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INTRODUCTION

The St. Michael’s Hospital Department of Family and Community Medicine—often referred to as “the Department” in this document—is an integral part of St. Michael’s Inner City Health Program and provides a range of primary care services to a largely inner city population in downtown Toronto. In 2010, the Department’s medical staff constituted itself as a Family Health Organization and joined with St. Michael’s to form the St. Michael’s Hospital Academic Family Health Team—often referred to as “Family Health Team” in this document. St. Michael’s Family Health Team, the largest academic family health team in Ontario, is comprised of 73 physicians, 6 nurse practitioners, 53 health care professionals and 64 staff who work across six clinical practice sites and serve approximately 35,000 patients. It is estimated that by 2019 there will be 45,000 patients accessing primary care services at St. Michael’s Family Health Team. In preparation for this time of growth and change, it is essential for the Department and Family Health Team to formalize a strategic plan to set the course for the next three years.

BACKGROUND

St. Michael’s Department of Family and Community Medicine currently provides primary care services at six clinical practice sites that are distributed in the neighbourhoods surrounding the hospital (see Box 1). Each site serves as a health resource to the local community. The Department serves a diverse patient population which includes urban professionals, hospital employees, newcomers to Canada and many at-risk groups. The Department cares for a high proportion of patients with HIV, serious mental illness and addictions and is known for caring and advocating for the poor and homeless, the LGBT community and those living with disabilities. The St. Michael’s family medicine obstetrics program has seen enormous growth in recent years.

Box 1: St. Michael's Family Health Team Clinical Practice Sites

- 61 Queen St. Family Practice Unit
- St. Lawrence Health Centre
- Health Centre at 410
- St. James Town Health Centre
- Health Centre at 80 Bond

The characteristics and needs of the growing inner city communities served by the Department drives the development of the Family Health Team clinical services and programs. In response to many of our patients’ highly complex needs, the Family Health Team has recruited and trained providers with expertise in a number of clinical areas. We have also created unique positions to address patients’ broader health needs including income security health promoters, a community engagement specialist and a Health Justice Initiative on-site lawyer. The Sumac Creek Health Centre at 73 Regent Park Boulevard opened on July 13, 2015 to care primarily for patients from three priority underserviced neighbourhoods. The Sumac Creek Health Centre uses a new service model with co-location of laboratory and diagnostic services and shared physical space with community partners, namely the FOCUS mental health team. The Department is committed to addressing health inequity and the social determinants of health by partnering with local communities and using a population health approach. The Family Health Team has numerous new and innovative programs to deliver collaborative primary care (see Box 2).
Box 2: Clinical programs and services offered in the Family Health Team:

<table>
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<tr>
<th>Aboriginal health promotion</th>
<th>Legal education and advice service</th>
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<tr>
<td>Addiction services</td>
<td>Maternity care, including prenatal classes</td>
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<td>Chiropody services</td>
<td>Mental health care, including trauma groups</td>
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<td>Chiropractic care</td>
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<td>Clinical psychology</td>
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<td>Common chronic disease management</td>
<td>Physiotherapy</td>
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<td>Dental care</td>
<td>Registered Dietitian care</td>
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<td>Diabetes education</td>
<td>Services for people living with disabilities</td>
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<td>HIV care</td>
<td>Smoking cessation</td>
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<td>Home-visit service for elderly</td>
<td>Gay, Lesbian, Bisexual and Transgendered care</td>
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<tr>
<td>Income security health promotion</td>
<td>Transitioning to home support</td>
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OUR CORE BUSINESS: High-Quality Clinical Care, Research, and Education

The Family Health Team is committed to delivering high-quality clinical care to a diverse patient population across their lifespan. An interprofessional Quality Steering Committee, comprised of 29 members, meets monthly to guide quality improvement activities across all practice sites. Each site has its own interprofessional quality improvement team that operationalizes Family Health Team priorities by testing changes locally. Since 2013, the Quality Steering Committee has led the development of an annual Quality Improvement Plan that outlines change initiatives focused on the Ministry of Health and Long-Term Care priority areas of patient access, patient-centredness, and integration of care.

The St. Michael's Department of Family and Community Medicine is a core teaching site for the Department of Family and Community Medicine at the University of Toronto and annually trains approximately 75 undergraduate medical learners, 42 family medicine residents and several clinical fellows to develop enhanced skills in areas such as addictions, HIV, developmental disabilities, care of the elderly and adolescent mental health care. In addition, approximately six nursing trainees, four nurse practitioner students, 26 chiropractic learners, 19 psychology residents, eight dietetic interns, two Masters in Social Work students and one pharmacy student are supervised by Departmental staff each year. The on-site lawyer also supervises approximately two law students from the Disability Law Intensive Program at York University. The Department has been a leader in developing and supporting interprofessional education opportunities for Faculty as well as learners at all levels of health professions training. The Department is also a highly sought after site for unique clinical experiences in inner city health.

The Department is highly productive in research and supports ten primary care researchers. Our researchers are leading significant work in areas of: global and international health; social, economic and policy determinants of health; population health; immigrant and refugee health; primary care models; HIV and AIDS; diabetes and other chronic diseases; homelessness and pediatric research. Several Department researchers are actively involved with the St. Michael's Centre for Research on Inner City Health. In addition, there is abundant creative professional activity within the Department.
PARTNERSHIPS

The Department has a history of collaborating and partnering with a broad range of hospital departments and community organizations to expand and enrich the delivery of clinical programs and services to benefit patient care.

