Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

4/3/2017

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

The Marathon Family Health Team (MFHT) is committed to continuous quality improvement and the development of annual quality improvement plans (QIP). The MFHT QIP is used to help us achieve aims of improving population health, patient experience, health outcomes while maximizing efficiency and reducing overall costs.

Once completed, the MFHT QIP reflects our priorities for primary health care program and service delivery. Organizational goals and objectives are identified in alignment with our strategic plan. The final QIP document is used as a reference tool throughout the year to help us guide our work.

Certain supports are in place to help us with quality improvement:

1. Patient feedback, communicated to us via patient surveys, email messages and community information sessions, help inform what the MFHT QIP objectives should be for subsequent years. The information given is also used to help MFHT develop their three year strategic plan.

2. Collaboration and shared learning with partner agencies provides us with opportunity to share challenges, lessons learned and best practices. This helps further inform our QIP and strategic plan.

3. Data retrieved from the MFHT electronic medical record, compared to established benchmarks provides us with information to monitor performance. This evaluation helps us identify areas needing further quality improvement.

4. Having long established a culture of quality improvement within our organization, staff are committed to and understand the value of its fundamental purpose.

Of course there are challenges to face as MFHT implements the annual QIP. Program goals become unattainable if human resources are lost during the fiscal term due to: vacancy of positions, other superceding priorities, and lack of available resources that challenge development of collaborative relationships. MFHT has learnt to accept such challenges as part of the process, with the realization that any objective we accomplish is still movement forward on the pathway to quality improvement.

To provide the highest quality service to the communities of Marathon, Biigtigong and Pic Mobert First Nation reserves, the MFHT will continue to incorporate quality improvement in all that it does.

QI Achievements From the Past Year

The achievements over the last year, summarized below, reflect the 5 strategic directions from the MFHT 2014-2017 Strategic Plan.

ADDICTIONS AND CHRONIC PAIN MANAGEMENT: The Marathon Family Health Team (MFHT) social worker and health promoter employees were provided with additional training for non-opioid chronic pain management as follows:

a)In collaboration with the North West Community Care Access Centre, the MFHT social worker and health promoter employees completed training and conducted six weekly group sessions for 14 patients on Chronic Pain Self Management. Information and skills were provided to these patients with ongoing pain management and health issues, in order to assist them in managing their symptoms and hopefully improve their quality of life. This program will be scheduled regularly and held annually in early Spring.
b)In collaboration with the Manitouwadge Family Health Team staff, the MFHT social worker, health promoter and one family physician attended a one-week leader training session on Mindfulness Based Therapy. In March 2017, public information sessions were held and in May of 2017 group sessions for patients on this topic will be implemented. Individual appointments for Mindfulness have also been made available for patients.

In addition to these two programs, the MFHT Health Promoter continued to offer appointments for the HealtheSteps program, SMART goals annd exercise prescriptions to assist patient with chronic pain as well as others wanting to make healthy lifestyle improvements. This program was initially offered on-site at MFHT, but in fiscal 2016-2017 expanded to include an off-site public information sharing session and a monthly patient clinic with Biigtigong First Nation health clinic. MFHT hopes to continue this partnership through fiscal 2017-2018 with Biigtigong First Nation health clinic.

HEALTH PROMOTION: There were significant achievements in a number of areas of Health Promotion over the past year:
a) smoking cessation: The MFHT health promoter became TEACH certified and was able to work in collaboration with the MFHT registered nurse employee to provide appointments to patients for the MFHT STOP smoking cessation counseling program. The smoking status recorded in the measurements section of the patient electronic medical record (EMR) increased significantly this past fiscal year, from 15% to 59% and as a result MFHT will be able to improve on the QI indicator to enroll a higher number of patients for smoking cessation counseling in fiscal 2017-2018. There was an increase in the number of patients accessing smoking cessation from 81 in fiscal 2015/16 to 93 as of Feb 28 of fiscal 2016/17. This is expected to increase further in fiscal 2017/18 with a full year of access to appointments for these sessions via the health promoter in addition to registered nurse staff.
b) Community communication about health promotion: This has continued with information being shared via local newspaper, local radio and the Facebook health promotion page. The community communication was expanded from local communities in order to share health promotion articles, information and initiatives with other Regional Family Health Teams for use in their respective communities. The percentage of patients surveyed in the annual patient survey having seen or heard MFHT health promotion messages has increased from 62% in January 2016 to 77% in January 2017. In addition, visits to the indoor walking program increased from 147 in fiscal 2015/16 to 240 as of Feb 28 of the current fiscal year.
The health promoter continued collaboration/link with the Healthy Kids Community Challenge committee.
The health promoter is organizing a local community health fair for end of April 2017 in collaboration with other local health care agencies.
The health promoter was identified as the MFHT prevention practitioner for the BETTER WISE program to be launched in 2017-2018 if MFHT is identified as an approved site. The BETTER WISE program will focus on engaging patients to become active participants in their health by integrating evidence-based guidelines and

resources into an actionable, comprehensive approach that proactively addresses chronic disease prevention, screening and cancer survivourship - including poverty and lifestyle risks.
c) Pneumovax vaccination: Over the past year there was a focus on increasing pneumovax vaccination rates for patients with COPD or 65 and over. As of December 2016, 52.1% of COPD patients and 48% of patients 65 and older had pneumovax recorded as completded, up from 22% and 39% at baseline respectively.

