Family Health Team

Annual Operating Plan Submission: 2016-2017

FHT Name: OakMed Family Health Team (OFHT)

Date of Submission: April 25, 2016

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

Part A: 2015-2016 Annual Report

1.0 Access

Increasing access to comprehensive primary health 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

Patient enrolment	Actual March 31, 2016	Target March 31, 2016	
Number of enrolled patients	8088	8200	
Are physicians enrolling new patients?		Yes ☒	No ☐

1.2 Patient Enrolment – Access for New Patients in 2015-2016

	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, CCAC, 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.

It is well documented that the 1%-5% users of healthcare, characterized as the complex/high user patients, comprise specific target population that decline enrolment or are not rostered due to a variety of needs that cannot be met by the FHT alone.

Utilizing our Nightingale EMR system and ICD codes we are able to create patient registries to show primarily the correlation between non enrolled patients and certain disease types and illnesses. This has informed the additional services and programs as well as the community supports and relationships that we are creating to identify and meet the needs of these target groups.

Most specifically OFHT has found that there is a distinct relationship between non enrolled patients and the following issues:

1. Care of the Elderly (Frail Elderly)
2. Serious Mental Health, Addictions (Concurrent Disorders and Dual Diagnosis)
3. Chronic Pain; Degenerative Diseases
4. Older teens (transition between Child & Youth Services, to Adult Services – well documented gap in the transition)
5. Socio- Economic Status issues, other Social Determinants of health

Additionally there is a notable bolus of patients whose decision to not roster could collectively be described as simply wanting convenience. They understand their obligations with respect to being rostered and so do not agree to do so. They do not want to give up the convenience of stopping at any walk in clinic whenever and wherever they want. Until there are some changes to the existence and convenience of walk-in clinics, these unrostered patients will always exist.

<u>Care of the Elderly/Frail Elderly</u>

OakMed FHT has a large demographic of older patients as 3 Physicians have a specialty in care of the elderly. Therein, many patients come from the surrounding areas (Hamilton, Burlington, Mississauga etc.) have the opportunity to receive our exceptional care.

Furthermore, during bad weather conditions frail elderly patients are reluctant to travel to their Family Doctor, especially when they are coming from surrounding areas. That is when the potential of going around the corner to a walk-in clinic for a quick concern seems like a good enough solution, therefore we have to come up with ways to address this predicament. To remedy this, OakMed FHT has created close relationships with our transportation services: Care-a-van and Red Cross, as well as we have partnered with Seniors in Need; these services, however, require 10-12 days advance notice in order to use them. In numerous cases, when elderly patients do not have family or friends available to drive them, or when they lack the funds for taxi, they end up visiting another health provider. We have tried to address this issue by providing home visits whenever possible, but unfortunately, since we have a large number of elderly patients, we cannot possibly provide home visits to all patients. Ultimately, the bulk of our physicians' time has to be dedicated to the in-house patients.

Additionally, we have tried to support this demographic by providing specialized services such as our Memory Clinic, Elder Care workshops, Chronic Pain management, Let's Talk Diabetes, Polypharmacy and Sleep Well. Our Seniors' program that we run in cooperation with the Oak Park Neighbourhood Community Centre and the Alzheimer's Society of Brant, Haldimand Norfolk, Hamilton Halton has proved to be a highly anticipated weekly event for the seniors

residing in the community. The program's recreational and educational components are structured to meet the needs of this demographic.

Serious Mental Health, Addictions, Concurrent Disorder and Dual Diagnosis

At present OakMed FHT has 1.0FTE RSW. Our RSW was seeing near 600+ individual patients for a mix of psychotherapy, harm reduction, discharge planning, case management, resources provisions, system navigation and supportive counseling while running near 8 groups. It is impossible to meet multi-dimensional needs of this population with this limited resource. More often than not this population does not have an address, access to transportation and very limited, if any, financial means. It is frequently a choice between having a next meal and purchasing a prescribed medication, so missed appointments, no shows, going to walk-in clinics have become the norm as we're trying to accommodate these patients to the best of our abilities.

OakMed FHT continues to find ways to better service this group by partnering with community support services such as Summit Housing, Addictions supportive housing (ASH), ADAPT, AA, NA, CMHA, TEACH programs/services, STRIDE (dual diagnosis services for employment support), Halton Women's Centre, Ready4Life, Our Scars, Homewood, and HHS outpatient. We have done our best to ensure that appointments are booked at times which accommodate patient needs (evenings, mornings, weekends), we provide reminder calls and use a strengths based solution focused empowerment approach to patients coming to the FHT for their own care.. We partnered with the Oak Park Neighbourhood Centre in order to accommodate more patients willing to attend our programs.