Within the hospital there has been a long history of forging partnerships with a variety of speciality services to provide shared care to Family Health Team patients, with the service often located at the family practice site to facilitate patient care.

There are also partnerships with other institutions and community organizations to provide services to Family Health Team patients. Key partnerships are listed in Box 3, with formal partnerships marked with an asterisk (*). In addition to outside institutions and organizations providing service to Family Health Team patients, Department physicians and other health professionals also provide clinical services at several community-based facilities and organizations, including hostels and shelters.

St. Michael's Hospital Academic Family Health Team has been recognized nationally and internationally as representing an exemplary model of primary care.

Box 3

- St. Michael’s Hospital Departments of:
  - Medicine
  - Psychiatry
  - Pediatrics
  - Palliative care
  - OB/GYN
- Hospital for Sick Children – Target Kids*
- Youthdale
- Covenant House*
- Regent Park and South Riverdale Community Health Centres
- Fred Victor Employment/Training Service
- Fife House
- Casey House*
- Scadding Court Community Centre*
- Community Care Access Centre (CCAC)*
- New Visions
- Seaton House*
- Fudger House
- Ryerson University Department of Psychology*
- Canadian Memorial Chiropractic College*
- Centre for Addiction and Mental Health
- The Sherbourne Health Centre
- Toronto Public Health*
- Behavioural Support Ontario (BSO)
- Inner City Family Health Team
- Inner City Health Associates (ICHA)*
- Baycrest Health Sciences
- ARCH Disability Law Centre*
- Legal Aid Ontario
- Aboriginal Legal Services Toronto
- HIV Aids Legal Clinic of Ontario
- Neighbourhood Legal Services

Accomplishments of the Department of Family and Community Medicine over the past three years:

A five-year review of the Department was concluded in April 2012. At the time, several future directions were identified which have now been successfully accomplished, namely:

- Developed local expertise in mining data from the Electronic Medical Record (EMR) for research and quality improvement.
- Quality improvement has become a fully embraced aspect of the core business within the St. Michael’s Family Health Team and Quality Improvement Plans are submitted annually to Health Quality Ontario.
- Establishment of a sixth clinical practice site to meet the needs of unattached patients in the Toronto Central Local Health Integration Network (TCLHIN) with an emphasis on TCLHIN identified priority neighbourhoods.
THE CHANGING ENVIRONMENT

The Department recognizes the continually changing environment in which it seeks to fulfill its mission:

• St. Michael’s has recently renewed its three-year strategic plan. The St. Michael’s Vision and key strategies are very much focused on urban communities:

  o St. Michael’s vision: World leadership in urban health

  o Key Strategies – Comprehensive care for our entire urban community; Advance systems of care for disadvantaged patients; and Excel in the care of critically ill patients

The St. Michael’s Strategic Plan explicitly recognizes the importance of “systems of care” and this includes primary care as the consistent thread that supports continuity of care throughout a patient’s health care journey. Smooth transitions of care are an essential component of system transformation and the Department and its Family Health Team are key intermediaries between the hospital and the urban community, particularly for the marginalized and disadvantaged.

• The University of Toronto Department of Family and Community Medicine has recently released its 2015-2020 strategic plan: Advancing Family Medicine Globally through Scholarship, Social Responsibility and Strategic Partnerships

• The Department has partnerships with multiple universities and colleges and participates in the teaching and education of a wide range of health professions students. The focus and advancement of interprofessional education as a key mechanism for promoting interprofessional collaborative practice is of high importance to the Department and is an area where the Department aspires to continued leadership and innovation.

• There is increasing accountability of the Family Health Team to the Ministry of Health Long Term Care through priorities of: access for unattached patients; timely access for current Family Health Team patients including expanded after hours and weekend coverage; integration and partnerships and quality and safety. There are also new accountabilities for demonstrating impact of the interprofessional team and increased expectations regarding Family Health Team performance measurement.

• Patient engagement has become an increasingly important theme in the delivery of care, the education of future health practitioners and in directing research questions. St. Michael’s Inner City Health Program has a rich history of engaging patients in developing programs and services that meet the needs of the most disadvantaged individuals in our community. Four St. Michael’s Community Advisory Panels (Homeless and Underhoused; Women & Children’s Health; Aboriginal Health; Mental Health & Addictions) provide a unique lens through which recommendations for improvements in service provision are made and implemented. The Department will continue to design ways to engage patients more effectively across all its activities.
# VISION AND MISSION

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<th>VISION</th>
<th>Excellence in urban primary health care</th>
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<tr>
<td>MISSION</td>
<td>Our interprofessional primary care team collaborates with our patients and community to improve the health of our patients, advance the learning of our students, create and disseminate knowledge, and advocate for policies that benefit underserved and marginalized communities. We demonstrate this by:</td>
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<td>• Providing exemplary physical, emotional and spiritual care for all of our patients and their families</td>
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<td>• Balancing the continued commitment to the care of the poor and those most in need with the provision of highly specialized services to a broader community</td>
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<td>• Building a work environment where each person is valued, respected and has an opportunity for personal and professional growth</td>
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<td></td>
<td>• Advancing excellence in health services education</td>
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<td></td>
<td>• Fostering a culture of discovery in all of our activities and supporting exemplary health sciences research</td>
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<td></td>
<td>• Strengthening our relationships with universities, colleges, other hospitals, agencies and our community</td>
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<td></td>
<td>• Demonstrating social responsibility through the just use of our resources.</td>
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The commitment of our staff, physicians, volunteers, students, community partners and friends to our mission permits us to maintain a quality of presence and tradition of caring – the hallmarks of St. Michael's.
VALUES

The Department is guided by the values of St. Michael’s:

**Human Dignity**

We value each person as a unique individual with a right to be respected and accepted.

