Family Health Team

Annual Operating Plan Submission: 2018-2019

FHT Name: Barrie and Community Family Health Team

Date of Submission: May 31, 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: Print FHT Name: Barrie and Community Family Health Team  *I have the authority to bind the corporation*	**Date: 05/31/2018** Nancy Roxborough, Board Chair

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.

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	141,000	144,215 (by MOH roster lists) 141,157 (as designated in EMR)	
Are physicians enrolling new patients?		Yes ☒	No ☐

Please explain:
Over the past fiscal year several physicians have retired and new physicians that have been added have generally taken over existing practices. A few of the physicians are enrolling new patients.

There is an ongoing Roster Management project, which identifies discrepancies between the MOH and the EMR patient roster lists. This enables participating physicians to maintain accurate rosters and to ensure that their patients become rostered. About 40 physicians are participating in that project at this time. The discrepancy between the MOH number and the EMR number points to the need to expand that project.

In addition to the enrolled patients, there are13,000 – 16,000 patients who are attached to a physician of the BFHO but not rostered. The EMR lists 157,212 attached patients in total (rostered and fee for service).

If the target was not met, please explain why and outline your plan to meet this target:
N/A It is important to note that the BCFHT's physician group as of March 31, 2018 had 157,212 attached patients. While the BCFHT's physicians have 141,157 enrolled (rostered) patients, they also have 16,055 fee-for-service patients that are under the direct care of BCFHT physicians.

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.

The Prenatal and Well Baby (PNWB) Program

Prenatal and Well Baby: 2714 patient visits (884 patients)
Breastfeeding: 668 patient visits (510 Patients)

The PNWB Program provides routine prenatal and well-baby care for women and children (up to the age of 6 years), without a family doctor in the Barrie area, along with lactation consultant services. Our goal is to improve health outcomes for individuals in the maternal child population by providing access to health care, lactation support, education as well as referrals and links to community supports, as appropriate. Care is

provided by a team of 4 physicians, one RN, one part-time NP and 2 part-time Lactation Consultants. Breastfeeding services are provided by a Lactation Consultant (RN) within the PNWB program, for all women (FHT and non-FHT) in the Barrie area. We have been able to successfully roster some of our Prenatal and Well baby program patients to a family doctor within our FHT. Some patients continue to remain non-enrolled because physicians are at maximum capacity or these patients have recently moved into the community.
A specialist (pediatrician) is now available in the PNWB program to provide increased, timely access to care for frenulotomy procedures and other pediatric consults, as needed.
The PNWB program delivers the following:

Routine Prenatal Care (initial and follow up appointments)
Routine Newborn care
Well Baby Checkups, including Immunizations
Lactation Consultant appointments
Breastfeeding information and support
Links to Community Supports, as needed
Smoking cessation support, including access to free Nicotine Replacement Therapy through the STOP program
Breastfeeding Education (group) sessions – available during the day or evening

Breastfeeding services at the BCFHT are available to ALL childbearing families in our community, including non-rostered patients.

Breastfeeding support is provided by an International Board Certified Lactation Consultant (IBCLC), who is also a Registered Nurse, 4 days per week (this includes RN support from the SMDHU 0.5 day per week). The BCFHT strives to promote, protect and support breastfeeding in our community in the following ways:
• Offer Breastfeeding support (1:1 Appointments) to ALL childbearing families in our community.
• Collaboration of our Lactation Consultant with other BCFHT Team Members, including BCFHT Family Practice Office Staff, as needed.
• Group Classes are offered monthly to promote and support successful breastfeeding for childbearing families.
• Link with Community Partners, as appropriate, around breastfeeding issues.
We are actively involved in system integration and coordination to increase access to breastfeeding services. We have an agreement with our local Public Health Unit, which provides the services of a Public Health Nurse, one half day every week, in our breastfeeding clinic. This will ensure that women requiring this service will have improved access to care. The BCFHT provides the space and additional support necessary for this service provision. The clinical manager of the PNWB program is actively involved in a community breastfeeding collaborative, which strives to promote, protect, and support breastfeeding in our community.

The LINKS Team (formerly The MVP Clinic)

719 unique patients serviced - Apr. 1, 2016-Mar. 31, 2018
2380 total patient interactions – Apr. 1, 2016 – Mar. 31, 2018

The LINKS Team sees unattached patients over the age of 18 with more than 2 medically complex health concerns who are frequent users of the healthcare system. These patients require a great deal of medical and socio-economic support. Our goal is to stabilize their health and wellness and attach them to primary care (physicians within the Family Medicine Teaching Unit and the BCFHT and the Barrie Community Health Centre). The clinic uses a multidisciplinary approach with NP, RN, Social Worker, Pharmacist, Occupational Therapist, Registered Dietitian, and Barrie Community Health Centre, Community Health Worker on the team working with Family doctors and specialists. Linkages have been made with other health sectors such as Royal Victoria Hospital, CMHA, local CCAC, and Crisis Services and OTN.

These patients are incredibly complex, often transient, and require a great deal of support both medically and socio-economically, which makes it difficult to become attached to primary care and to stay attached to a particular care provider.

Barrie Family Medicine Clinics
The BCFHT's affiliated FHO supports four after hours clinics (Barrie Family Medicine Clinics). In these clinics, patients who are non-enrolled or unattached can receive care. The majority of patients receive acute episodic care. A few, particularly the transient or homeless receive some degree of chronic disease management such as medication renewal and monitoring of clinical status.

From April 1, 2017-March 31, 2018 – 86772 patients were seen in the Walk In clinics. Over 69% of patient visits are for non-enrolled patients. Many of these patients have chosen not to enrol with family physicians of the BCFHT for personal reasons related to the fact that they have a physician in another community or that they prefer not to have a family physician.

Mental Health
The program offers an Eating Disorders group and a Dialectical Behaviour Therapy skills based group in collaboration with the Canadian Mental Health Association (CMHA).

An After Baby group is available to new parents experiencing depression and difficulties coping. It is a collaboration between the BCFHT Mental Health Program, the Georgian Nurse Practitioner-led Clinic and the Barrie Public Library.

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

Our FHT Telemedicine Program has been very successfully integrated into our FHT and has grown to increase local access to specialists by patients in our community (for both FHT and non-FHT patients). 447 patients have been seen in the program from April 2015 to Feb 2016, for a total of 791 clinical telemedicine encounters. The following specialists were accessed during those visits: mental health/ psychiatry, dermatology/wound care, neurology, respirology and others. **Other includes visits such as allergy, gastro-enterology, hematology, orthopaedic surgery, genetics, paediatrics and a few others.

Our Telemedicine Program has also been used for educational and administrative purposes to support the needs of our large interdisciplinary team.

Non-rostered patients accepted to The LINKS Team are referred to and can be seen in all FHT programs such as the Lung Health Program, Diabetes Program, and Aging Well Clinic.

Breastfeeding services at the BCFHT are available to ALL childbearing families in our community, including non-rostered patients. The BCFHT Breastfeeding Services began in October 2010 in response to a community need for additional breastfeeding services to support childbearing families in our community. Breastfeeding support is provided by an International Board Certified Lactation Consultant (IBCLC), who is also a Registered Nurse, 2.5 days per week. The BCFHT strives to promote, protect and support breastfeeding in our community in the following ways:

• Offer Breastfeeding support (1:1 Appointments) to ALL childbearing families in our community.

• Collaboration of our Lactation Consultant with other BCFHT Team Members, including BCFHT Family Practice Office Staff, as needed.

• Group Classes were offered monthly to promote and support successful breastfeeding with childbearing families.

• Link with Community Partners, as appropriate, around breastfeeding issues.

Barrie & Community Family Medicine Clinics (BCFMC) are open for extended hours well beyond the contractual obligations of the Barrie FHO (BFHO). In addition they provide regular daytime hours for patients who are unable to be seen in their primary Family MD's office on any given day. The service is also available to unattached patients in the community.

The Clinics operate using a shared EMR with the BFHO and BCFHT providing remarkable continuity of care. As clinic patients are seen their visits are recorded in their family practice chart with immediate notification going to the Family Physician.