Chronic Pain/Degenerative Diseases

We partnered with the existing chronic pain services in our community – Maximize Your Health and Arthritis Society to service patients with established chronic pain more efficiently. However, unfortunately, we've experienced a low demand in the program due to a very limited population needing the services; this development prompted the decision to close the program and to divert human and financial resources to the programs with the higher demand.

Older teens (transitional services)

It is a well-documented gap that transitional services are notorious for. OakMed FHT understands that healthy behaviors and wellness starts at a young age so, we try to ensure that patient and family health is always looked after. That being said, self-harm/injury behaviors, eating disorders and substance use and abuse are prevalent in our demographic and we are unable to continue to meet the demands of serious issues that impact mental, physical and emotional health. OakMed FHT has created partnerships with the local high schools, public health, Halton parents, ADAPT for youth, the navigator program (HHS), Oak Park Neighborhood Centre, Reach Out Centre for Kids (ROCK), Eating Disorder program at HHS and Credit Valley Hospital. Currently, our RSW provides an array of services to this population, including psychotherapy, harm reduction, discharge planning, case management, resources provision, system navigation and supportive counselling. When appropriate, older teen patients participate in mental wellness groups alongside adult patients. When that isn't suitable, older teen patients are connected to mental wellness groups in the community that are specific to this population. Our RSW has specialized training in Eating Disorders and is consulting adolescent patients on the issue.

SES, other Social Determinants to Health

While it is an undisputed fact that our clinic specializes in primary care and disease prevention, the social determinants of health are some of the crucial factors contributing to one's overall well- being that cannot be overlooked. Some of our patients fall into a range of a lower socio-economic group and as a result experience precarious employment, sub-standard housing (or living in shelters), inadequate income and food insecurity amongst other issues. Unfortunately, a great majority of this population experience poor physical and mental health. Our team tries to address these issues by accommodating concerns these patients might have in terms of accessibility to our doctors and services.

Our patients are able to obtain their medication on site through Total Health Pharmacy (in partnership with OakMed FHT), thus eliminating the need for traveling and postponing the administration of prescribed medication.

Patients' access to various financial and medication support is eased with an aid of our RSW who works with Ontario Works, ODSP, ODB on patients' behalf. The on-site Registered Dietitian is providing nutrition counselling using national guidelines and through the established relationships with STRIDE, Employment Halton, local food shares, and local food banks. OakMed's patients can now access the information on resources in the community while waiting for the doctor's appointment – we have slides playing in every clinical room on various health topics as well featuring the links to the community access sources. This is especially important highlighting our role as a bridge between primary and social services in the community as outlined in the Patients First Report (2015).

OakMed FHT is in direct on-going contact with Crisis Outreach and Support Team (COAST) in order to reach patients in need; we also employ social media avenues like Facebook, YouTube, Twitter, Instagram, LinkedIn, Website in order to reach community at large with the aim to provide information pertaining to access to service, appropriate medical information (especially during high epidemic seasons). Our clinic also provides urgent care evenings appointments, specifically convenient to patients in dire medical need and/or crisis.

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

FHT programs are available to non-rostered patients with the referral of a family physician. Members of a broader community currently are now able to join OakMed's programs; this development expands our outreach into the community.

1.4 French Language Services

	Physician		IHP	
Does the FHT serve patients whose mother tongue is French, or patients who are more comfortable speaking French?	Yes ☐	No ☒	Yes ☐	No ☒
If yes, provide an estimate of how many patients				
What FHT programs/services are provided in French?				
We do not have any programs/services provided in French due to the absence in demand.				

1.5 Regular and Extended Hours

	Physician	IHP
What are your regular hours of operation when patients can access IHP and physician services? *Ex.: Mon: 9-5, Tues: 8-4, etc.*	Hours of operation: Mon: 9:00am-5:00pm Tues:9:00am-5:00pm Wed:9:00am-5:00pm Thurs:9:00am-5:00pm Fri:9:00am-5:00pm Sat: Sun:	Hours of operation: Mon: 9:00am-5:00pm Tues:9:00am-5:00pm Wed:9:00am-5:00pm Thurs:9:00am-5:00pm Fri:9:00am-5:00pm Sat: Sun:
When are FHT services available after hours?	Extended hours: Mon: 5:00pm-8:00pm Tues: 5:00pm-8:00pm Wed: 5:00pm-8:00pm Thurs: 5:00pm-8:00pm Fri: Sat:10:00am-1:00pm Sun: *Physicians will make home visits when required/needed*.	Extended hours: Mon: 8:30am-9:00am; 5:00pm-8:00pm Tues: 8:30am-9:00am; 5:00pm-8:00pm Wed: 8:30am-9:00am; 5:00pm-8:00pm Thurs: 8:30am-9:00am; 5:00pm-8:00pm Fri: 8:30am-9:00am Sat: 10am-1:00pm Sun: *IHPs are available to patients through groups and later evening appointments/ Weekend appointments and home visits as required*