**Excellence**

We value quality in care, work life, education and research.

**Compassion**

We value a quality of presence and caring that accepts people as they are and fosters healing and wholeness.

**Social Responsibility**

We value integrity and the promotion of the just use of resources entrusted to us for the enhancement of human life.

**Community of Service**

We value a work climate of mutual trust and harmony to enable healing, collaboration and the fulfillment of human potential.

**Pride of Achievement**

We value our colleagues, our work and our accomplishments and take pride in bringing our rich tradition of hope and healing to every person in our care.
STRATEGIC PLANNING PROCESS

In 2014, Department leadership identified the need for a planning process to set out the strategies, goals and priorities for the Department. The planning was initially guided by a Strategic Planning Committee (Appendix 1) and included a consultation process through key informant interviews, a department-wide survey (30 respondents) and two planning retreats (held on Oct. 21 and Nov. 27, 2014) attended by approximately 50 members of the Department.

The initial draft of the Strategic Plan was prepared by Susan Tremblay Consulting and reviewed by the Strategic Planning Committee and content experts in the Department. This draft was then reviewed and revised by members of the Department’s executive, management and interprofessional education committees, research and education leaders, and St. Michael’s Office of Strategic Planning. The draft was then circulated to the entire Department for feedback and was presented for discussion at the St. Michael’s Hospital Academic Family Health Team Annual General Meeting on Sept. 16, 2015 and the Department’s General Staff Meeting on Oct. 15, 2015.

Figure 1

Approved Dec. 7, 2015 by the St. Michael’s Hospital Academic Family Health Team’s Board of Directors
DEPARTMENT STRATEGIES AND GOALS

The five priority strategic areas for 2015-18 (see Figure 1) that have been generated align the Department's future direction with the priorities of Ontario's Ministry of Health and Long-Term Care, the Toronto Central LHIN, Health Quality Ontario, St. Michael's and the Department of Family and Community Medicine at the University of Toronto. Our core business of quality patient care, education and research spans our five key strategic directions. Supporting our people and strengthening the infrastructure will assist the Department in achieving these goals over the next three years.

Strategy #1: Improve the health of the community by increasing access to primary care services

A strong primary health care system has been shown to be associated with better health outcomes, lower health system costs, and fewer health inequities. The Minister of Health and Long-Term Care has committed that all Ontarians will have access to a primary care provider and the government is asking family health teams to take a leadership role in providing access to care for unattached patients. The opening of a sixth clinical practice site in Regent Park provides the Department with a unique opportunity to provide primary care services to a population that has traditionally had difficulty accessing such care. Patient, family and community engagement will be critical to success in this area and this will require creative thinking and innovative approaches to find ways to reach out and engage with the community and encourage them to build a relationship with a primary care provider. As the largest primary care unit in the Mid East Toronto Health Link, the St. Michael's Family Health Team has the opportunity to define and lead local efforts in population-based primary health care.

GOALS:

a. Roster unattached patients from the priority neighbourhoods of Regent Park, Moss Park, and St. Jamestown with the goal of providing care to an additional 10,000 unattached patients over the next three years.

b. Position St. Michael's Family Health Team as a local leader and provincial exemplar in regionally governed population-based primary health care.

c. Expand primary care service delivery in the community through partnership with community agencies.
Strategy #2: Integrate primary care, specialty care, community-based care and hospital services

The Family Health Team plays a critical role as coordinator of the patient’s overall health care experience. Patients deserve seamless and coordinated care across all transitions in the health system including those between primary care, specialist care, community-based care, and hospital services. Family Health Team health care providers must be able to assist patients in accessing the right health care services from the right provider at the right time; this is the essence of a truly integrated health care system.

St. Michael’s strategic plan clearly articulates the need for the hospital to improve co-ordination and integration of hospital services with primary care, ensuring that Family Health Team patients have seamless access to diagnostic and specialty care services in the hospital. St. Michael’s is committed to improving transitions of care for patients admitted to hospital and to improving access to its hospital-based specialty services. Over the next three years, the hospital aims to create and study innovative ambulatory models of care that integrate hospital-based specialty care with primary care. One example of such a model is a new collaboration between the Department of Surgery and the Department of Family and Community Medicine to operate a Minor Surgical Procedures (MiSP) clinic with the goal of providing timely access to office-based procedures for Family Health Team patients as well as much needed training in procedures for family medicine residents.

Initiatives at the community level with the Toronto Central CCAC and Mid East Toronto Health Link also aim to integrate out-of-hospital care. The Family Health Team community engagement specialist will also work to strengthen relationships with many of our community partners to better serve our patients.

