Family Health Team

Annual Operating Plan Submission: 2022-2023

FHT Name:

Date of Submission:

Primary Health Care Branch
Ministry of Health

**Version française disponible sur demande*

Ontario

TABLE OF CONTENTS

Introduction

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

PART A: 2021-2022 Annual Report – **mandatory**
PART B: 2022-2023 Service Plan – **mandatory**
PART C: 2022-2023 Governance and Compliance Attestation – **mandatory**

Ontario's health care system 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 and community and local partners 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.

Part A: 2021-2022 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 2021-22, as indicated in Schedule A, Appendix 3 of your current agreement. Please also state the number of patients you have enrolled by March 31, 2022.

Patient enrolment	Target March 31, 2022	Actual March 31, 2022	
Number of enrolled patients			
Are physicians enrolling new patients?		Yes ☐	No ☐
If **Yes**, please confirm the following:			
a. Number of physicians accepting new patients:			
b. Please estimate the FHT's capacity to accept new patients (specify # of patients)			
Additional details (optional):			

If the target was not met, please explain why and outline your plan to meet this target:

1.2 Patient Enrolment – Access for New Patients in 2021-2022

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)	☐	☐

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 non-enrolled patients served in 2021-22.

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

1.4 French Language Services

Did 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 accessed programs and/or received services in French.		

1.5 Accessibility to Cultural and Language Services

Did the FHT address the linguistic and cultural needs of the population being served, where possible? Please explain.

1.6 Regular and Extended Hours

What are your regular hours of operation when patients can access Interdisciplinary Health Providers (IHP) services? *Ex.: Mon: 9-5, Tues: 8-4, etc.*	Hours of operation: Mon: Tues: Wed: Thurs: Fri: Sat: Sun:
When are IHP services available after hours?	Extended hours: Mon: Tues: Wed: Thurs: Fri: Sat: Sun:
Identify which programs are offered after hours:	
Additional information:	

1.7 Timely Access to Care

Please provide information on how appointments were scheduled in 2021-2022.

Timely Access to Care		
Did the FHT schedule appointments on the same day or next day (within 24 to 48 hours)?	Yes ☐	No ☐

If yes, what percentage of total enrolled patients was 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)*	%

1.8 Other Access Measures

Please provide information on other types of access measures provided in 2021-2022.

Other Access Measures		
Percentage of FHT practitioners who provided home visits?	%	
Which types of IHPs perform home visits?		
Number of home visits performed by IHPs in 2021-2022?		
Did the FHT deliver care virtually in 2021-2022?	Yes ☐	No ☐
If yes, was virtual care provided via telephone?	Yes ☐	No ☐
If yes, was virtual care provided via video?	Yes ☐	No ☐
What percentage of IHP services were provided virtually (e.g., telephone/video/online)?	%	
Emergency Department (ED) Diversion		
Did the FHT have a strategy to divert enrolled patients from the ED (**aside from physician contractual requirements for after hours**)?	Yes ☐	No ☐

Please describe the strategy: (Examples: NP after-hour clinics, ED Reports (CTAS 4, 5), triaging, patient awareness procedures (phone calls, posters, website, reminders), hospital discharge follow-up, outside use reports follow up)
How are patients made aware of hours of operation? (Examples: visible clinic signage, voicemail, patient pamphlets, FHT website or other means)

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	☐	☐	☐	☐	☐	
Ontario Health - Home and Community Care	☐	☐	☐	☐	☐	
Community Health Centre	☐	☐	☐	☐	☐	
Community Support Services	☐	☐	☐	☐	☐	
Developmental Services	☐	☐	☐	☐	☐	
Diabetes Education Centre	☐	☐	☐	☐	☐	
Local Hospital	☐	☐	☐	☐	☐	

Mental Health and Addiction Services	☐	☐	☐	☐	☐	
Public Health Unit	☐	☐	☐	☐	☐	
Senior Centre/Service	☐	☐	☐	☐	☐	
FHT: (specify)	☐	☐	☐	☐	☐	
Long-Term Care Homes	☐	☐	☐	☐	☐	
Other: (specify)	☐	☐	☐	☐	☐	

2.2 Local Planning and Community Engagement

What process/mechanism did the FHT have in place to include input from Ontario Health and other community partners into program and service planning, including health human resources planning?

Please describe FHT involvement in Ontario Health-led initiatives.