Identify which programs are offered after hours:	• Diagnosis and treatment • Nursing services: Administration of routine immunizations, administration of flu vaccines, administration of injections such as Vitamin B12, testosterone and TB testing. Wart treatment, ear syringing, wound care, skin tag removal, blood pressure checks, ECG testing, application of heart monitor, Suture/Staple removal. • Nursing Counseling: cholesterol, diabetes, blood pressure, osteopenia/osteoporosis, UTI, yeast infection, bacterial vaginosis, pap test, mammograms, baby care • Primary reproductive care (e.g., counseling on birth control and family planning) • Primary mental health care (early identification and treatment of emotional and psychiatric illnesses) • Providing psychotherapy, and/or supportive counseling for prevention of depression, grief, anxiety, self-esteem, and chronic pain. • Couples Therapy • Family Counselling • Primary palliative care (direct provision or support to the team responsible for providing palliative care) • Support for hospital, home, public health and long-term care facilities (through formalized linkages, assist with discharge planning, rehabilitation services, out-patient follow-up and arrangement of home care services) • Service coordination and referral (coordination of services within the FHT and, where appropriate, connecting patients to necessary resources, supports, health care providers, agencies in the community) • Patient education and preventative care (e.g., development of self - care tools and supports) • Medication Review and Reconciliation • Medication Management (change or taper) • Adverse Drug Reaction assessment • Smoking Cessation information and counselling • Sleep Hygiene information and counselling • individual review of your medication • Information and education about your medication • Keeping your medication record up-to-date with your physician (if you have just been released from the hospital with new medications or you are seeing specialists who are prescribing you medications) • Strategies to help you deal with the side-effects of medication • Home visits for the frail elderly and patients with severe mental illness (i.e. house bound) • Counseling and outreach services utilizing technology i.e. visits over Skype, phone • Outreach through Social Media – health promotion, chronic disease management and preventative care direct to patients in their homes via technology

	• Organized health promotion, chronic disease management and preventative care programming and initiatives such as: ○ **BREATHE** ○ **Parenting Program** ○ **Diabetes Program** ○ **Rise Up** ○ **Healthy You** ○ **Healthy Heart** ○ **Smoking Cessation** ○ **Polypharmacy** ○ **Memory Clinic** ○ **Sleep Well** ○ **Seniors Program with Oak Park**

Indicate if the physician group is exempt from the after-hours requirement	Yes ☐	No ☒

Additional information:

OakMed Family Health Team is available to patients through 1:1 visits, programs, house and community visits, urgent care clinics and scheduled services throughout the day/evening in order to offer the access to services to our patients. Both Physicians and IHPs schedules are adjusted to meet the needs of the patients, not the needs of the providers. Providers' schedules are not set, and with a rare exception, are regularly altered in order to meet the demands of our patients and their families. We also utilize services such as skype and social media to reach our patients irrespective of any geographical, transportation and accessibility barriers. We also do access translators both for hearing impaired and language differences in order that patients have their best care. Our motto is to be accessible for all our patients, to satisfy their health needs and concerns and to show that we genuinely care about them!

1.6 Timely Access to Care

Please provide information on how appointments were scheduled in 2015-2016.

Timely Access to Care	Physician		IHP	
Does the FHT currently schedule appointments on the same day or next day (within 24 to 48 hours)?	Yes ☒	No ☐	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?	100 %		100 %	

1.7 Other Access Measures

Please provide information on other types of access measures provided in 2015-2016.