GOALS:

a. Strengthen the Transition to Home program through collaboration with General Internal Medicine to optimize the transition of patients from primary care to hospital and back again.

b. Demonstrate improved access for Family Health Team patients to ambulatory consultations with two or more specialty services at St. Michael’s.

c. In conjunction with the Mid East Toronto Health Link, develop care plans for the most medically and psychiatrically complex patients.

d. Enhance informational continuity at times of transitions in the health care system, including optimizing communication with the emergency department and ensuring medication reconciliation for patients discharged from hospital.
**Strategy #3: Collaborate with St. Michael’s and community partners to advance systems of care for disadvantaged patients including positively impacting the social determinants of health**

The Department has long advocated for the role of primary care in addressing social determinants of health for individuals, families and the communities in which they live. The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

St. Michael’s Family Health Team is engaged in several innovative projects targeted specifically at reducing the negative impacts of the social determinants of health: socio-demographic data collection, Income Security Health Promotion; Health Justice Initiative; Reach Out and Read, Community Engagement, and the Employment and Better Employment through Relationships (EMBER) project. The Family Health Team is committed to developing, implementing, evaluating and disseminating interventions that are aimed at making a positive impact on the social determinants of health.

Achieving health equity for our Family Health Team patients is a priority. We aim to ensure equitable access to care and equitable outcomes for the individuals and communities we serve. This requires the Department to use a population health approach to understand the social and systemic barriers our patient population faces in achieving healthy outcomes and to plan, implement and evaluate our programs with a goal of helping our patients overcome those barriers and achieve equitable health outcomes. This work happens in many parts of the Department, including how staff and physicians interact with patients, how health professional students are trained, how quality improvement is conducted and how research is focused on achieving health equity.

The Department also has a Social Determinants of Health Committee. This Committee is tasked with assisting the Family Health Team, its programs, and its staff to analyze, develop and evaluate initiatives targeted at improving health equity through addressing social determinants. The Committee includes broad representation from all Family Health Team clinical practice sites, including health disciplines, residents, management, and our community.
**GOALS:**

- **a.** Expand current social determinants of health initiatives (Reach out and Read and the Health Justice Initiative) to all six Family Health Team clinical practice sites.

- **b.** Evaluate the effectiveness of social determinants of health initiatives and disseminate research findings through knowledge translation within the Department, the hospital and wider academic community, community stakeholders, the general public, and policy makers.

- **c.** Engage in advocacy focused on reducing the negative impact of the social determinants of health in our community of practice, the City of Toronto, and the province of Ontario.

- **d.** Support the completion of health equity impact assessments and the development of equity-focused evaluation measures for the Family Health Team diabetes, COPD, HIV, addictions, and cancer screening programs.

- **e.** Support the development and evaluation of interventions to improve outcomes for underserviced populations for the Family Health Team diabetes, COPD, HIV, addictions, and cancer screening programs.

- **f.** Educate Family Health Team staff in the use of equity-focused data to evaluate and target programs to the needs of the most vulnerable and marginalized persons in our target population.

- **g.** Support neighbourhood-level social determinants of health interventions that occur within the Family Health
Strategy #4: Engage our patients and community to optimize delivery of primary care services, health professional education, and research

Patient and community engagement has been identified as a priority by both the Ministry of Health and Long-Term Care and Health Quality Ontario. Bringing this focus to our strategic plan will also align the Department with the hospital strategic plan. The opening of the new Sumac Creek Health Centre provides an exciting opportunity for us to further engage patients and the community to optimize delivery of primary care services, health professional education, and research.

The Department has a history of working closely with a number of community provider agencies and organizations to ensure the best and most appropriate care meets the needs of the community. Examples include the partnerships with Toronto Public Health for dental care, Ryerson University for psychology services and Canadian Memorial Chiropractic College for chiropractic services. Patients are aware of the academic and teaching role of the Department and willingly participate in the education of our trainees. Our Health Justice Initiative partnership with specialty and community legal clinics strengthens engagement with our patient population in the community we serve and will assist the development of a robust community engagement strategy that includes collaborative advocacy efforts to enhance policies that benefit underserved and marginalized community members.

Our commitment to patient and community engagement initiatives drives our vision to be more responsive to the needs of our patients, families and the communities they live and thrive in. Over the next three years, the implementation of Department patient and community engagement strategies will strengthen relationships with patient and community stakeholders to advance innovative approaches to address community and population-health needs.

The Steering Committee on Patient Engagement will be tasked with setting priorities for the direction on how patients, families and the community will be actively involved to help us improve primary care services.

GOALS:

a. Develop a robust patient and community engagement strategy that includes the patient and community voice on optimizing primary care service design, delivery and organizational governance of primary care services, health professional education and research.

b. Build and maintain community relationships and partnerships in the Department’s priority neighbourhoods, in particular Regent Park, Moss Park and St Jamestown.

c. Identify and better understand the common barriers to accessing primary care faced by Family Health Team rostered patients and unattached people in the catchment area.

d. Integrate the voice of patients and families in redesigning our patient appointment booking system.
Strategy #5: Optimize team-based primary care: Enabling multiple health professionals to work collaboratively and to full scope and skill to deliver timely, effective and efficient patient care

The Department has a long record of providing exemplary primary care and has demonstrated excellence and leadership in strengthening interprofessional collaborative care models. In 2012, the Department was recognized by the Health Care Innovation Working Group of the Council of the Federation (Canada) as one of four notable and innovative primary care models in the country. Building on this strong foundation, the Department continues to strive for improving interdisciplinary team-based and patient-centred care through purposeful interprofessional planning in providing clinical care services to a growing and diverse urban community, mindfully educating our health professional learners and conducting research on outcomes related to the delivery of team-based care. Providers across the Department’s six clinical practice sites represent a comprehensive mix of disciplines who possess diverse clinical skills and scopes through which patient and community needs are identified and met. Expanding the type of providers within an interprofessional collaborative care approach enables improved access for patients to a wider range of clinical services and more timely access to appropriate care. Continuing to build the Family Health Teams internal referral service and facilitating increased interaction and dialogue amongst these diverse providers will help to support this evolving interprofessional collaborative care model.