Public Engagement Strategy: What was the process/mechanism that the FHT had in place to include patient and community input into FHT planning and priorities?

Ontario Health Team (OHT) Involvement: Is the FHT involved in any activities related to the development of Ontario Health Teams? Please describe the extent of the FHT's participation in OHT implementation as applicable.

2.3 System Navigation and Care Coordination

How did 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; Ontario Health collaboration for home care supports, other follow-up care, etc.

2.4 Digital Health Resources

Clinical Management System/Electronic Medical Records

Please provide information on your EMR

Which EMR vendor/version is being used?		
	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
OH – Home and Community Care	Choose an item.	
Emergency Department	Choose an item.	
Hospital	Choose an item.	
Laboratory Service	Choose an item.	
Other (specify):	Choose an item.	

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

Were 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 visit	☐	☐

Did FHT patients have access to the following patient-facing online services?	Yes	No
Email communication with the FHT	☐	☐
Request prescription refills/renewals	☐	☐
Book appointments with Family Health Team providers	☐	☐

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

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

2.5 Data Management Support

Please provide information on any data-management support activities in 2021-2022.

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

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

3.0 Other

3.1 Other Information and Comments

The Ministry of Health likes to promote the work done by FHTs. Please describe any awards, acknowledgements, or achievements from 2021-2022.

Is there anything else that the organization would like to communicate to the ministry regarding its activities in 2021-2022? Any challenges, opportunities and recommendations for the ministry can also be detailed in this space.

Part B: 2022-2023 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 2022-2023. Organizational factors such as articulating a clear vision and establishing clear priorities are 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 2022-2023, 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 and indicate if this has been clearly articulated to staff, patients and partners.*

2. *Identify the strategic priorities for the FHT that will apply to the 2022-2023 fiscal year.*

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

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, provide a brief project description, including anticipated timelines and budget (if known).*

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: 2022-2023 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. All Family Health Teams are required to complete and submit the Governance and Compliance attestation annually.

Please complete the Governance and Compliance Attestation 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:

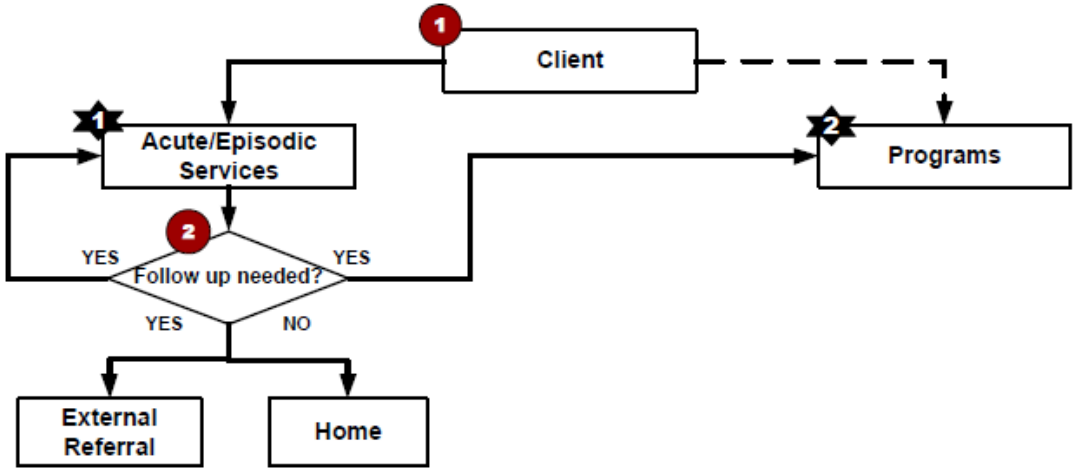
- access (e.g. availability of same day/next day appointments)
- system level indicators such as impact on patients seen within 7 days post hospital discharge, Emergency Room diversion, etc.

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

APPENDIX B – FHT EXPENDITURE GUIDELINES UPDATED 2022-2023

1. Overview

To help FHTs adapt to evolving provincial and local priorities and to patient need and in recognition of FHTs' growing organizational maturity, beginning April 1, 2018, the budget flexibility features previously associated with the Accountability Reform Initiative (ARI) are being extended to all FHTs. This will assist FHTs in supporting the needs of their patients and communities in a more flexible and efficient manner.