Other Access Measures	Physician	IHP
Percentage of FHT practitioners who currently provide home visits?	95 %	95 %
Which types of IHPs perform home visits?		RSW, RN, NP
Number of home visits performed by IHPs in 2015-2016		11

Emergency Department (ED) Diversion		
Does the FHT have a strategy to divert enrolled patients from the ED (**Aside from physician contractual requirements for after hours and advanced access**)?	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)

1. OakMed FHT partnerships with CCAC, Links2Care, Homewatch Caregivers, Maximize Your Health (pain management program), Alzheimer's Society, Meals on Wheels, Halton Diabetes Mobile Team, Seniors in Need, Acclaim Health, Nurse Next Door, March of Dimes, Red Cross who work with the IHPs (most specifically the RSW, NP and RN) to collaborate on care plans to identify what services/provisions are required and that which need to be put in place in order for patients to live well at home.

2. OakMed's Executive Director Paul Faguy and Dr. Corinne Breen are active members of the Oakville Health Link Steering Committee. Their involvement translates into close cooperation between the OakMed FHT and Oakville's Health Links.

3. Our NP is seeing pre-booked and same day patients, thus allowing doctors to take on more patients with more complicated health needs, hence increasing clinic's overall patient volume.

4. The OakMed FHT MDs provide more than the Ministry's required after hours on site care, including a 3 hour weekend urgent care clinic, urgent 24 hour lab result coverage and around the clock Palliative Care. Same day appointments are offered throughout the day, as well as patients' phone triage to help ensure access to primary care as a first option. 72 hour patient follow up upon hospital discharge is provided by the RN to ensure repeat admissions are avoided.

5. The OakMed FHT promotes access to care at our clinic by utilization of our website, social media avenues, health promotion materials, advance access, patient portal and

triaging for urgent patients' concerns, including mental health emergencies.

6. Our Social Worker provides urgent appointments (same week) for both adult, adolescent and child populations to support our rostered and non-rostered patients.
7. Our health care professionals also provide on-site urgent care, such as suturing, minor procedures and wound care to divert emergency room visits. This provides timely access, excellent quality and cost efficient patient care. This encompasses the principles of Ontario's Action Plan for Health Care.
8. Our redesigned FHT programs, such as our Memory Clinic, Breathe, Anticoagulation Management, Healthy Heart help to anticipate, reduce and prevent issues that would have normally ended up as an emergency visit.
9. Access to Halton Healthcare Service Meditech (EMR) allows us tracking patient admissions in order to follow up with their recovery progress, a feature that ultimately lowers readmission rates and allows us to treat patients in the community. Our Complex Patient Care Coordination offers a follow-up of patients discharged from the Trafalgar Memorial Hospital with the aim to prevent re-admission and/or avoid post-hospitalization complications.
10. Optimization of our services and programs contribute to self-management strategies for the patient and their families, which lead to an improvement in overall patient care outcomes.

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	☒	☐	☒	☐	☒	Collaboration with Reach Out Centre for Kids (ROCK), Posse Project, Nelson Youth Centres, Woodview Mental Health and Autism. Halton Parents, Oakville Parent and Child Centre as well as Oak Park Neighborhood Centre. CCAC nurses in Halton School Boards for transitions in care. Halton Public Health Partnering programs. LHIN Adolescent Mental Health Committee. Knowledge and resource sharing. Early Years Parent Child Programs.
Community Care Access Centre	☒	☐	☒	☐	☒	Physicians, RSW, NP and Nurses collaborate regularly to ensure appropriate home care for seniors, palliative patients, and those patients that require wound care. OakMed is gearing up for the upcoming changes to the CCACs structure by upgrading our Quality Improvement Plan and reviewing our routine opeartions.
Community Health Centre	☐	☐	☐	☐	☐	No CHC in community
Community Support Services	☒	☐	☒	☐	☒	MD's participate on MHLHIN committees. We partner with The Alzheimer's Society (First Link), The Halton Diabetes Center, for our Diabetes Management Program, Halton Parent Centre and Public Health for our parenting programs. Oakmed MD participates in the Peel Region Primary Care and Cancer Network for MHLHIN and Central West LHIN Cancer Care Ontario. The RSW works closely with CMHA, BSO, MDAO, Summit/Ash, ADAPT, SSO, SAVIS, Hope Place, EH and a variety of other community support services. We are partnering with Oak Park Neighborhood Centre to share space in order to provide more opportunities for patients to access allied health groups.
Developmental Services	☒	☐	☒	☐	☐	DIEPP, (Autism Services), Early Years Parent Child Programs.
Diabetes Education Centre	☒	☐	☒	☐	☐	We continue to collaborate with the Halton Diabetes Program in a joint venture to provide additional group education sessions for our patients with diabetes by offering counselling/education session once a month to out of target diabetic patients. In clinic, our FHT Registered Dietitian and/or FHT Registered Nurse/FHT Registered Pharmacist will see diabetic patients on a regular basis for routine monitoring and on-going education related to various diabetic topics.
Local Hospital	☒	☐	☒	☐	☐	OakMed FHT liaisons with Halton Healthcare Services (HHS) to accept unattached patients. At risk patients attend HHS Outpatient Congestive Heart Failure Clinics, Kidney Failure Clinics, and Geriatric Falls Clinic. MD's participate on HHS Palliative Care Committee, Elder Care Committee, IT Collaborative Committee and MRP/Primary Care Committee.
Mental Health and Addiction Services	☒	☐	☒	☐	☐	Halton Geriatric community Mental Health Program, Halton Healthcare Services Outpatient Mental Health Program (Adult, Adolescent and Eating Disorder Programs), North Halton HHS Mental Health Program, Phoenix Program, Transitional Teens Mental Health Program, ADAPT, SAVIS, CMHA, COAST, OurScars, CHR.
Public Health Unit	☒	☐	☒	☐	☐	Immunization program collaborations, as well as Public Health Campaigns, such as hand washing, sexual health and parenting programs.
Senior	☒	☐	☒	☐	☐	Kerr St. Seniors Centre, Sheridan College Seniors Program. SENECA Day Program, ORCA, Seniors' Wellness