The Family Health Team is committed to strengthening its interprofessional collaborative care practices, and expanding initiatives to continue to improve timely access to care, continuity of care, chronic disease management and health promotion. These areas are already key themes in the Quality Improvement Plan prepared and submitted to Health Quality Ontario annually.

GOALS:

a. Adopt evidence-informed models of interprofessional and integrative patient-centred primary care pathways, tailored to the Department’s inner city context.

b. Strengthen interprofessional team processes for achieving effective and efficient collaborative patient management. This includes a review of current meeting structures, educational opportunities, and practice models to incorporate an advanced interprofessional framework.

c. Develop and report on meaningful population outcome measures to demonstrate the contribution of interprofessional collaborative care to clinical outcomes for Family Health Team programs (i.e. Schedule A).

d. Increase standardization of the roles of health professionals across all six clinical practice sites, promoting working to full skill sets and practice scope, while being attentive and responsive to departmental, specific site, community and patient needs.

e. Promote and increase internal intradepartmental and interprofessional consultation amongst Department health care providers within recognized areas of expertise (including clinical, educational and research expertise).
OUR EDUCATION PRIORITIES

The Department has a long track record in the education of medical and health professional learners. At the undergraduate medicine level, the Department participates to a significant degree in pre-clerkship teaching, provides highly regarded clinical experiences for clinical clerks, and is a consistently competitive site for elective experiences. The inner city health clerkship elective is highly sought after by senior medical students from across the country. The Family Medicine Residency Program is desired due to its breadth and depth of training. We have the largest training program within the University of Toronto and are well-known for our inner city and urban focus, diverse patient populations (HIV, addictions, mental health, musculoskeletal care), advocacy, award-winning teaching/administration, resident support and wellness, collegial environment, flexible elective opportunities, and mentorship. Innovative programs such as development of the Minor Surgical Procedures (MiSP) clinic and Balint groups for residents (both collaborations with Surgery, Psychology, and Psychiatry), address the training and wellness needs of residents. We also house Fellows that are developing Enhanced Skills training in areas such as HIV, addictions, developmental disabilities, care of the elderly and adolescent mental health.

The Department is engaged in the teaching and training of health professional students in a broad range of disciplines. The Department has a large and committed group of health professional educators (HPEs), who lead and support interprofessional education programming that achieves consistent successful outcomes for pre-licensure and post-licensure learners. Good integration of HPEs exists in many Departmental education activities.

New developments in education include new pre-clerkship Foundations curriculum (debuting in Fall 2016), the ongoing development of the longitudinal program in undergraduate medical education, expanded opportunities for HPEs’ engagement in education activities and education scholarship, including more research on education models and innovations (e.g., interprofessional education, longitudinal education). Furthermore, there is considerable interest in engaging patients in the teaching and learning process.

GOALS:

a. More formally engage HPEs and increase interprofessional teaching, evaluation and cross-supervision for medical and other health professional learners

• Expand Basics Program to other HPEs; optimize faculty development for engagement of all teaching staff
• Outline specific teaching expectations for all staff
• Facilitate and advocate for faculty appointments or cross appointments for HPEs in the Department

b. Build capacity for teaching a broad spectrum of family medicine experiences

• Launch a Minor Surgical Procedures (MiSP) clinic in partnership with the Department of Surgery
• Develop a robust curriculum for the Family Medicine Maternity Care program
• Recruit on-site specialist shared-care medical staff and fellows to provide regular training to family medicine residents
• Develop a formal educational program for patients regarding topics such as working with and giving feedback to learners
c. Facilitate development of individual resident practices and resident well-being

- Promote development of regular resident practices emphasizing continuity of care
- Ensure that residents are achieving generalist competencies, whilst offering enriched clinical opportunities unique to the Department’s training environment including providing care to marginalized patients
- Enhance resident wellness by incorporating Balint groups for residents

d. Support and nurture education scholarship for both current and new projects

- Develop an inventory of unique and distinct teaching and learning experiences within the department relevant to education scholarship
- Promote faculty development on education scholarship and encourage and support student and resident academic projects
- Invest in supporting education research and ensure infrastructure (e.g., St. Michael’s Research Ethics Board) understands education research/scholarship

OUR RESEARCH PRIORITIES

St. Michael’s Department of Family and Community Medicine has the largest primary care research program among Ontario family medicine teaching sites. The Department is a core teaching site for the University of Toronto and has a strong academic mission, supporting a number of primary care practitioners to do research. The Department supports ten clinician-scientists and scientists, with many additional clinicians actively involved in research. In 2014, the Department as a whole published 112 manuscripts involving 34 staff, gave 329 presentations and received over $3 million in research funding with Departmental staff as primary investigators. The research program has links to a number of internal and external partners including St. Michael’s Centre for Research in Inner City Health (CRICH), Institute for Clinical Evaluative Sciences (ICES), the University of Toronto Department of Family and Community Medicine’s Practice-Based Research Network (UTOPIAN), and TargetKids.