Each FHT's budget is now allocated across five* semi-global budget categories:

- Operating Overhead
- Salaries and Benefits
- Specialist Sessionals
- Physician Consulting
- One-Time Funding

**NOTE: The ministry may choose to preserve a budget line outside of these five categories (e.g. premises costs) in select circumstances where unique reporting requirements are needed.*

FHTs are expected to manage funding within each category in accordance with the following guidelines:

- Funds must be expended according to terms and conditions stipulated in the funding agreement. Schedule B, and its amendments, form the basis of quarterly financial reports. **Financial reporting, as outlined in Schedule D, remains unchanged: FHTs must report expenditures on a line-by-line basis in their quarterly reports.**

- Any funding (or any part of funding) advanced and not spent in accordance with the terms of the Funding Agreement, **must be reported** and may be dealt with by any one or combination of the following:
  - Will be offset by the ministry against any money owed by, or to become due from, the ministry to the FHT
  - Will be repaid to the ministry by the FHT within four weeks of the FHT's receipt of written notice from the ministry
  - Is in accordance with the terms of the ministry's additional written instructions to the FHT.

Reallocation

- FHTs are eligible to reallocate funds equaling the lesser of up to 10% of the total annual budget or $10,000 (the "tolerance threshold") between semi-global budget categories **without written ministry approval**, **<u>except</u>**:
    - From/to any category to/from the Physician Consulting category
    - From/to any category to/from Physician Compensation, including Specialist Sessionals

- Requests to reallocate funds in excess of the tolerance threshold **must be submitted to the ministry in writing**, **and the FHT must obtain written ministry approval before proceeding.** The ministry will consider the reallocation request according to the following criteria:
    - The FHT is in good standing
    - The FHT has made progress in accordance with the goals and objectives as set out in Schedule A, Appendix 3
    - The reallocation request aligns with program/service expectations of the FHT as per Schedule A, Appendix 3

- Funding may be reallocated to any Interprofessional Health Provider (IHP) that the FHT identifies as necessary for appropriate patient care, and compensation must align with the organization's approved compensation plan.

- Funding reallocations to IHPs must not result in reductions to front-line care (staffing commitments as captured in Schedule A, Appendix 3).

- The ministry is not liable for any unapproved expenditure or reallocation.

- Ineligible reallocations will be recovered at a time stipulated by the ministry.

3. Human Resources

- No single IHP category may account for more than 50% of the total IHP complement, **unless prior ministry approval is provided in writing.** If a FHT has a single profession accounting for more than 50% of the total complement at the onset of the initiative, the previously approved ratio will be honored, but going forward it may not be surpassed without ministry approval. The Nursing profession includes all funded nursing positions, including Nurse Practitioners, Registered Nurses and Registered Practical Nurses.

- If a FHT wishes to make minor changes to their staffing complement during the course of the year they may do so without seeking ministry approval**, provided that such changes are cost neutral.**
- If a FHT wishes to permanently change their staffing complement, **they must request ministry approval through the Annual Operating Plan process**. The corresponding changes must be reflected in the FHT's Schedule A, Appendix 3 - Programs and Services and Schedule B – Budget.
- If a FHT wishes to use contracted services, they must ensure that they have been granted a ministry exemption to the Funding Agreement requirement that all FHT interdisciplinary and administrative staff must be employees of the FHT.
- A FHT may allocate Specialist Sessional funding to any registered specialist physician within their FHT.

4. HST Rebates

FHTs qualify as not for profit organizations since they receive over 40% of their funding from the provincial government. This makes them eligible to claim rebates for the provincial and federal components of the HST paid or payable on most inputs used to provide exempt supplies. When providing financial statements, FHTs should report actual costs **net** of the rebate and book the projected rebate as a receivable so that their financial statements reflect actual expenditures. FHTs who choose not to book expenses net of the rebate **must first seek approval to reallocate the rebate** toward operational costs. FHTs should contact the Canada Revenue Agency for information and forms.

5. Blended Salary Model physicians

The ministry does not include estimates for Blended Salary Model (BSM) physician salaries, benefits and locum funding in the annual operating budget. These details are **NOT** required as BSM physician salaries and locum funding are funded separately from the FHT agreement and are calculated on a monthly basis based on actual enrolment and FTE status. Actual Expenditures for BSM physicians (**excluding OHIP Remittance Advice funding**) must be reported in quarterly financial reports and the Audited Statement of Revenues and Expenditures (ASRER).