Centre and Services						Program/Burlington. Palliative Hospices including Ian Anderson House and Carpenter House. Collaboration with Halton Community Palliative Services. Osteoporosis Exercise Program (Oakville Physiotherapy).
FHT: (specify)	☒	☐	☒	☐	☐	Working with other FHTs (Summerville FHT, Credit Valley FHT, Prime Care FHT) for quality improvement with shared QIDS person Memory Clinic – Dr. Linda Lee – The Centre for Family Medicine FHT, Hamilton Family Health Team, Guelph Family Health Team, Garden City, North York Family Health Team, Southlake Family Health Team, and Taddlecreek – program sharing.
Long-Term Care Homes	☐	☐	☐	☐	☐	Connections to LTC through CCAC partnerships.
Other: Oak Park Neighbourhood Centre http://opnc.ca Alzheimer's Society of Brant, Haldimand, Norfolk, Hamilton, Halton	☒	☐	☒	☐	☐	OakMed FHT's patients are benefitting from the availability of Oak Park Neighbourhood Centre facilities where various new programs are available to a wider segment of population. Oak Park Seniors' program (OakMed's collaboration with the Centre) attracts a lot of seniors residing in the community. OakMed is currently running highly successful Healthy You, Breathe and Rise Up programs. A highly anticipated Sleep Well program will be the next addition to our plethora of successful and well-attended programs. The latest collaboration is a highly successful seniors' educational/recreational program offered at the Oak Park Neighborhood Community Center.

2.2 System Navigation and Care Coordination

Is the FHT involved in Health Links? Indicate if Lead or Partner	Yes	No	Partner/**Lead**
	☒	☐	

Working with the Mississauga Halton LHIN on transition to integrated primary care teams in accordance with directives outlined in the Patients First Report (2015).

Care coordination is one of OakMed FHTs top priorities, as these are often the areas where patients fall through the gaps in the transition from one service to the next. OakMed FHT utilizes many protocols in order to ensure that patients move through the healthcare system as smoothly as possible, such as:

1. To aid in assisting our patients in navigating the health care system, our staff uses established referral protocols and practices to help inform and prepare patients for specialist appointments and diagnostic tests so that patients arrive appropriately prepared and on time to these appointments. This is done by collecting all information pertaining to doctor's request(s) in order to send a complete package and to streamline the referred protocol. This is done in order to facilitate patients' recovery, as well as not to put extra burden on Ontario's health care by reducing/eliminating missed or delayed

appointments. Our physician assistants manage information transfer between the FHT and local hospitals, ensuring that appropriate information is obtained for the patient's post-discharge, follow-up appointment with our physicians. It is important to note that our staff is performing these duties in lieu of a professional discharge navigator, beyond their prescribed duties

2. Our Registered Nurse also collaborates with CCAC regarding child, adolescent and adult immunizations, wound care, and home care support. Our patients are discharged to community by being referred to care coordinators, who often consult our RN on the next course of action for a particular patient.

3. Our RSW works closely with the CMHA to provide case management services to patients with mental illness that have a plethora of physical and social difficulties. Due to a large work load of our RSW, we cannot provide in-house calls at this time; however, connecting patients with CMHA allows the patient to have guidance and constant service provision as they are connected to the other support services.