The EMR also provides some continuity of care for the unattached patients utilizing any of our clinics because their health records are available at any of the 4 locations they choose.

The clinics divert enrolled and unenrolled patients from the Emergency Department. They are situated in four different areas of the community for easy access. The clinics are staffed by 92 BCFHT/BFHO physicians and 32 BFHO contract physicians. These clinics provide access during the daytime, evenings, weekends and holidays 364 days per year. Patients can find the clinic hours of operation as well as up to date wait time and registration status on our website barriewalkinclinics.ca

Clinic hours:
Wellington - 121 Wellington St. W. Ste 112
Monday to Thursday
8 am to 10 pm
Friday
8 am to 9 pm
Saturday, Sunday
and Holidays
10 am to 4 pm

Prince William - 829 Big Bay Point Rd. Unit D12
Monday to Thursday
8 am to 10 pm
Friday
8 am to 9 pm
Saturday, Sunday
and Holidays
10 am to 4 pm

Bell Farm - 125 Bell Farm Rd. Ste 101
Monday & Wednesday 2 pm to 10 pm
Tuesday, Thursday
6 pm to 10 pm
Friday
6 pm to 9 pm
Saturday, Sunday & Holidays
10 am to 4 pm

Innisfil - 2101 Innisfil Beach Road
Monday, Tuesday, Thursday
6 pm to 10 pm
Wednesday
2 pm to 10 pm

Friday
6 pm to 9 pm
Saturday & Sunday
9 am to 3 pm

From April 1, 2017 to March 31, 2018 - 86772 patients were seen in the Barrie & Community Family Medicine Clinics. 69% of the patients seen are un-attached to a BFHO family doctor. We estimate the BCFMC sees as many patients as the Royal Victoria Regional Health Center Emergency Department on an annual basis.

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	Small Minority – less than 2%	

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 BCFHT has several staff fluent in many languages. These include Italian, German, French, Cantonese, Mandarin, Romanian, Russian, Afrikaans and Polish. Many of the FHT staff have received Aboriginal Cultural Awareness Training. 19% of doctors surveyed offered appointments in other languages. The following languages are provided in some of our FHT Physician offices. Afrikaans, Polish, Hindi/Urdu, Gujarati, Swahili, French, Konkani, Urdu & Hindi, German, Cantonese, Spanish, Russia, Hungarian, Portuguese.

Patient education materials are available in different languages.

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: 8–4 Tues: 8-4 Wed: 8-4 Thurs: 8-4 Fri: 8-4 Sat: Closed Sun: Closed Mental Health Services are Monday to Friday 9-5
When are FHT services available after hours?	Extended hours: Mon: 4-6 Tues: 4-6 Wed: 4-6 Thurs: 4-6 Fri: 4-5 Sat: Closed Sun: Closed Mental Health Services work extended hours of 5-7 pm.
Identify which programs are offered after hours: Breast feeding, smoking cessation	RDs 730am on Fridays OTN until 5 daily as needed Pharmacists until 5 Diabetes 730 Mon-Thurs, until 430 M,W,F Aging Well until 430 Links until 430 daily as needed

Additional information:	
Registered Dietitians run programs in the evening – Healthy You is Tuesday 530-730, Cooking Class is Wednesday 530-630 and Craving Change is Thursday 530-730. PNWB runs a Breastfeeding program once every other month and is 6-8pm – the day varies.	

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)		100%

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?	35%
Which types of IHPs perform home visits?	OT, Pharmacist, NP, Nurses, Social Worker, Navigators
Number of home visits performed by IHPs in 2017-2018	1102

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 X	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)		
The BCFHT, through a partnership with the Barrie and Community Family Medicine Clinics, is initiating a public awareness campaign to help patients make educated decisions as to where and when they need to access care. One of the intended outcomes of this is to divert CTAS 4 and 5 to our walk-in clinics if that is the most approperate place of care. The BFHO after-hour clinics see enrolled (and unenrolled) patients and are open for hours that far exceed the MOH contractual requirements. This clearly diverts significant numbers of patients (both enrolled and unenrolled) from the ED. Opening hours are as follows Wellington - 121 Wellington St. W. Ste 112 Monday to Thursday 8 am to 10 pm Friday 8 am to 9 pm Saturday, Sunday and Holidays 10 am to 4 pm Prince William - 829 Big Bay Point Rd. Unit D12 Monday to Thursday 8 am to 10 pm Friday 8 am to 9 pm Saturday, Sunday and Holidays 10 am to 4 pm Bell Farm - 125 Bell Farm Rd. Ste 101 Monday & Wednesday 2 pm to 10 pm Tuesday, Thursday 6 pm to 10 pm		

Friday
6 pm to 9 pm
Saturday, Sunday & Holidays
10 am to 4 pm

Innisfil - 2101 Innisfil Beach Road
Monday, Tuesday, Thursday
6 pm to 10 pm
Wednesday
2 pm to 10 pm
Friday
6 pm to 9 pm
Saturday & Sunday
9 am to 3 pm

Outside use reports do not report on ED visits and are therefore not helpful with respect to reducing ED visits or following up with patients about those. They are also provided individually to the physicians of the BFHO, not to employees or administration of the BCFHT.

The LINKS clinic, in cooperation with RVH, compiles a list of enrolled patients who are frequent users of the ED and works to advise each physician of any patients they have on that list. The LINKS Team accepts patients who are high users of the emergency department (as well as high users of the healthcare system in general). This clinic works closely with our local hospital (RVH) to divert emergency visits as possible using the following strategies:

-direct referrals of patients meeting LINKS Clinic criteria from RVH ED to The LINKS Team

-The LINKS Team participates in RVH team meetings aimed at discussing the 'ED high users' and creating care plans to 'manage' these users

The FHT looks after a large population of women and children in our community who do not have a primary care provider. By providing routine prenatal and well-baby care, as well as breastfeeding support, and some acute care to more than 1316 patients last year, we likely have prevented these patients from accessing care through walk in clinics and/or emergency rooms.

How are patients made aware of hours of operation? (Examples: visible clinic signage, voicemail, patient pamphlets, FHT website or other means)
Our hours are posted on our Website, are on a screen in the lobby of our main building and are posted in the Waiting Rooms. This is also on our Facebook and Twitter accounts.

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	☒	☒	☒	☐	☐	OTN/Mental Health- The Virtual Emergency Room is an urgent service available through Ontario Shores to provide children and youth with quick access to psychiatry via telemedicine.

						Mental Health-informal referral protocols with New Path Youth and Family Services. Collaboration and care coordination with Family Connexions. Access to Youth Services including Crisis Response, Early Psychosis Intervention, Youth Case Management and Youth Addiction Counselling through the Canadian Mental Health Association.
LHIN - Home and Community Care	☐	☐	☐	☐	☒	Embedding of Home and Community Care coordinators in FHO physician offices
Community Health Centre	☐	☐	☐	☐	☒	We are partnering with BCHC to support physiotherapy services within our current FHT programming. BCHC provides physician support to the BCFHT Aging Well Clinic. The BCHC physician (who holds an advanced competency in care of the elderly) works collaboratively with clinic IHPs to diagnose, treat and manage patients referred with concerns re cognitive impairment &/or multiple complex medical conditions. Barrie Area Diabetes Collaborative - The Barrie & Area Diabetes Collaborative is a community partnership of key stakeholders involved in diabetes care, that work together to ensure that all diabetes patients in our community are seen in the 'right place, by the right provider, at the right time'. Coordination of diabetes services, improved access of diabetes care and improved efficiency of health care delivery involving diabetes are some of the collaborative main goals. Mental Health-referral/recommendations including the

						Chronic Pain Management Program of the BCHC.
Community Support Services	☐	☐	X	☐	X	The FHT Pulmonary Rehab Maintenance Program is offered at our local YMCA. We host our dietitian run Healthy You patient education group sessions at the Barrie YMCA and work in partnership to support patients' needs for physical activity. Mental Health - Collaboration and care coordination with the Women and Children's Shelter of Barrie, Athena's Sexual Assault Counselling and Advocacy Centre, Family Mental Health Initiative, Triple P Parenting programs, Gilda's Club etc. Through consultation and collaboration with other service providers, the program provides for the effective management of shared patient care.
Developmental Services	☐	☐	☐	☐	☒	Mental Health-Collaboration with Catulpa Community Support Services and Developmental Services Ontario to coordinate the care of patients with developmental disabilities.
Diabetes Education Centre	☐	☐	☒	☐	☒	The Barrie & Area Diabetes Collaborative is a community partnership of key stakeholders and programs involved in the provision of diabetes care, that work together to ensure that all diabetes patients in our community are seen in the 'right place, by the right provider, at the right time'. Coordination of diabetes services, improved access of diabetes care and improved efficiency of health care delivery involving diabetes are some of the collaborative main goals. The primary agencies involved include: BCFHT, BCHC, RVH and LMC Diabetes and Endocrinology.
Local Hospital	☐	☒	☒	☐	☒	The BCFHT Diabetes and Lung Health programs are integrated with RVH.