Future opportunities exist in leading research in socially disadvantaged populations, supporting practice-based research with new Electronic Medical Record data and practice profiles from ICES, and building opportunities to engage more clinicians and residents in research. The Department seeks to support a program of research focused on its priorities and those of St. Michael’s Hospital, taking into account the priorities of the University of Toronto Department of Family and Community Medicine.

The aim of the Department is to strengthen St. Michael’s as a centre of excellence for primary care research. We will work to improve dissemination of research, the integration of quality improvement, education scholarship and research, establish new mechanisms to involve patients and community in setting research goals and objectives, and build a robust practice-based research network.
GOALS:

1. Build a Department of Family and Community Medicine practice-based research network (PBRN)

A practice-based research network is a group of primary care clinicians, practitioners and researchers working together to answer community-based health care questions and translate research findings into practice. Our goal is to increase the research done using practice-level data to improve patient care and health outcomes. The goal is to involve all staff in the development of research questions. We will:

- Establish mechanisms to engage staff and community to participate in the PBRN
- Identify the spectrum of topics and research projects that fall within the scope of our PBRN
- Establish a Steering Committee and leadership structure for the PBRN
- Increase collaboration with UTOPIAN to conduct large scale primary care studies

2. Increase patient and community involvement in research

Patient and community involvement in research ensures that research priorities identified by clinicians and researchers are also important and relevant to patients and leads to research that addresses patient needs. Patient engagement in research has become a priority amongst funding bodies and follows the integration of patients across the health care system.

- Work with the hospital, Department and Family Health Team to develop approaches to have patients and community members identify, participate in, and address research within the Department
- Develop community engagement mechanisms to facilitate partnerships with community organizations, as applicable
- Engage with global partners, as applicable

3. Embed research in all Departmental activities

Education, quality improvement and research are complementary aspects of the core business of our department. Our goal is to increase the overlap of these areas and ensure that we integrate research with quality improvement and education.

- Establish mechanisms to incorporate research or evaluation in new Family Health Team or Departmental initiatives, programs or interventions
- Increase connections to research with both quality improvement and education to ensure that our quality improvement and education initiatives and programs are rigorously evaluated
- Continue to encourage and support student and resident academic projects within the Department
4. Enhance infrastructure support for research

The number of clinicians and staff in the Department has grown rapidly. In order to maintain the high level of research productivity within the Department, we need to increase the infrastructure and support for research, especially for clinicians without protected research time.

- Clear communication of the availability of research support in the Department, including roles
- Seek funding sources to increase administrative support, salary support for protected research time including endowed research chairs and infrastructure, including space and other needs

5. Strengthen impact and awareness of research

While the Department is consistently productive, one of the shortcomings we have realized is the lack of awareness of the scope of work going on within the Department. It is important to increase the awareness of research across the Department, which will increase engagement in research.

- Include a research report in medical staff pre-meeting minutes
- Highlight research activities (publications, presentations, grants, etc) in weekly DFCM InfoMemo
- Increase research content on the Department's internal and external websites
- Develop an accessible repository listing current research projects within the Department
- Pursue additional opportunities to profile research and build research capacity within and outside our department including rounds, teachers' meetings, and possibly host a Department of Family and Community Medicine research day
OUR QUALITY IMPROVEMENT PRIORITIES

The Department’s Quality Improvement Program has made significant strides in the last five years. The Quality Steering Committee has grown into a large, active interprofessional committee that meets monthly to establish and monitor improvement priorities for the Department. Smaller interprofessional quality improvement teams at each of our practice sites test changes related to departmental priorities using the a standard model for improvement. Since 2013, we have submitted an annual Quality Improvement Plan to Health Quality Ontario and have recently begun reporting on these priorities to our patients. In 2014, we launched a patient experience survey that we email to patients annually during their birth month. This past year, we hired a Quality Improvement Decision Support Specialist who, together with our EMR Administrator, provides us with practice-level data from a variety of sources to help us measure our progress and patient-level data to assist us in delivering planned proactive care. Finally, we now locally deliver a quality improvement curriculum to our first year residents and supervise a large number of resident quality improvement projects. In 2014-15, approximately 65 staff and 20 residents were involved in quality improvement initiatives in our Department.

The health care landscape is evolving rapidly and will influence our future directions. Currently, the Ministry of Health and Long-Term Care continues to ask family health teams to focus on three areas for improvement: timely access, patient-centredness, and integration. We anticipate increased accountability for indicators related to these priorities and other quality dimensions in the Family Health Team contract that will be reviewed in 2016. The University of Toronto’s Department of Family and Community Medicine has made enhancing patient safety a priority in its new strategic plan.

We envision becoming leaders in quality improvement in primary care in Ontario. We will shift our culture to one where all managers, physicians and staff consider continuous quality improvement to be a part of their day-to-day work. Data on the quality of clinical care will be reviewed regularly at all meetings and data, together with the patient voice, will inform service delivery. We will lead the way in demonstrating meaningful, manageable measurement in primary care practice. We will strive for scholarly dissemination of our quality improvement initiatives so others can learn from our endeavours.

