Guelph FHT Strategic Plan Alignment	2019/2020 QIP/cQIP Indicator	2019/2020 Change Ideas
	People get the care they need when they need it	
	Follow-up with patients within 7 days of a discharge from hospital.	1. We will test supporting clinics to adopt clinic specific approaches to 7 day post hospital discharge processes by identifying the critical components of a visit: Medication reconciliation, service navigation, and follow-up. 2. We will work collaboratively with GGH clinical teams to simplify the booking process of post hospital visits with primary care teams 3. We will work collaboratively with GGH IT department to make improvements to notifications from acute care to ensure the ability of timely follow-up
	Decreasing the percentage of non-palliative care patients newly dispensed an opioid.	1. We will support clinics with documentation and workflow tools around opioid use and pain management 2. We will test a team based approach for in clinic pain management using PCNC, RPh and other team members. 3. We will develop patient/provider education materials around other options for pain management
	Improving the number of patients with a progressive, life threatening illness who have had their palliative care needs assessed and documented.	1. We will support clinics to have a consistent process for documentation of palliative care needs and assessments in the EMR (i.e. toolbar, problem list etc.) resulting in searchable lists for teams. 2. We will support clinic teams to have a process for capturing advanced care planning wishes.
	**Patients feel good about the care we provide**	
	Improving patient involvement in decisions about care	1. We will initiate our patient and family advisory committee at the Guelph FHT and bring their ideas into the Guelph FHT 2. We will encourage patient centered goal setting across disciplines through standardized prompts in charting tools (i.e. custom forms, toolbars, etc.)
	Ensuring timely access to a primary care provider	1. We will plan and launch a communication campaign about how to access care including regular clinic hours and after hours. 2. We will continue to encourage the use of enabling technologies around access (email, virtual visits, and online booking)
	**We work with our community to build a better health system**	
	Improvements in Heart Failure Care in Guelph (cQIP)	1. We will continue to spread Heart Failure EMR tool and searches for consistent identification, and assessment of HF 2. We will work to identify and pursue the initiation of a Heart Failure hub in Guelph 3. We will continue improvements towards smooth transitions for patients with Heart Failure in Guelph (GGH communication, EMS Remote patient monitoring, WWLHIN Rapid Response Nursing) 4. We will focus on patient and provider education of Heart Failure and fluid assessment
	Improvements in COPD Care in Guelph (cQIP)	1. We will continue the development and spread of COPD EMR tools/enablers for identification and assessment of COPD and support of team based care 2. We will improve patient education at discharge by interdisciplinary team (GGH) and through standardized teaching tools between organizations (i.e. GGH, WWLHIN home care teams, CHC, Paramedic Home Monitoring, SJHCG) 3. We will continue improvements towards smooth transitions for patients with COPD in Guelph (GGH communication, EMS Remote patient monitoring, WWLHIN Rapid Response Nursing, Guelph airways clinic)