						BCFHT Lung Health Program now accepts direct referrals from Royal Victoria Regional Health Centre for COPD patients being discharged from the hospital to ensure prompt follow up and seamless transition of care. • IT integration: Physicians receive most RVH reports through the Hospital Report Manager. There is access to RVH Meditech in LINKS Clinic. • The Family Medicine Teaching Unit for the University of Toronto Medical School Department of Family and Community Medicine is part of the BCFHT but located at RVH and fully integrated • The DFCM Quality Improvement Program representative from Barrie is a BCFHT Family Doctor • The BCFHT physicians are members of the Quality and Operational Committee at RVH • The Research arm of the BCFHT, REQIP,(Research, Education and Quality Improvement Program) collaborates with the Research Program at RVH. REQIP utilizes the RVH Ethics Committee The BCFHT Aging Well Clinic has partnered with the Simcoe Muskoka Regional Arthroplasty Intake Clinic at the Royal Victoria Health Centre to offer a preoperative optimization program to medically complex & frail seniors booked for elective joint arthroplasty. BCFHT is represented at the hospital's Senior's Strategy Working Group

						BCFHT Registered Dietitians accept pediatric feeding referrals from RVH's SLP in order to decrease patient wait times. Our RD's also have partnerned with the RVH RD's to develop a protocol for malnutrition screening and follow up to help improve outcomes and reduce hospital re-admissions. The BCFHT Aging Well Clinic accepts direct referrals from RVH for inpatients being discharged back to the community and for at risk seniors assessed in the ER Department. RVH's Outpatient Geriatric Clinic diverts referrals for FHT patients to the Aging Well Clinic Mental Health- Collaboration and care coordination including admission and discharge planning. Facilitate referrals to the Partial Hospitalization Program, Eating Disorders Services and Addiction Services. RVH staff is on the Steering Committee of the Health Link. BCFHT and RVH have a data sharing agreement to share information. Many physicians of the BCFHT are on staff at RVH.
Mental Health and Addiction Services	☐	☐	☒	☒	☐	CMHA is on the Steering Committee of the Barrie Health Link. CMHA provides case consultation for the LINKS Team Clinicians in order to better support LINKS patients with addiction issues Formal agreement with the Canadian Mental Health Association-Simcoe to provide the Mental Health Program of the BCFHT. This partnership ensures access to an array of Mental Health and Addiction Services including Crisis

						Services, Early Psychosis Intervention, Youth Services, Case Management, Addiction Services, Assertive Community Treatment teams, Justice Services, and Family Support. It also allows for the effective managmenet of shared care. The Health Link Navigators participate in ALC Rounds to identify potential Health Link Clients The Health Link Navigators work very closely with Various departments and discharge planners at the hospital to promote smooth transitions in and out of hospital. For the past 3 years there has been a MOU in place placing a dedicated RVH Data Analyst on secondment to the Health Link
Public Health Unit	☐	☐	X	☐	X	The Simcoe Muskoka District Health Unit and our FHT have a formal written agreement supporting one Public Health Nurse to work out of our PNWB Clinic supporting Lactation services one half day per week. This is a donation in kind offered to the FHT by the Simcoe Muskoka District Health Unit, which helps improve access issues for women in our community requiring support with breastfeeding. The BCFHT and the SMDHU are also founding partners on the Healthy Barrie initiative. The Executive Director of the BCFHT and the Chief Medical Officer of Health collaborated closely over the past year to see this initiative move forward with the other founding partners.
Senior Centre/Service	☐	☐	☐	☐	☐	Many of the FHO Physicians provide service to Retirement Homes.

						The BCFHT medical director and the Aging Well Clinic Team Lead sit on the RVH Seniors Strategy committee. The Aging Well Clinic is aligned with the North Simcoe Muskoka Specialized Geriatric Services.
FHT: (Integration within FHT programs and services)	☐	☐	X	☐	☐X	Mental Health- Collaboration and care coordination with BCFHT Pharmacists and Dietitians-counselling and co-facilitation of groups (Healthy You, Craving Change, Depression Group and the Anxiety Series).Collaboration and care coordination with the Aging Well Clinic. RD working in our PNWB program to provide care for that specific population and implement the Nutristep screening program. Enables collaboration with NPs, MDs and RNs working within that program as the location is offsite. Our RD and Pharmacy program have developed a class for Saxenda starts and co-facilitate it. OT works with our lung health program in their pulmonary rehab program. Diabetes Educators work within some MD offices, including our FMTU, to provide DM education to patients and collaboration with MDs. Pharmacist support is available within in the FMTU and other MD offices for collaboration and care coordination.
Long-Term Care Homes	☐	☐	☐	☐	X☐	The Barrie FHO has many doctors who work in Long Term Care homes. Long Term Care has a representative that is a voting member of the Barrie and Community Health Link.
Hospice Simcoe					X	Pharmacy and RD participate in Hospie Simcoe weekly rounds

Family Medicine Teaching Unit (FMTU) Quality Improvement Projects and Academic Reseach			☒	☒		The BCFHT is a strong partner of the FTMU through the providing of QIDS and IT support, and EMR access to the physicians and residents at the FMTU. One of the areas of largest contribution by the BCFHT is thorugh the its QIDS team. QIDS provides support to the FMTU for the residents annual quality improvement and research projects. The Manager of QIDS is a sitting member of the Research, Enducation and Quality Improvmeentr Program (REQIP), wihich is a committee of the shared Board of Directors between the BCFHT and the Barrie FHO. The QIDS assists resident physicians in the drafting of their QI and research projects, accessing and cleaning data, and providing analytical assistance. Mental Health- Provides an academic session to 1st year residents- Introduction to Counselling Skills. Offers a biweekly mental health clinic to supervise residents working with patients experiencing mental health issues.
School Success	X	X	X	X		The BCFHT has formed a strong partnership with the Simcoe County District School Board in an effort to roll out the School Success Program for our community. This program is an attempt to provide seamless transitions and coordinated care between the education system and healthcare system for children who are struggling in school with behavioral issues, likely due to a medical condition. Timely access to: system navigation, counselling, occupational therapy and pediatrician support are key components that will support students and families in Barrie. This integration and collaboration will improve the

						students' chance for success in school along with improved quality of life and well-being for children and their families.
BBAT					X	The BCFHT is a key partner in the Barrie Breastfeeding Action Team, a community collaborative involving key stakeholders interested in promoting, protecting and advocating for breastfeeding in our community.
OTN	X	X	X	X		Our FHT uses the Ontario Telemedicine Network (OTN) in our Telemedicine Program to ensure that patients receive the right care at the right time and the right place. The OTN system is used to ensure that patients get more out of the health care system by bridging the distance of time and geography to bring more patients the care they need, where and when they need it. Using innovative technology, OTN streamlines the health care process, while also expanding the way knowledge is shared and how members of the medical community interact with each other and with patients. Referrals are accepted from all physicians and NPs in our FHT and from providers outside of our FHT. Using the Telemedicine program, patients are now able to access timely health care in their local area instead of travelling long distances and incurring long wait times. The LINKS Team partners with CAMH (Toronto) to case conference with and for clients
Barrie Smoking Cessation Task Force					X	The BCFHT is represented and actively involved in the Barrie Smoking Cessation Task Force.
Healthy Barrie		X	X	X		Healthy Barrie The goal of the Healthy Barrie Initiative is to position Barrie at the forefront of health system and population health

						improvement. The founding partners of Healthy Barrie are: • The City of Barrie • The Barrie Community Family Health Team (BCFHT) • The Barrie Community Family Health Organization (FHO) • The Simcoe Muskoka District Health Unit (SMDHU) • The University of Toronto: Dalla Lana School of Public Health • The Family Medicine Teaching Unit (FMTU) One of the key objectives of Healthy Barrie is to create a more integrated and collaborative platform for improved population health and health system sustainability. One way that this can be achieved is through projects that have mutual accountabilities for their overall success.
Navigation	X				X	As part of the Health Links, we have created a network of system navigators chaired by the Health Link navigator who meet regularly to provide assistance to community wide patients. The following organization participate in the Navigation Committee. • Home and Community Care (HCC) formerly CCAC • Barrie Area Native Advisory Circle • Barrie Native Friendship Centre • Independent Living Services • Barrie Fire Department • County of Simcoe Housing • Spinal Cord Injury of Ontario • Jarlette (long term care and Retirement Representative) • CMHA • County of Simcoe Paramedics • RVH • Gilbert Centre • Barrie Community Health Centre

