our quality improvement plan for the upcoming year accordingly. In addition, patient experience data is collected via the ongoing patient experience survey available at all sites of the Department of Family and Community Medicine (DFCM). Our patient experience survey data empowers patients to articulate their experiences and involvement in their care decisions. This valuable feedback is integral to our quality improvement interventions, guiding our efforts to enhance patient satisfaction and care delivery. Additionally, we utilize some of this data to establish objective metrics, such as perceived wait times on the phone, further refining our processes, and ensuring optimal service delivery.

PROVIDER EXPERIENCE

Recruitment and retention continue to be a challenge in primary care, where compensation often does not keep pace with hospitals and other healthcare settings. Despite these pressures, SAFHT has

taken intentional steps to create a workplace where staff feel supported, valued, and motivated to stay and grow.

Over the past year, SAFHT focused on strengthening workplace culture and staff experience. These efforts were recognized through an AFHTO Bright Lights Award in the category, “Growing Great Teams: Building Culture, Retaining Talent, and Transforming Care Through Collaborative Learning.” This award highlights SAFHT’s shift from crisis hiring toward building a strong sense of belonging, trust, and team connection. Initiatives such as flexible scheduling, visible leadership, staff wellness support, professional growth and daily recognition practices have helped improve morale, teamwork, and staff retention.

SAFHT continues to use an annual staff satisfaction survey to gather feedback on staff experience. Results are reviewed by leadership and the Board of Directors to guide improvement goals. Staff are also supported through opportunities to participate in committees, quality improvement work, teaching, and mentorship, helping staff feel engaged and valued in their roles.

In addition, SAFHT continues to work closely with the AFHTO to advocate for improved funding and compensation for primary care teams. These advocacy efforts have contributed to the recruitment and retention funding received this year, which has helped slightly to stabilize staffing and reduce immediate pressures. However, this funding does not fully close the compensation gap between primary care and other healthcare sectors. Continued investment will be needed to support long-term workforce stability and ensure teams can meet growing patient needs.

SAFETY

Our organization previously experienced significant successes in promoting patient safety awareness and engagement internally with our Doing It Better rounds, which was restarted after COVID in 2025 and continues regularly over the past year. Also as part of the patient safety curriculum for resident physicians, these sessions provided formalized, collaborative education on the process of significant event analysis to all members of our clinical and administrative team including staff, residents and allied health professionals. Cases analysis was led by a staff physician and discussions were documented in patient safety flow sheet designed by the residency program. We aim to host these sessions twice a year.

We continue to encourage staff to continuously reflect on potential safety concerns in their work, including those unique to a hybrid environment of in-office and virtual care. Repeated reminders to the team have been issued to bring forth safety incidents, which also helps to build an incident repository in preparation for resuming these rounds in the near future. With support from resident physicians, and as part of our work towards safe and effective care, we are working on standardizing our approach towards identifying and documenting cognitive impairment, advanced care planning conversations, and substitute decision maker/power of attorney in patient’s electronic medical records. This helps to improve recognition of these patients who may be at increased risk for errors due to challenges with communication and complex medical needs.

PALLIATIVE CARE

Our Advance Care Planning (ACP) project aims to document cognitive impairment, advanced care planning conversation, and substitute decision maker/power of attorney for patients who may require additional support for high-quality care delivery including those with palliative needs and end-of-life care. Initial chart review showed that more than 140 patients have a documented Montreal Cognitive Assessment (MoCA) score of less than 26 points, indicating at least mild cognitive impairment. We also hope to identify those with functional decline by assessment and documentation of independent versus dependent status of activities of daily living (ADL) and instrumental activities of daily living (iADLs), further risk stratifying patients who may require additional palliative care support.

With this data, we hope to implement tracking systems for goals of care, advance care planning, power of attorney and substitute decision makers. With support from our medical learners, we developed patient handouts to help facilitate these discussions with patients or caregivers utilizing resources from ACP Ontario. Documentation opportunities are currently embedded into the preventative screening toolbar. We hope that these quality improvement initiatives will lay down the foundation for planning high-quality palliative care delivery.

POPULATION HEALTH MANAGEMENT

SAFHT advances population health management through strong partnerships and a structured, data-informed approach to care. SAFHT is an anchor partner within the Northern York South Simcoe (NYSS) Ontario Health Team (OHT) and serves as the fund holder for two Interprofessional Primary Care Teams (IPCTs) within the NYSS

OHT. Through these roles, SAFHT works closely with hospital, primary care, community, and social service partners to better understand and respond to the health and social needs of our communities.

Guided by the Rapid Improvement Support Exchange (RISE) framework, our approach begins with population identification. Through our IPCT model, we systematically segment our patient population based on physical, mental, and social needs. Using intake tools and EMR data, patients are assigned a level of complexity ranging from prevention to palliative care and identified as managed or unmanaged. This allows our teams to prioritize outreach, assign care managers to patients with advanced needs, and proactively follow patients at risk of falling through gaps in care.

As part of this work, our IPCTs operate a Mobile Health Unit to reach patients who may face barriers to accessing traditional clinic-based care. This outreach model helps connect underserved individuals to primary care, screening, and social support.

Through collaboration within the NYSS OHT, our IPCTs continue to strengthen data sharing, improve hospital-to-primary care transitions, and align health and social services. By linking shared data with coordinated care pathways, our IPCTs are improving equity, continuity, and health outcomes across the region.