4. Our Registered Pharmacist and Registered Dietitian work with the Halton Diabetes Program receiving training and mentorship as well as consultation, thus contributing to a community at large.

5. Moving forward we are improving protocols for system navigation and coordination in order to comply with *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario (2015).* We have scored lower than other FHTs on percentage of patients who have a subsequent non-elective re-admission within 30 days after discharge.

2.3 Clinical Management System/Electronic Medical Records

Please provide information on your EMR

Which EMR vendor/version is being used?
Nightingale On Demand V9.2.1.2

	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
Community Care Access Centre	None	Case conferencing is in place regarding mutual patients.
Emergency Department	Read-only	A physician's referral letter as well as the copy of patient's CPP is provided by OakMed FHT. An emergency treatment copy is enclosed in case the emergency treatment is

		administered on site. Our staff able to access the Emergency Department visit information, thus facilitating the follow-up of these patients.
Hospital	None	The IT infrastructure has not yet been established.
Laboratory Service	Read-only	Life Labs, Gamma X-ray, CML Labs and OLIS.
Other (specify):	Read-only	Oakville Cardiologist - ECG readings.

Are you able to electronically exchange patient clinical summaries and/or laboratory and diagnostic test results with other doctors outside of the practice?	Yes ☐	No ☒

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	☐	☒

Please explain if and how the EMR is used for tabulating patient statistics, identifying and anticipating patient needs, planning programs and services, etc.
The EMR is used to comply patients' immunization reports, active/inactive patients' reports, health maintenance reports, etc. Patients identified by certain medication and/or diagnosis are encouraged to attend the programs tailored to meet their needs. EMR is used as a component of an environmental scan when researching the need for a new program/service.

2.4 Data Management Support

OakMed FHT currently utilizes Nightingale to collect and manage patient data. We have been using this EMR since our inception, and are integrated with OLIS. All of our staff have been trained on the usage of our EMR, and the importance of routinely entering patient data. In the next year we hope to work on training our staff on the importance of placing data within the appropriate sections of the EMR and standardizing codes for certain chronic conditions in order to create patient registries that can be queried against. We have created some queries in our EMR that enabled us to measure and report on our progress with certain measures outlined in the QIP. None-the-less Nightingale is extremely deficient as a tool for information generation and communication.

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?		
Position is shared with 3 other FHTs. OakMed's QIDS Specialist provides excellent support and leadership to our team. OakMed FHT has an active and engaged Quality Improvement Committee which includes the QIDSS, ED, allied health, administrative staff and physician leadership.		

For the 2015-16 fiscal year OFHT focused on the five mandatory indicators for our Quality Improvement Plan. Throughout the 2015-16 fiscal year we collected patient experience surveys from OFHT patients. We used the information we gathered from this survey to set change ideas in our 2016-17 quality improvement plan. An area of improvement that we noted through the survey ties into the ministry mandated indicator of Access. Our FHT average for patients selecting same day/next day access is currently 53%. Our TNA for our physicians indicated that 76% of our physicians are able to offer same day/next day appointments. We have included change ideas in our quality improvement plan to address these concerns that our patients have.

3.0 Other

3.1 Other Information and Comments

At OakMed FHT everything we strive to do is to meet the needs of our patients, their families and our community. The goal of the OakMed FHT has always been to ensure the expansion and programming aligns with the Ministry's priorities of strengthening patient-centered care and integrating with community partners as outlined in Patients First: *A Proposal to Strengthen Patient-Centered Health Care in Ontario* (2015).

We have created many new relationships with various community services. OakMed FHT has shown support to our local community by participating in the Ovarian Cancer Canada Walk of Hope Burlington/Oakville on September 13, 2015. OakMed FHT is excited about participating in yet another community project. The collaboration between the Oak Park Neighborhood Centre and the Alzheimer Society has allowed OakMed to use the team of interdisciplinary health professionals to bring knowledge and expertise to the senior citizens of our community. Assisting the elderly has been our priority and we approach it as a matter of great importance. Collaborating with two outstanding partners has given us the opportunity to reach more seniors and to educate them on the issues of disease prevention, health promotion, and chronic disease management. The collaboration assisted us in fulfillment of our mandate on caring for seniors in community settings (as outlined in 2015 Bringing Care Home Report).