						• Red Cross • David Busby • 211 • Health Quality Ontario • Helping Hands • County of Simcoe Ontario Works • City of Barrie Accessibility • Acquired Brain Injury

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

Our interim Executive Director is involved with the LHIN CDPM Steering Committee, the LHIN lung health planning committee and the Perinatal Mood Disorder (PMD) Steering Committee.

The NSM QI Network meets quarterly to discuss provincial and region wide issues surrounding quality improvement. This network is comprised of representatives from the NSM LHIN, HQO and various healthcare provides in NSM. The Network works closely with health providers to provide understanding of Quality Improvement Plans and to provide knowledge translation of any major projects that have been undertaken by network members.

Barrie and Community Health Link

As the lead organization for the Barrie and Community Health Link (BCHL), the BCFHT continues to support the provincial goals of the initiative.

Over the past year the BCHL identified the need to expand our navigation

The BCFHT and BFHO are participating in the NSM LHIN project to connect Home and Community Care (HCC) Care Coordinators into Primary Care Practices. This is a major strategic direction under Patients First. 19 physicians were involved in a pilot project in 2017-2018 and this is continuing. An additional 9 physicians are planning to participate in the next phase. A Care Coordination Summit was held on January 10, and was attended by the MD and ED of the BCFHT.

The Primary Care Network of NSM is a group of physician leaders from the region who meet about every 2 months. Meetings are organized by the LHIN VP Clinical, Dr. Becky Van Iersel. At these meetings Primary Care providers share new developments, local initiatives, information about resources, and other items of interest. The MD and IT Clinical Lead of the BCFHT participate in these meetings.

The IT Clinical Lead participates in the LHIN eHealth Advisory Council. This Council is working on an e-prescribing project for the region and improvement of integration of primary care medical records.

On April 11th the North Simcoe Muskoka LHIN hosted their annual networking and planning meeting in Orillia. This was a meeting of regional telemedicine coordinators, managers and LHIN staff, hosted by Marsha Moland director ehealth NSM LHIN.

During this one day event we had presentations on :

- Telemedicine utilization and reporting in NSM – strategic measures and outcomes from data collected over the last year.
- Discussion around what was working and the program strengths were at each telemedicine site.
- Presentation on opiod, addiction and Mental Health in relation to telemedicine
- Spotlight presentation from a surgical pre-op program from sault area hospital.
- We had clinical brainstorming and telemedicine program design with small groups to facilitate uptake and utilization of the telemedicine programs at each location. Each group presented their brainstorming ideas to the room.

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
	☒	☐	Lead

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.

LINKS Team – The LINKS Team Clinicians work closely with all community agencies to ensure these complex patients have access to a variety of services within the community that will support all aspects of the patients physical, mental, and socio-economical wellness. This includes direct referrals to all community services. We also regularly contact government agencies (ODB, ODSP, OW) and local centres such as David Busby Centre to assist with issues regarding housing, transportation, finances, and medication coverage.

This clinic also connects with patients and hospital staffs while patients are admitted to the local hospital (RVH) to ensure appropriate plans of care (home services, follow-up appointments and testing) are in place for patient discharge in order to support a smoother transition back to the community.

LINKS Team patients are also linked with Healthcare Connect to support efforts to attach these patients to primary care once their chronic conditions are stabilized.

Aging Well Clinic - The Aging Well Clinic works closely with the local hospital and community agencies. This ensures dementia patients and medically complex/frail seniors receive specialised community based geriatric care and are connected with appropriate community services. Patient referrals are accepted from RVH hospitalists, Arthroplasty Intake Clinic, ER Dept & local vascular surgeons. RVH's Geriatric Clinic diverts FHT patients to the Aging Well Clinic. The sharing of personal health information between the Aging Well Clinic and RVH inpatient units/RVH Geriatric Clinic facilitates appropriate medical interventions & medication reconciliation as patients transition between the community and acute care. The Aging Well Clinic provides system navigation to ensure patients have access to a variety of services within the community. This includes direct referrals to services such as CCAC, Alzheimer's Society, Simcoe Community Services, Simcoe Muskoka Brain Injury Services, CMHA, Waypoint, Wendat, Accessible Transportation Services & Simcoe Independent Living Services. Patients/families are linked to Lifeline, Safely Home Service, Adult Day Programs,

Respite Care, CHC chronic disease & fitness programs, foot care services, private pay community support programs and community centres

Barrie Area Diabetes Collaborative - The Barrie & Area Diabetes Collaborative is a community partnership of key stakeholders involved in diabetes care, that work together to ensure that all diabetes patients in our community are seen in the 'right place, by the right provider, at the right time'. Coordination of diabetes services, improved access of diabetes care and improved efficiency of health care delivery involving diabetes are some of the collaborative main goals.

Mental Health- The Mental Health Program engages in system navigation and care coordination through the facilitation of referrals to other appropriate services including: the Canadian Mental Health Association, New Path Youth and Family Services, Royal Victoria Regional Health Centre, Developmental Services Ontario, Kinark Child and Family Services, Athena's Sexual Assault Counselling and Advocacy Centre, Barrie Community Health Centre, Family Mental Health Initiative, Women and Children's Shelter of Barrie,Triple P Parenting programs, Hospice Simcoe and Gilda's Club. Through consultation and collaboration with other service providers, the program provides for the effective management of shared patient care.

2.3 Digital Health Resources

Clinical Management System/Electronic Medical Records

Please provide information on your EMR

Which EMR vendor/version is being used?
Accuro Version 2017.01.447 Vendor is QHR

	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	Choose an item.	Pilot project HCC

Emergency Department	Read-only	The BCFHT has a data-sharing agreement with the Royal Victoria Regional Health Centre (RVH). This data sharing agreement was created as part of Health Links and allows for the BCFHT to identify chronic and complex patients and provision of hospital clinical data to physicians. This agreement is a first step towards more broad data integration between the BCFHT and RVH.
Hospital	Read-only	The BCFHT has a data-sharing agreement with the RVH. This data sharing agreement was created as part of Health Links and allows for the BCFHT to identify chronic and complex patients and provision of hospital clinical data to physicians. This agreement is a first step towards more broad data integration between the BCFHT and RVH. Currently the Health Link, BCFHT is working with the Royal Victoria Regional Health Centre (RVH) to establish a data sharing program to improve referrals and reporting for the Health Link. The BCFHT is connected to RVH through Hospital Remote Manager, which is integrated with the BCFHT's EMR. Doctors with Full privileges have full Integration.