ACCESS and HUMAN RESOURCES: Operational changes were implemented in this past fiscal year in order for MFHT to optimize use of providers to full scope of practice, and to ensure administrative tasks are aligned with administrative roles and clinical tasks are aligned with clinical roles.
The health promotion employee, in addition to what was discussed above, also provided appointments to patients for MMSE/MoCA exams which helped improve access to both the Registered Nurse and Social Worker employees for appointments and delivery of other services / programs.
The Registered Practical Nurse was trained and qualified by McMaster University in the Clinical Skills in Well Woman Care program, in order to provide well woman and pap appointments for women. This improved access to the Registered Nurse for implementation of other programs and services such as the MFHT community nursing program organized and implemented in collaboration with the Wilson Memorial General Hospital. In addition, MFHT can routinely partner with Biigtigong First Nation medical clinic to provide monthly well woman clinics on-site at their facility (with their permission) to ensure pap screening visits are more accessible and convenient to Biigtigong residents.
Healthcare Assistant staff received Urine Drug Screening training to enhance their skills in order to facilitate the twice-weekly Urine Drug Screen program as part of the Addictions & Chronic Pain program. With these appointments shifted to the Healthcare Assistant employees, the Registered Practical and Registered Nursing staff were able to improve appointment access to patients for primary healthcare services and programs.
In addition, MFHT was successful in recruiting a full-time Nurse Practitioner employee after significant vacancy in the position, providing improved access to same day appointments.

An ACCESS strategy document was prepared, in compliance with MFHT strategic direction, to identify supply and demand issues as well as infrastructure barriers to access.
A policy binder was written and implemented outlining all established appointment booking policies and processes into one easy reference site. All staff were educated regarding these appointment booking policies and procedures and an ongoing process for revision and updating was identified and implemented. Subsequent to this, the plan in fiscal 2017-2018 will be to provide patient education around appointment use as well as their responsibility to prepare for appointments, etc., in an effort to maximize efficiency and decrease no-show appointment statistics.
QI queries were developed for easy monitoring of panel sizes (Q 4 months) and urgent care appointment use (monthly). A literature review was also conducted regarding approaches to panel size management.
There was also an expansion of physician recruitment program to include recruitment and retention strategies for allied health care provider positions.
There was ongoing collaboration with the local hospital for shared resources of nursing staff in order to facilitate the community nursing program together to meet community needs and maintain financial efficiency. MFHT nursing staff are available to provide community nursing services either in-home or on-site at the MFHT clinic, providing access to care for immuno-compromised patients within a controlled environment.

GOVERNANCE: Continuing education for Board members regarding governance and Board roles occurred at monthly Board meetings. MFHT Board meetings were restructured to be strategic rather than operational.
MFHT is working with other local health agencies to develop a shared patient advisory council.

Population Health

Some unique population groups that Marathon Family Health Team (MFHT) serves are:

1. Patients with COPD:
Care for patients with COPD and asthma at MFHT is achieved through shared care of these patients between the physicians, NP and PA and the certified COPD/asthma educator. Using data extracted from the EMR and assistance from the local health unit, the pneumovax status of COPD patients was updated over the past year and recall lists were used to contact and bring in patients due for pneumovax.
Patients with COPD were also identified who had not had a diagnostic spirometry and these patients were contacted and had spirometry testing completed.
2. Patients with Diabetes: MFHT continues to work in close collaboration with the Marathon Diabetes Clinic at Wilson Memorial General Hospital, to share the care of patients with DM. This program is well integrated between the two partners with shared use of the EMR which facilitates communication in care and reduction in duplication of services
3. Patients with Addictions and Chronic Pain: Much energy has been committed to improving care and management of additions and chronic pain. This work has been described in other sections of the QIP.
4. CHF: MFHT continues to work towards identifying measurable CHF initiatives and to develop a process for improved management of CHF, including creation and implementation of a new CHF flowsheet.

Equity

Marathon Family Health Team (MFHT) has worked to incorporate a health equity lens into Quality Improvement Planning mainly through QI initiatives centered on vulnerable population groups such as Asthma & COPD patients, Diabetes patients, Seniors and First Nation residents.

Population Health QI initiatives are focused on routine screening objectives for cervical, colorectal and mammogram procedures, diabetes management objectives such as HbA1c testing and regular eye & foot exams. Identification of diabetics who smoke and subsequent smoking cessation counseling. PneumoVax vaccination for all COPD patients and elderly patients who are obtaining the flu shot annually.

When retrieving data from the EMR to identify patients and population groups at risk, the query is for all patients with identified risk factors and vulnerable patient population groups are part of those queries.

MFHT works in collaboration with neighbouring First Nations communities to provide on-site clinics for Paps, health promotion (HealtheSteps, SMART goals) and participation in Health Fairs.