Our focus is and has always been to ensure expansion and programming aligns with the Ministry's initiatives. OakMed strives to link patients with primary care services and to connect these services with inter-professional providers for ensuring comprehensive care – the Patients First Report (2015) emphasizes the importance of more effective integration of services. We approach things in a creative, innovative and fiscally responsible manner to ensure we are able to reach as many people effectively as we can within the restraints of our budget. We are improving upon learnings from our peers by participating in the annual AFHTO seminar and by and placing ourselves in a position to be leaders in healthcare within our LHIN, HealthLinks and other FHTs.

Is there anything else that the organization would like to communicate to the ministry regarding its activities in 2015-2016? Any challenges, opportunities and recommendations for the ministry can also be detailed in this space.

OakMed FHT has a clinic culture very conducive for a productive performance. We pride ourselves in being able to achieve collaborative team work and the ability to reach our goals in terms of patient satisfaction and having an impact in the community. Having strong cooperative ties between all team players makes our organization a wonderful environment for a healthcare provider to work in. OakMed is very proud to be able to score at 84.8 % in Cervical Cancer Screening (participating in AFHTO's Data 2 Decisions) whereas other FHTs participating in D2D were at 70.7 % and all Ontario primary care was at 69.4%. This development was the results of

the team effort with all team players working hard in reaching our strategic goals!

The ability to have both autonomy in your role while being able to access the expertise of a team and understanding that all patients are multidimensional and that no care provider even within their full scope could meet every need, provides passionate healthcare providers the ability to focus care around patients.

In the past year we have concentrated on consolidating new members who have joined our team. Now we feel we are ready to move on in the direction of fulfilling our mission as a group of health care providers in primary care setting overseeing health promotion, disease prevention and looking after those afflicted by chronic illness.

Part B: 2016-2017 Service Plan

1.0: Strategic Priorities and Vision

OakMed Family Health Team is a primary care team of physicians, nurses, nurse practitioner, social worker, dietitian, and pharmacist focusing on health prevention and health promotion. The team is providing exceptional patient-focused, family- centered, community-oriented clinical care. OakMed focuses on educating patients, their families and their caregivers so that they may better manage their health needs. The team has assumed the role of a "patient navigator" to help guide patients through the health care system in order to facilitate their rehabilitation and recovery.
The objective of the organization has always been to ensure the expansion and programming aligns with the Ministry's priorities of *integration with community partners* as outlined in *Patients First: A Proposal to Strengthen Patient -Centered Health Care in Ontario Report* (2015). Oak Med specializes in chronic disease management, health promotion and disease prevention by offering a variety of programs geared towards educating patients most vulnerable to various physical and psychological aliments. The programs offered at the Oak Med have clearly identified goals, a target population, and a measurement framework for an easy assessment of the target goal.

Identify the strategic priorities for the FHT that will apply to the 2016-2017 fiscal year.

1. We plan to create a system to improve communication between our FHT and the Oakville hospital site for admitted patients to ensure effective information transfer and follow-up to ultimately prevent re-admission.
2. We plan to further our collaboration with community partners such as CCAC and Health Links as the transformation of primary care takes place. Our priority are frail, complex seniors as well as palliative patients; we plan to use more efficiency in organizing our physician and IHP resources, and by providing anticipatory team management in home, rather than reactionary care management from the hospital.
3. Plan to continue the on-going collaboration between OakMed and Diabetes Central Intake Program to ensure patients are connected to the appropriate community resources as required
4. We plan to use a system navigator to help patients newly diagnosed with cancer

address both the practical parts of keeping appointments, along with managing the physical and emotional impact and side effects of cancer treatment and diagnosis.
5. We plan to use the readmission prevention program to oversee any patient who has more than 3 specialists or is being managed at specialty clinics. The intent is to have monthly phone reviews with the patient and family to ensure appointments are met, follow up tests are being done and that any changes to diagnosis, treatment or investigations are being transferred to all Health Care providers in the patient's care circle. This should also help eliminate repeat tests being ordered amongst multiple providers because information is not being copied or shared amongst the care circle.
6. Plan to participate with the newly forming Diabetes Central Intake Program to ensure patients are connected to the appropriate community resources as required.