Laboratory Service	Full integration	
FMTU:	Full integration	
Links Clinic:	Full integration to EMR Read-Only to RVH Meditech	
Specialists – Atrium Cardiology Barrie Sports Medicine Dr. McClelland	Full integration to EMR	
Barrie and Community Family Medicine Clinics	Full integration to EMR	

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	☒	☐

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.
The BCFHT considers itself as an advance user of the EMRs. The BCFHT is one of the few FHTs in the province that has a fully fleshed out EMR Joint Management Agreement that allows for the accessing and usage of all patient information in the EMR for purposes of information management, quality improvement and decision support. The BCFHT's QIDS team uses the EMR for a verity of iniatives and projects including, but not limited to: • A bi-annual roster management process of approx. 60 physicians that improves the accuracy of the physician rosters, both in the EMR and MOH roster lists, by and average of 15%. • The QIDS team works on any research based projects that require access to EMR data. This includes the annual resuident quality improvement and research projects, and other research initiatives that are either initated by the local physicians or through research partnership like the BCFHT's partnership with the Dalla Lana School of Public Health at the University of Toronto. • The QIDS team has been leading annual, scientific program evaluations that rely heavily on data from the EMR. Data from the EMR that is used include workload, statistical and clinical information of patient that are both in the BCFHT's program and those that are not, but would quality to be in. • The creation of an alpha version of a physician sorcecard that provides comparative statsitcal and clinical infomraiton of a physicians partice. This also includes the provision of patient lists that allow for improves monitoring of care for those that are the most in need. • The BCFHT, along with the City of Barrie, Simcoe Muskoka District Health Unit and the University of Toronto, are in the midst of developing a Health Atlas for the City of Barrie that will allow community partners to identify georgraphic areas of need while allowing for the evaluation of current efforts in improving care.

The BCFHT accomplishes the about both through the use of the forward EMR interface query tool and access to the back end of the EMR through a SQL server system. Lastly, the BCFHT is one of the pilot FHTs using QHR's Accuro New Analytics Tool. This tool is similar to provide back end access to the EMR with regards to the amount of data that is accessible. In addition, it provides a user friendly interface that also allows so the publishing of finalised reports and dashboards that can be access by users of the publishers choosing.

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.		
The BCFHT has two members of its QIDS team that provide services to six BCFHT clinics and 92 member physicians. The QIDS team has been involved in a wide variety of initiatives and projects in 2017-18, which include, but are not limited to: • Standardizing and Modernizing Lung Health assessment forms in the EMR. • Providing research support to the FMTU and University of Toronto. • Conducting BCFHT program evaluations. • Designing implementation plans and charters for the School Success Program an the LINKS program. • Improving EMR data quality. • Providing support to the Barrie and Community Health Link. • Overseeing the BCFHT's project approval process. • Development of Quality Improvemt Plan		

The QIDS Team has achieve many success in 2017-18 including the evaluation of the BCFHT Diabetes Program. The biggest challenge faced by the QIDS team is current resources not meeting current demand for quality improvement assistance.

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?

Mental Health- The program uses the Ontario Perception of Care Tool for Mental Health and Addictions. This survey is completed by patients and identifies both areas of strength and improvement for the program.

The BCFHT has historically surveyed patients in an ad hoc manner that produced results that were not truly reflective of the patient population that it serves. In 2017-18, working with Georgian Colleges Research Analytics Program, the BCFHT implemented a bi-annualy patient survey that draws on BCFHT patients from all available sources (BCFHT clinics, walk-in clinics and physician offices). The survey has been designed to not only meet provincial standards, but to meet the specific needs of the those withing the BCFHT community. The survey process is uniquely focused on achieving the highest level of representation, to ensure that the feedback we receive is statistically representative of our patient population.

We have four Community members on our Board of Directors. They are involved in the Strategic planning process for the BCFHT.

Healthy Barrie

Healthy Barrie is a collaborative that brings together leaders from the community (including the City, public health, primary care, and researchers) to explore how they can align their work to better address complex health issues in the community.

Healthy Barrie is co-led by the BCFHT and the Dalla Lana School of Public Health. Over the past year the Healthy Barrie collaborative has been active in pursuing three initiatives:

1. Piloting an initiative called Park RX

2. Developing a Health Atlas Indicator Tool

3. Championing the 'Active People for a Healthy Barrie' initiative which is funded by the Ontario Trillium Foundation through their Collective Impact funding stream.

Park Rx

Park Rx was a small pilot involving a small co-hort of Physicians within the BCFHT to offer a prescription for 'Park Time' to select patients that met the criteria of stable depression and or anxiety. This initiative was based on the hypothesis of biophilia which looked at patients overall sense of wellbeing after being present in green space a minimum of 30 minutes per week.

Health Atlas Indicator Tool

The Health Atlas Indicator Tool will be used by partner organizations (the City of Barrie, BCFHT, SMDHU, Uof T) to inform program planning, service delivery, support the health system, population health and healthy community design improvements.

This tool could be used by Healthy Barrie to design Collective Impact community and individual level prevention and intervention strategies.

'Active People for a Healthy Barrie'

As part of the Stage 1: Define the Impact Trillium grant, the working group under Healthy Barrie is working with a broad range of community partners to tackle the complex system challenge of increasing the overall activity levels and opportunities for engaging in physical activity for the citizens of Barrie.

An active lifestyle is good for health, however, getting people to be physically active is a challenging issue. Physical activity is not just a personal or lifestyle choice, but also a function of the built environment, quality programming, socio-economic status, and a host of other factors that either promote or discourage engagement in physical activity.

Our aim is to optimize the community's ability to engage in physical activity through built environment and neighbourhood characteristics while ensuring inclusivity based on age and ability, from youth to seniors, in order to improve individual and community health.

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

No

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.

Our Diabetes Program presented a poster at AFHTO 2017 titled “Sharing is Caring: Our model for dividing FHT patients among diabetes services in Barrie”. At the same conference an NP and pharmacist from our Aging Well Clinic did a joint presentation with Leeds Grenville CFHT titled “Aging Well & At Home: Two Approaches for Primary Care Teams”. The Barrie FHT portion was titled “Aging Well, a Team Based Approach to Complex Elder Care” and highlighted how our Aging Well Clinic uses an interdisciplinary team to provide comprehensive geriatric services to a specific population, partnering with the patient-caregiver dyad and focusing on capacity building with a patient first philosophy. Also at AFHTO 2017 and RD and Pharmacist from our FHT did a presentation titled “Community Palliative Care Rounds – strengthening our Expertise” where they highlighted our Palliative Care Rounds, how it has evolved and its benefits.

Our Barrie FHT RDs collaborated with RDs from Orillia, Midland and Georgian College to organize, plan and host the 12th Annual Dietitians of Canada Ontario Family Health Team Registered Dietitian Conference in Barrie ON last year. This conference was attended by 100 IHPs with the majority of them being RDs and was quite successful.

The BCFHT QIDS Team presented a poster at the 2017-18 AFHTO Conference highlighting its work at improving the data quality of the one of the largest EMRs in the province. The QIDS team has worked closely with 53 out of its 92 physicians to improve the accuracy of their rosters. The QIDS team has been able to reduce the error rate between EMR rosters and MOH rosters from an average of 25.1% to 9.6%. 89% of all

participating physicians and staff believe that their rosters are more accurate due to the initative.

Mental Health- The Program Lead completed quality improvement training through the IDEAS (Improving & Driving Excellence Across Sectors) Advanced Learning Program through Health Quality Ontario. The program equips healthcare professionals with the knowledge, practical skills and tools to lead quality improvement initiatives that aim to improve patient care, experience and outcomes. The new Quality Standards for Depression were the focus of this project.

The 6th Annual Mental Health FHT'ness Conference was held in April 2017. This is a Continuing Medical Education event that is offered to physicians, residents, nurse practitioners and other IHP's.

We are proud to announce that we are now members of HOOPP! This is something that was very important to our employees and we made the commitment to use available funding to ensure it would become a reality. This year we also made the decision to terminate the long standing contract of our benefit provider to move in the direction of a cost neutral/option based benefit plan. Our employees now have the ability to choose the benefit package that best suits the needs of them and their families, while allowing our FHT to save money to ensure the viability of HOOPP for years to come. These changes have been welcomed by staff and have increased moral and engagement.

REQIP

In association with the Family Medicine Teaching Unit (FMTU), the BCFHT supports REQIP (Research, Education, and Quality Improvement Program). This innovative program supports primary care research and QI projects by guiding providers through the process and providing relevant assistance. Family Practice residents are required to do QI and Research projects as part of their training. The BCFHT, BFHO, and FMTU share a single EMR. This creates potential for significant research and QI projects. Examples of QI projects include: "Advance Care Planning in Primary Care" and "Smoking Status and Cessation in the CPP". Examples of Research projects include "Acute Otitis Media in Children and Antibiotic Use" and "FP Follow-up after Admission for COPD and Effect on Readmission"

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.