GOALS AND POTENTIAL INITIATIVES:

1. Improve access to primary care when patients are sick and need care, including after-hours
   - Improve patients’ first contact experience, for example, by reducing the amount of time patients spend on hold when calling the clinic
   - Explore the use of information technology to facilitate appointments and deliver care
   - More effectively share the care of patients amongst the team to help ensure patients can be seen by the right provider in the right place at the right time

2. Integrate the voices of patients and their families into our improvement efforts
   - Embed Experience-Based Design principles into our quality improvement work, incorporating the patient voice in a methodologically rigorous manner
   - Engage management and staff in reviewing and responding to patient feedback from the patient experience survey
3. Support patients at important points of transition
   • Understand which patients discharged from hospital would benefit most from timely follow-up and develop a process to optimize follow-up for these patients
   • Ensure that patients discharged from a St. Michael’s medical service to their home are seen by a Family Health Team provider in a timely fashion, if appropriate
   • Develop a process for ensuring that medications are reconciled for patients discharged to their home from General Internal Medicine at St. Michael’s

4. Improve health outcomes through the delivery of evidence-based chronic disease prevention and management
   • Explore the best method of recalling patients overdue for cervical, breast, and colorectal cancer screening
   • Investigate how best to integrate health disciplines in the care of patients with diabetes, particularly those at high-risk to ensure that patients with diabetes receive regular A1C and blood pressure checks
   • Identify the best method for recalling patients with HIV for viral load testing and regular cervical cancer screening

5. Measure and reduce income-related inequities in every quality dimension
   • Analyze all quality improvement measures using a health equity lens
   • Use the Health Equity data to understand characteristics of patients who are not receiving recommended care
   • Develop interventions for reducing inequities in at least one area (e.g. cancer screening)

6. Continue to build a culture of safety
   • Continue to review incidents to ensure that incidents are investigated in an open and honest manner
   • Explore ways to reduce inappropriate prescribing
   • Streamline specialist and test referrals and develop a process to close the loop on urgent referrals
   • Develop processes for following-up on abnormal test results
SUPPORTING OUR PEOPLE AND STRENGTHENING INFRASTRUCTURE

The Department’s excellent work in high-quality clinical care, education and research relies on a committed and engaged provider and staff group, reliable administrative supports, responsive technology, timely communication, effective governance and management and adequate space and facilities.

The strategic planning process identified several needs and opportunities to better support our people and strengthen the infrastructure supports to ensure continued excellence in the Department’s core work.

<table>
<thead>
<tr>
<th>PROPOSED OPPORTUNITIES</th>
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<tbody>
<tr>
<td><strong>Supporting our People</strong></td>
</tr>
<tr>
<td>• Develop mechanisms to address the health, wellness and work-life balance of our providers, staff and learners.</td>
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<tr>
<td>• Encourage and support faculty and staff development</td>
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<tr>
<td>• Encourage and support mechanisms for appointments, promotions, career planning, mentoring</td>
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<tr>
<td>• Ensure adequate administrative assistance in supporting strategic goals and core business</td>
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<tr>
<td>• Address workload issues and staffing disparities (utilization of human resources)</td>
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<tr>
<td><strong>Technology</strong></td>
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<tr>
<td>• Develop policies, procedures, guidance on use of email, messaging, and other technology-enabled communications in patient care processes</td>
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<tr>
<td><strong>Communications</strong></td>
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<tr>
<td>• Strengthen communications across the Department by connecting providers and staff at multiple sites, including the development and use of an internal website</td>
</tr>
<tr>
<td>• Hold provider focus groups regarding optimum communication</td>
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<tr>
<td>• Create website enhancements</td>
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<tr>
<td>• Continue to enhance evolution of our interprofessional team through team-based communication practices which support collaborative care and leadership (case-based team meetings, interprofessional faculty development opportunities, integrated departmental management meetings, etc)</td>
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Governance and Management

- Determine “best practices” of Family Health Team governance models and intersection with the Department and St. Michael’s
- Finalize an organizational structure (Org Diagram) detailing the intersection between the Department and Family Health Team governance and related committees
- Strengthen site-based leadership through a collaborative leadership approach
- Acknowledge and address areas for policy or procedure development

Space and Facilities

- Identify and plan for upgrades to select older facilities
- Work with St. Michael’s Foundation to develop an advancement strategy

MOVING FORWARD – SELECTIVE IMPLEMENTATION PRIORITIES

The Strategic Plan outlines a broad range of goals across five key strategic domains. To ensure that the goals are achieved in a timely manner the Department of Family and Community Medicine Executive Leadership Committee will provide leadership and oversight of the implementation of the Strategic Plan. Working groups will be struck to oversee each strategy and related goals utilizing existing Department committees as much as possible. The Department of Family and Community Medicine Executive Leadership Committee will develop a monitoring and tracking process, as well as confirm the specific measures and indicators, and will regularly report to the Department on progress.

The following priorities have been identified for the first 12 months of this plan and will provide a solid foundation for advancing the remaining goals.

<table>
<thead>
<tr>
<th>PRIORITIES FOR FIRST 12 MONTHS</th>
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<tbody>
<tr>
<td>Strategy 1: Improve the health of the community by providing access to primary care services</td>
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<tr>
<td>- Open Sumac Creek Health Centre to serve patients from the priority neighbourhoods of Regent Park, Moss Park, and St. Jamestown</td>
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<tr>
<td>- Increase awareness of primary care services available at Sumac Creek Health Centre for unattached patients and begin to establish relationships with primary care providers</td>
</tr>
<tr>
<td>- Build relationships with community agencies within the priority neighbourhoods</td>
</tr>
</tbody>
</table>
### Strategy 2: Integrate primary care, specialty care, community-based care and hospital services