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

1. OakMed is partnering with Oak Park Neighborhood Centre. This most recent collaboration will enable the expansion of our programs across the community. OakMed's patients are to benefit from the availability of the Oak Park facilities where various new programs will be available to a wider segment of population. The partnership will allow us to share space to facilitate better access for patients to existing group programs as well as creating more opportunities for new program produce in collaboration with OPNC. The partnership with OPNC will bring patients together in a positive way, motivating them to get involved and take charge of their health. For example, patients may be inspired to participate in other community activities, programs, and services as a function of exposure through the variety of collaborative relationships that OakMed FHT has with its various community partners.
2. Our collaboration with Mississauga Halton CCAC is going to target specific patient population to improve health outcomes by being one of the primary service providers in the community.
3. Plan to enhance our collaboration with the Halton Diabetes Program. The OakMed patients attending Halton Diabetes group sessions will be returning to the clinic to continue with one-on-one session.
4. We plan to maintain our collaborative partnerships with the Canadian Cancer Society for our Cancer Survivorship Program to enhance support for patients and families dealing with cancer and to ensure comprehensive preventive care after these patients are discharged by their oncologists.
5. To utilize our nursing resources to improve communication between the FHT and local hospitals on admitted and soon-to-be discharged patients to ensure seamless transitions.
6. To collaborate with Health Links project teams as pertaining to frail seniors and palliative patients.
7. This year we will also be partnering with our local Mississauga Halton LHIN with a focus on participating in Health Links and a goal to improve access, quality and value across the LHIN in areas such as transitions from hospital and prevention of re-admission in

light of current developments in primary care transformation.

8. We have built productive working relationship with Telederm (dermatology e-consults) that has translated into both patient and health provider satisfaction. The Oakville Cardiology group has expressed interest in establishing similar "cardiology e-consults". There is significant administrative work in transferring the data securely and accurately, but our patients benefit from the convenience of undergoing the ECG procedures at our office and having the results back within a short period of time.
9. We are continue working on collaborating with the Halton school board, CCAC school nurses, LHIN, Halton Public health and parenting programs to create programs for parents regarding how to deal with and support children, looking at basic skills such as discipline and navigating the teen years, to dealing with their children who have anxiety or depression.
10. This year OakMed FHT has become an Ontario telemedicine Network site. This communications and technology capacity will enable huge improvements in terms of health professional/physician networking and communications, assist in the HealthLinks initiative and provide access to up-to-date on-line / video training.

We continue building up our team collaboration and strengthening our team culture as we consider it as one of the bedrocks of a successful Family Health Team. We base this precept on *External Evaluation of the Family Health Team Initiative,* where a big emphasis is placed on higher team interactions and cooperation. Furthermore, we cultivate strong and visionary leadership that paves the way for the progressive vision of our team. Our team members understand and successfully contribute to our mission, goals and priorities on daily basis. Last year we`ve implemented quality improvements targets. Our aspiration is that this development will translate in better adherence to clinical guidelines.

We continue to collaborate and adapt programs from our community partners and peers
We believe that OakMed Family Health Team has made incredible strides as a new and developing Family Health Team and we feel very proud to have contributed to positive outcomes for our patients, their families and our community.

We want to thank the Ministry for its support, patience and guidance during the past year and we look forward to fulfilling our commitment to *Patients First: Action Plan for Health Care*.

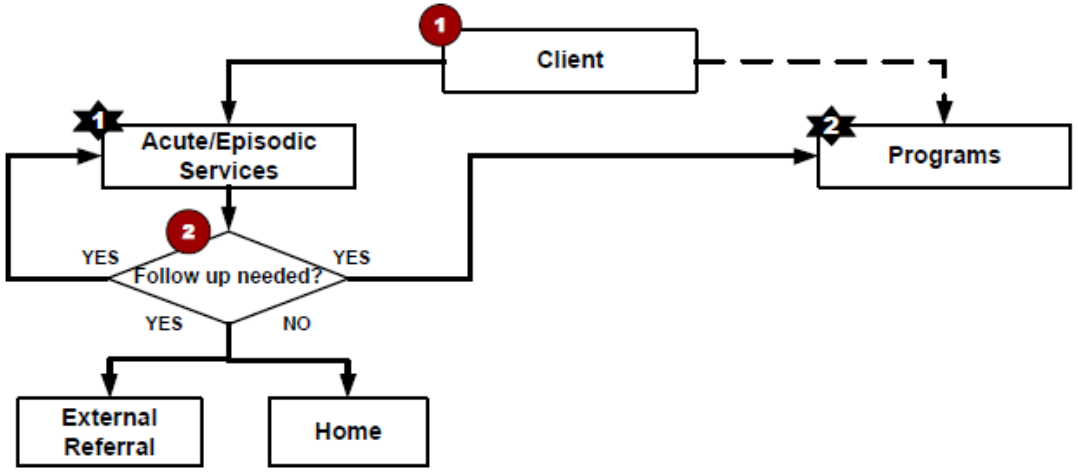
2.0: Operations, Programs and Services

see Schedule A

Part C: 2016-2017 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.

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