REQUEST FOR RESOURCES - SCHOOL SUCCESS PROGRAM

Program Description

The School Success Program (SSP) is a coordinated, multidisciplinary approach to assist school-aged children, along with their parents and care givers, address health-related issues that are affecting their ability to be successful in school. This strategy has recently been initiated at the BCFHT as a pilot program during the last quarter of 2017-18.

The Barrie & Community Family Health Team (BCFHT) has created strong partnerships over the past year with the Simcoe County District School Board and local pediatricians in our community to better understand the needs and existing gaps impacting the inability of school aged children in Barrie to be successful in school. From there, they have worked together to implement a strategy that will provide timely and coordinated clinical services and connection community resources and supports, to school-aged children and their families in need.

The main program goal is to create a more positive educational experience for children through collaboration between the education and health care systems to better address the challenges students are facing. The program aims to improve communication between the education system and primary care providers for purposes of identifying students that are struggling or at risk in the school system. Another goal of the program is to provide families and their children with a coordinated, wrap around approach to addressing challenges, by eliminating some of the barriers that currently exist and by creating more seamless approaches to care.

In order for the program to continue, however, we need commitment from the Ministry of Health and Long Term Care to provide permanent human resources to sustain and enhance the program. The BCFHT would like to continue the program on an ongoing basis, and expand to service all eligible school aged children in our community. The risk of this program not continuing due to insufficient resources is enormous for the impacted children, families and the community.

Program Planning-Pilot Phase

In response to a huge community need, the BCFHT partnered with the Simcoe County District School Board and local pediatricians to explore the issues and create a solution to the identified problem. We are continuing to gather information regarding the existing gaps in our community that are required to adequately service the needs of children who are struggling in school. We have been working closely with the Couchiching Family Health Team, which is in close proximity to us. The Couchiching FHT already has a School Success Program which has been up and running for several years now and demonstrating great success and value in their community. Our community has similar populations and need, in terms of support for children and families at risk of not being successful at school, and other areas of their lives.

There are a large number of young families living in Barrie and many children are struggling with behavioral and development issues. These issues are especially problematic for them in school. The struggles are often due to undiagnosed medical conditions such as: anxiety, depression, and attention deficit hyperactivity disorder, amongst others, and learning disabilities. Unmanaged, these conditions will prevent children from being successful in school and ultimately have a negative short-term and long-term impact on their health, well-being and quality of life.

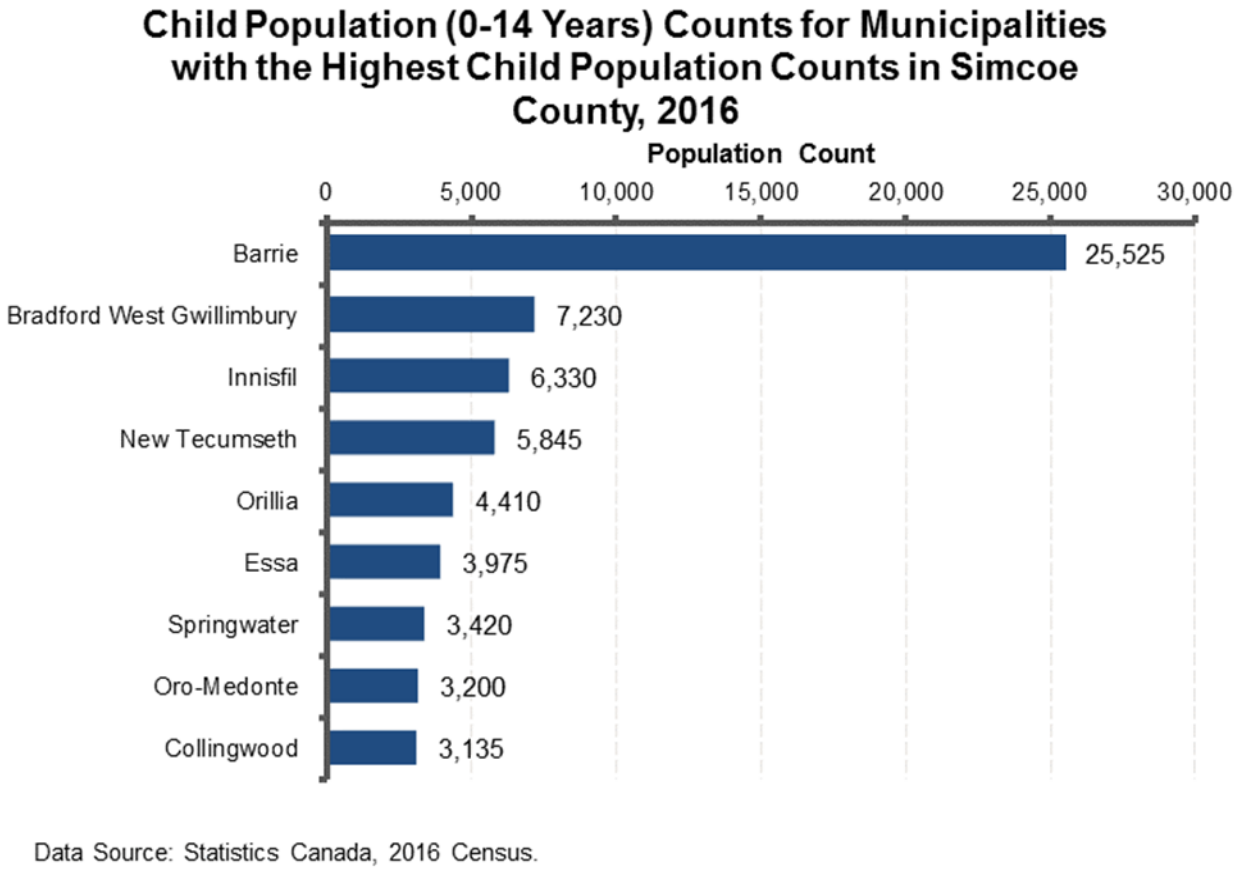
The SSP program has started as a very modified and small scale program, servicing only select schools in the community, to start and with a very select and small team. Funds from the BCFHT unused 'human resources salaries' 2017-18 budget were used to hire the team which included: a part time RN, SW and OT. As such, the team has not been able to grow to include the health care professionals required on the team and can only service limited numbers of the students needing support. This approach is unsustainable long-term, since these funds will be allotted to the positions they were intended for in 2018-19 (there were temporary gaps in some positions in 2017-18 for various reasons including: unfilled maternity leaves, difficulty recruiting some positions, etc.). To continue with this extremely valuable program, and expand its reach beyond select public elementary schools, the BCFHT is requesting additional resources, which will be outlined in this proposal. We hope that the program value will be recognized with sufficient support from the MOHLTC to expand the team to what is needed for the population of Barrie.

Statistics

According to Statistics Canada, in 2016, children ages 0 to 14 years accounted for 16% of the population in Simcoe Muskoka, for a total of 86,720 children. In Simcoe County alone there were a total of 79,100 children. The largest populations of children in Simcoe Muskoka live in the southern municipalities of Simcoe Muskoka, one of which is

Barrie. The Simcoe County District School Board, which is only one of three major school boards in Barrie, services nearly 13,000 elementary school students.

Nearly one in five of these children live in low-income families. Simcoe County also has one of the largest indigenous child and youth populations in Canada. Furthermore, according to the 2015 Ontario Student Drug Use and Health Survey (OSDUHS), 20% of Simcoe Muskoka students (Grades 7-12) experienced severe psychological distress in the four-weeks prior to the survey, which was significantly higher than the provincial average of 14%. Statistically, there are a large percentage of children living in our community, many of whom are experiencing high risk factors and require support, such as that available through the School Success Program, in order to obtain equitable access to healthcare resources and services. Many of the resources that would be available to these children and families in the SSP are either not available to these children due to financial barriers (not publicly funded) or lengthy wait times.