- Launch a minor surgical procedures clinic within the Family Health Team to serve patients and educate learners
- Further develop partnerships with hospital departments (Pediatrics/Geriatrics) to provide ambulatory services to Family Health Team patients
- Strengthen relationships with the CCAC by integrating CCAC staff at clinical practice sites
- Establish St. Michael's diagnostic services at Sumac Creek to serve patients both within the Family Health Team and surrounding community

### Strategy 3: Advance systems of care for disadvantaged patients including positively impacting the social determinants of health

- Establish Reach Out & Read at all clinical practice sites
- Expand access to the Health Justice Initiative to three sites
- Utilize experiences from the income security health promotion program to solidify a logic model and structured intake and assessment process for the program
- Expand the income security health promotion program's capacity by instituting a second full time health promoter
- Obtain funding for, and initiate evaluations, of the income security health promoter and health justice projects
- Engage in health advocacy work, including deputations to government on access to decent work relating to pending revisions of the Employment Standards Act
- Disseminate the work of the Social Determinants of Health committee through presentations to Department staff, St. Michael's leadership, the medical community, and policy makers (including at the MOHLTC and the TCLHIN)
| Strategy 4: Engage our patients and community to optimize delivery of primary care services, health professional education, and research | • Establish patient and family engagement working groups  
• Partner with and lead patient and community engagement activities in the Family Health Team catchment area to connect to people in the places and spaces they thrive  
• Think creatively to develop primary care services that reach, engage and serve the needs of our most vulnerable patient and unattached populations, for example youth and seniors  
• Develop non-traditional mechanisms to bring community voice to inform the social determinants of health and population health priorities of the Department |
|---|---|
| Strategy 5: Optimize team-based primary care | • Increase standardization of nursing roles across sites while allowing for flexibility dependent on site needs  
• Identify and implement interprofessional collaborative care outcome reporting (interprofessional competencies as a performance measure, patient reported outcome data)  
• Contribute to the development of an interprofessional, patient-centred diabetes care pathway |
| Our education priorities: | • Optimize faculty development to engage all teaching staff and pursue faculty appointments for HPEs  
• Outline specific teaching expectations for all staff and revise provider job descriptions to include teaching  
• Further develop resident practices, encouraging continuity of care within resident practices  
• Identify educational scholarship opportunities and inventory current unique educational experiences |
### Our research priorities:

- Include research report in medical staff pre-meeting minutes and report research activities in weekly DFCM InfoMemo
- Establish a Steering Committee and governance structure for the PBRN
- Establish mechanisms to engage staff and community in research and the PBRN
- Develop an evaluative framework for new Department or Family Health Team initiatives and programs
- Actively seek a range of funding sources to support administration and infrastructure for research
- Develop a support strategy and funding strategy for PBRN

### Our quality improvement priorities:

- Explore the feasibility of using email for appointment bookings
- Apply Experience Based Design principles to at least one quality improvement initiative
- Analyze Transition To Home data to better understand who is and is not receiving follow-up post-discharge and why
- Develop a standard process for completing medication reconciliation post-discharge
- Develop a process map for the care of patients with diabetes outlining the current and ideal state for involvement of the Diabetes Education Program
- Use health equity data to understand characteristics of those not receiving cancer screening
- Explore the feasibility of restarting “Morbidity and Mortality” rounds
CONCLUDING REMARKS

At this pivotal time for primary care in Ontario, St. Michael’s Department of Family and Community Medicine and its Family Health Team is well-situated to make major contributions to the advancement of excellence in urban primary health care. Our alignment with the strategic plans of St. Michael’s Hospital and the University of Toronto’s Department of Family and Community Medicine will support the Department moving forward with our strategic priorities.

The Department of Family and Community Medicine’s strategic plan has benefitted from input from many members of the Department. We would like to thank everyone for their contributions in creating our three-year strategic plan. A special thank you to Susan Tremblay Consulting for getting us started and Dr. Curtis Handford for his leadership and contributions in helping us complete the process.

It is now time for us to see our VISION IN ACTION.

In three years we will know we have been successful if all of our patients have access to primary care services delivered by teams that integrate seamlessly with the hospital and community care. We will have engaged our patients and community in meaningful ways to help optimize the care we are providing. The lives of our patients will be improved by their interactions with our Family Health Team. At the same time, we will take care of each other to ensure we can all perform our roles to the best of our abilities.

Through the lens of quality, research and education, we will continue to advance scholarship in urban primary care and to have an impact on the future of primary care locally and beyond.

We look forward to working together to pursue our shared vision for our patients.

Dr. Karen Weyman
Chief
Department of Family and Community Medicine

Ms. Laurie Malone
Executive Director
St. Michael’s Hospital Academic Family Health Team
APPENDIX I: ORIGINAL STRATEGIC PLANNING STEERING COMMITTEE MEMBERS

Dr. Lisa Graves, Chief (Past), Department of Family and Community Medicine

Ms. Judy Shearer, Program Director, Inner City Health Program

Ms. Laurie Malone, Executive Director, St. Michael’s Hospital Academic Family Health Team

Dr. Tara Kiran, Chair, Board of Directors, SMHAFHT and Chair, Quality Improvement Committee

Dr. Holly Knowles, Physician Site Lead, SMH Health Centre at 80 Bond

Ms. Jacqueline Chen, Clinical Leader/Manager

Mr. Jason Manayathu, Corporate Planning Manager, Corporate Strategic Planning

Mr. Marino Fenandopulle, Corporate Planning Manager, Corporate Strategic Planning

Ms. Wanda Cooper, Administrative Assistant