Data Source: Statistics Canada, 2016 Census.

Current Situation

School boards have limited resources and supports to help children and families in need, and often require a validated need from the health care system to provide additional supports. Wait times for supports in schools, including psychological assessments, are lengthy and only available to those with the greatest need. Services including: Occupational Therapy, Psychology or Speech Language Pathology are not available to those who are unable to pay for it out of pocket or through private insurance. The current wait time to see a pediatrician for these types of reasons in Barrie is also lengthy (upwards of 18 months). Parents need a timelier and coordinated approach to break down barriers and reduce the time it takes to get the support needed for their child. Delayed intervention is critical for young, developing children in need of support. There is a tremendous, urgent need for dedicated resources to support the School Success Program in Barrie.

Proposed Solutio

Every attempt is made to identify children who are struggling in school early, and to make the referral process to the SSP seamless and reasonably quick. The referral process should be easy, regardless of where the need is identified (school system or heath care system). Communication and information sharing processes have been initiated in both systems in order to allow for ease of program entry by families in need. Efforts towards success in this area are shared jointly amongst the school personnel as well as the FHT health care team.

The SSP team will work with each child and their family to develop individualized solutions to the identified need, using a multidisciplinary team approach. A multidisciplinary team consisting of: a social worker, occupational therapist, registered nurse, and pediatricians use standardized assessments and best practice clinical decision making to confirm or rule out a diagnosis, which is likely resulting in the behavioral issues presenting at school. Based on this comprehensive assessment, together with the family, they create an individualized care plan necessary to support the children and families.

Specialized supports are provided by the team and/or connections to the most appropriate community supports to effectively manage the identified problem behaviour. There is a need for a clinical psychologist and Speech Language Pathologist to join the team, as these are identified gaps in services, which are not publicly funded by OHIP and currently has a very lengthy wait time to access in our community. Many children in need are going without the support of these services in our community.

The transition between the education and healthcare system is seamless and coordinated. Recommendations from the team are also shared with the school, with appropriate consent, in order to coordinate care and create the greatest chance of

success for the child. If there is a need for school visits, involving the healthcare team, school staff and the family, this will be accommodated.

Wait times are significantly less in the program. Care is taken to not duplicate any services or resources accessed in the community. To date, there are currently 50 children enrolled in the program, with an increase in referrals expected, due to the communications within the school board and the Family Health Team. Meetings are taking place between the SSP team and schools in Barrie to communicate and market the program and further explore how we can continue our mutual efforts for the benefit of this vulnerable population. Vulnerable populations are identified and targeted. Information exchange sessions are offered to the school board employees as well as the Family Health Team and affiliated FHO.

Rationale to continue with our program, beyond the pilot phase, and expand it to meet the needs of the community:

As the program is still in its infancy, we have little program specific data to share to date to support our rationale to continue with this program. However, we have incorporated a strong evaluation component in the program planning phase, which will allow us to pull data in the near future. There is evidence however, of a high need and interest in the program from key stakeholders in our community, as previously highlighted in this proposal. Other supporting evidence for the program is listed below:

1. Outcomes/metrics/data from the existing program, including patient satisfaction surveys or patient stories

- Improved coordination of care, improved access to care, collaboration between multidisciplinary team (RN, OT, SW, SLP. Psychologist and Pediatrician) as well as with external community partners where appropriate using system navigation.

- The program has just gotten off the ground and no meaningful performance information is available at this time. 50 children and their families enrolled in the program after only six weeks of operation.

- While there is not enough program specific data to present meaningful results at this time, the BCFHT is collecting data on the following indicators to evaluate the performance of the program:

o Number of referrals made to other organizations, programs or services

  - Including a breakdown of the organizations, programs and services
  - Also look at current services being offered before attending the program

- Satisfaction/Perception of the value added from the services
  - SERT/Schools will be provided a survey
  - Patients
- Parents/Caregivers
- Number of providers referring into the clinic
- Wait times for the program
- Referrals for the clinic
- Total unique patients seen
- Average visits per patient
- Total number of encounters
- # of new diagnoses (and diagnoses ruled out)
- Screening tools, including pre and post scores for:
  - SNAP Child ADHD checklist
  - SCARED (screen for child anxiety related disorders)
- Primary reasons for referral (such as behaviour, family, school concerns, sensory, etc.)

2. Waiting List/Number of Referrals

- 50 referrals received at start-up of program (first 6 weeks). This has been with a limited number of schools being eligible to refer patients. The BCFHT and the Simcoe County School Board have limited the number of referring schools to allow time for the program to mature, with the limited resources available to commit to the program.

3. Early intervention can have an astounding impact on young children

- Research has overwhelmingly shown that a child who is successful in school has better outcomes in terms of health and overall quality of life. This is strongly supported in the literature, including the infamous research published by Fraser Mustard. Early investments in children have the greatest value and long-term impact on the overall health, well-being and quality of life for children, families and societies, at large.

4. Have you tried to partner with others?

a. We have collaborated with and developed very positive relationships with key community stakeholders who have a keen interest in the program. Three pediatricians will provide team based support and the School Board has committed to being involved, to ensure there is a seamless approach to students and families needing the coordination of support and resources offered by the program. The school board has communicated and marketed the program in the community, starting with schools of the highest need in terms of families and students who are struggling in school and would benefit from a coordinated approach from both parties (the education system and the health care system).

b. We are connecting patients/families to community supports and resources, where appropriate including: New Path, Kinark, CMHA, and Family Connexions. Careful efforts are being made to not duplicate services or resources in the community.

5. Is there anything else in the community currently that supports this type of work?

No. Not in our community of Barrie. The Couchiching FHT in Orillia has implemented this program several years ago and is experiencing great results/success in meeting the needs of students and families in that community. We feel that our community needs are very similar…and the program has the potential to make a remarkable impact on our community.

6. Any other solutions have been tried?

Traditional approaches have been for school staff/families to think about a referral for the student to the family doctor if a student is struggling in school with behavioral/developmental/social/ emotional issues. The family doctor may then ask for information to be submitted from the school to gain a better understanding of the issues. Then, a pediatrician referral is likely to be made, of which there is currently an 18 month wait time. From there, there may be school meetings, and referrals for other types of supports (OT, counselling, parenting, etc.) which the families have arrange and get placed on yet another wait list. This uncoordinated and lengthy process (which can sometimes last for several years) does not efficiently meet the needs of students and families who are struggling. As a result, critical and unnecessary time is wasted without appropriate interventions and supports that can help the child be successful and achieve better outcomes in school. This also negatively impacts the overall quality of life for both the child and the family, as they are going through this process.

This program is a prime example of upstream population-based approach to health and wellness in our community, resulting from strong partnerships and shared resources.

This exceptional collaborative approach to care is not available anywhere else in our community. Without the commitment from the Ministry of Health and Long Term Care to provide permanent resources to this program, children and families will continue to struggle.

Resources Requested

Based on anticipated demand for program/team services, the BCFHT is requesting the following human resources to support the continuation of the SSP:

RN-1.0 FTE

Social Worker-3.0 FTE

Occupational Therapist-1.0 FTE

Clinical Psychologist-1.0 FTE

Speech and Language Pathologist-1.0 FTE

Administrative Support-1.0 FTE

Please see below an excerpt from an email communication received from one of our pediatricians who feels that a Speech and Language Pathologist is an essential request and need for the SSP:

“In conversation with the team today in SSP, I thought I'd send you a note about requesting funding for a SLP for the Barrie SSP.

The primary purpose would be for supporting children with reading based LDs. SLPs are skilled at using multi-sensory, phonetic-based programs with children with reading based LDs that are approaches supported by multiple LD societies (including LDAO) and clinical psychologists.

These approaches are aimed at remediation or attempting to "correct" the underlying issue. This is most effective when implemented prior to grade 4 as there is evidence that a child's brain is still very malleable at these ages. Remediation should be the primary goal when working with primary school children with flags for LDs. If the problem can be remediated, this will save the child from great frustration/negative self-esteem, potential academic failure with all the associated consequences (including unemployment), and use much less school resources over the long term (including accommodations such as technology or special classes/SERT resources, and behavioural supports).

Currently, the schools primarily focus on accommodations (IEP for SEA equipment or added time, etc). Although these accommodations may play an important role they should be considered secondary to remediation.

Our goal should be to address the underlying issue (LD) and not just "work around it" when children are younger. This is akin to screening for cancer so that it can be treated in early stages rather than waiting until it's metastasized -- treatment is more effective when implemented early.

LDs affect more than 15% of children and in the referred population of the SSP the percentage would be much higher. It's very difficult for me to properly address the "school success" of a child if we cannot address a LD properly. Remediation of LDs is not within my scope of practice, nor would it be in that of a SW, OT, or RN (our current team). These other team members bring other expertise which is invaluable to school success but we are still missing an important "piece".

Of course, a SLP would also be useful for children with articulation issues, fluency issues, etc. However, there is some access to SLPs for these indications via the school board (albeit limited). There is no access to SLPs for reading remediation.

Thanks for your consideration.

Miriam Hansen, Pediatrician"

Please also see the letter of support from Chris Samis, SCDSB School Board Superintendent, attached.

Barrie School
Success Program - L

Thank you for your consideration of our request for resources for the School Success Program. We will patiently await your response.

Respectfully submitted,

Kimberly Vickers,
Interim Executive Director
Barrie & Community Family Health Team

Mental Health

Patients experiencing mental health issues require timely access to appropriate care and as such would benefit from additional mental health resources. The program receives on average 350 new referrals per month. The current Therapist complement of 11.6 cannot effectively meet this demand. Efforts to reduce wait times have included a stepped care approach to service including increased self management, revised intake process, reduced child and youth services and increased group development.

IT/EMR

We are piloting add-on modules for our Accuro EMR in order to comply with our contract requirements re: Electronic Communication with patients. These include the following:

1) Patient Messaging: allows physicians to communicate with patients directly from within the EMR. Patients receive a "no reply" email telling them they have a secure message – they then login to a secure platform to view the message. Physicians can share lab results, provide treatment instructions, and even perform post-op and remote patient consults. Physicians fully control when communications are initiated and terminated through this module. Patient Messaging cost is $24.95 per provider per month. For our ask, we're considering each program to essentially be a provider and have broken the FHT down into twelve programs. Total cost: $24.95 x 12 programs x 12 months = $3,592.80 plus tax annually.

2) Online Booking: allows physicians to create blocks of time for certain types of appointments and make them available via a secure web interface. Patients sign on and are prompted to select their physician, type of appointment, time slot, and reason for appointment – the request is then reviewed by the physician staff and a confirmation email is sent to the patient when the request has been approved.

3) Appointment Reminder: provides automated appointment reminders to patients and is fully integrated into the EMR. Patients can choose to be reminded via automated phone call, text message, or email, and the reminder status is displayed on the EMR scheduler, including whether the patient confirmed, cancelled, or was unreachable for a response.

Appointment Reminders cost $0.35 per reminder. FHT saw 29,690 patients last fiscal (includes estimated School Success projection). Total cost: $0.35 x 29,690 = $10,391.50 plus tax annually.

4) ePrescribe: provides the option for a physician to send a prescription directly to a participating pharmacy (while still permitting them to fax if they so choose). A fully integrated and secure messaging system is available directly within the EMR so the

pharmacist may request clarification or correction to a prescription and includes drawing tools to permit the pharmacist to mark up the prescription for the physician to see. This module will eventually interface directly with the pharmaceutical management software so the prescriptions may be entered directly (though always with human review for final approval), which will help eliminate transcription errors.

We are requesting funding to allow us to move forward with this contract obligation of electronic communication with patients. We are requeting a total of $13,984.30 plus HST for a total of $15,802.26 to support our needs, as outlined above.

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.*

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

- **Improve timely appropriate access**
- **Continue to improve quality of care**
- **Promote primary care research**
- **Integrate care delivery among all health care and community service providers in our region**
- **Improve collaboration of care delivery among the FHT, FHO and BCFMC**
- **Encourage patient ownership of their personal health care plan**
- **Promote physician engagement and wellbeing**

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

Improve timely appropriate access

1) Advocate for improved access to Seniors Care and Mental Health
2) Improve access to specialist care
3) Advance use of the EMR in the clinics
4) Optimize use of staff in the clinics
5) Modernize office workflow
6) Support physicians in determining roster size

Continue to improve quality of care

1) Improve data quality in the EMR
2) Evaluation of FHT programs
3) Implement patient experience survey across all FHT programs and family practices

Promote primary care research

1) Continue to support community based research in family practices
2) Continue to collaborate on community research project
3) Identify areas of interest for research

Integrate care delivery among all health care and community service providers in our region

1) Integrate patient care with RVH
2) Explore integrated patient care with specialists
3) Improve communication with Health Care Connect
4) Improve communication Home and Community Care
5) Collaboration with the LHIN and its health service providers and fully participate in sub-region planning

Improve collaboration of care delivery among the FHT, FHO and BCFMC

1) Improve collaboration between FHO and FHT programs.
2) Improve collaboration with IT Department
3) Improved collaboration between the BFMC and physicians and their offices

Encourage patient ownership of their personal health care plan

1) Increase patient understanding of the Health Circle (relationship between the FHT, FHO and BFMC)
2) Empower patients to take responsibility for their own health
3) Educate patients about utilization of the health care system

Promote physician engagement and wellbeing

1) Ensure that the Vision and Mission of the organizations are well understood
2) Ensure a comprehensive orientation for all new physicians
3) Promote ongoing physician engagement to maintain a strong organization
4) Promote engagement in QI and optimize use of EMR
5) Promote physician health and wellness

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).*

Currently we have two clinical programs (Pre-Natal Well Baby and Aging Well) that are located at other locations, both of which have leases that will expire in fall 2020. It is our hope that we can complete our vision of having all programs in one location, our Primary Care Campus at 370 Bayview Drive. Our current location houses all programs and administrative staff, including the two out layers will be an additional benefit to patients that require combined care. 370 Bayview is located in a growing part of Barrie with many businesses choosing to make this area their home. We have a senior's facility opening beside our office that will certainly bring more patients to our Aging Well clinic if we could relocate it in our building. In order to move PNWB and Aging Well to our main campus after their leases expire we would require additional new office space within our existing building and would require additional capital funding to support this. We are currently in the process of working with our landlord to complete the costing of a new space to home approximately 15-20 employees.

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:

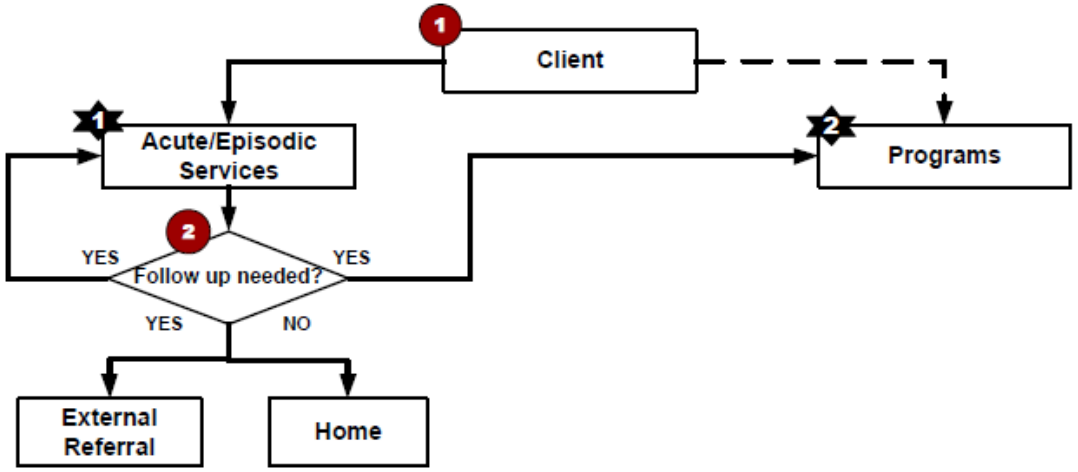
- access (e.g. availability of same day/next day appointments)
- system level indicators such as impact on patients seen within 7 days post hospital discharge, Emergency Room diversion, etc.

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