When accessible, we offer information in other languages, and recently, with the addition of a Syrian Refugee family to our community, we have made available

translation services when family members are attending the clinic for health appointments. These translation services are also available to Francophone residents, although a number of our health care provider staff are fluent in French. We also have health care providers on staff fluent in Spanish.

The MFHT Board is aware of the need to discuss future equity measures in order to determine QI indicators for this category, and will pursue these conversations at Board meetings in the next fiscal year.

Integration and Continuity of Care

Marathon is not part of a Health Link.

Objectives and accomplishments for cross system integration and continuity of care:

1. Primary care appointments are routinely provided for post-discharge care in collaboration with the local hospital - North of Superior Hospital (NOSH). Administrative staff are contacted by NOSH nursing staff prior to inpatient discharge to arrange primary care follow-up for patients with the patients most responsible provider (MRP). A classification of appointments is set aside weekly within the EMR schedule for easy access.

2. Collaborative partnership with Marathon Diabetes Clinic (MDC) at NOSH. The MDC diabetes RN/Educator, MFHT Registered Dietitian and MFHT DM Lead Physician have shared use of the MFHT EMR for DM patient care. Foot care provided by MDC and MFHT RPN staff is added to the chart as well as documentation of all visits to the MDC DM educator and registered dietitian. There is more accurate information regarding DM patients with DM foot exam and ease of communication/collaboration between agencies for DM patient care.

3. Collaborative alliance with local EMS Paramedics via the CHAMPS (Community Health Assistance by Marathon Paramedic Services) program. Patients with chronic diseases (DM, COPD, CHF) are visited in their homes and evaluated by paramedics. The evaluations are then circulated to MRP and Health care providers such as the Registered Dietitian and DM Educators. The MFHT referral form is easily accessed via the MFHT EMR e-form library and completed paper evaluation reports from the paramedics are scanned into the EMR patient chart. In addition, when paramedics visit the patient in their home and have concerns, they have direct access to the MRP in clinic at MFHT and if the MRP is not available, they can connect with the physician assigned to provide consults to other providers in clinic for that day.

4. On-site clinics for well woman and paps are provided by MFHT registered nursing staff at both Biigtigong and Pic Mobert First Nation off-site communities.

5. Participation in 2016 by MFHT Allied Health Provider staff at the annual Biigtigong First Nation Community Health Fair in May 2015. Collaboration and participation will occur again in May 2017, MFHT staff are already registered to present.

6. Collaboration with Marathon Seniors Center and MDC for community blood pressure and blood sugar level screening clinics annually.

7. Continued integration of a Physician Assistant High School program between MFHT and the local Marathon and District High School. The program provides for weekly walk-in/drop-in High School clinic for all students.

8. Continued integration of the MFHT Registered Dietitian with the Northern Ontario Dietetic Internship Program to provide research project/research advisory advice for dietetic interns. This is a collaborative project with the Thunder Bay District Health Unit, Northern Ontario Dietetic Internship Program and the MFHT.

9. Continued collaboration between MFHT Social Worker and St. Joseph's Care Group in Thunder Bay to increase access and improve continuity of psychiatric services through facilitation of scheduling telehealth appointments with a psychiatrist and indirect consultations for MFHT health care professionals working with patients with psychiatric illness.

10. Within MFHT, horizontal integration and continuity has been achieved through processes developed for various programs supporting inter-provider communication, for example:

* use of common EMR for all providers including common flow-sheets for various programs e.g. DM,
  Addictions and Chronic pain, CHF.
* Inter-provider messaging through EMR facilitating communication and referrals within MFHT.
* Flowcharts have been developed outlining program processes so that staff and providers know who does
  what and how.
* Standardized care using EMR templates and consistent data entry for some conditions.

Locally, collaboration is occurring between MFHT and NOSH to provide a shared community nursing program, as the contract for a local nursing service provider ended in April 2016 and the NW CCAC unit was unable to source a new service contract provider. This collaboration has been for the most part quite successful, in that patients are provided with community nursing services for complex wound management, IV and antibiotic therapy, and PICC line flushing for chemotherapy patients during the day at either clinic or at-home appointments. The clinic space offers quicker scheduled access to a nurse provider in a location that is more contained and less public than the emergency department. Chemotherapy patients in particular appreciate being able to access service at the clinic as opposed to the busy emergency department where they are at risk because they are immuno-compromised.

Regionally, MFHT also collaborated with the Thunder Bay District Health Unit, to immunize school age children between the ages of 4 years and 7 years, that were at risk for suspension due to non-immunization. The collaborative clinic offered on-site at MFHT was able to immunize two-thirds of the children at risk for suspension.

11. The Executive Director and Social Worker participated in the Regional Thunder Bay and District Service Collaborative as part of the system improvement through service collaboratives initiative supported by the Centre for Addiction and Mental Health's Provincial System Support Program. This service collaborative initiative is part of the 10-year mental health and addictions strategy committed to transforming the mental health and addiction services for all Ontarians. MFHT staff are part of a group of local service providers who are working together to improve access to and coordination of adult mental health and/or addiction services through the identification of key issues/gaps within the current system. The service collaborative initiative will continue through fiscal 2017-2018.

12. The Executive Director and MFHT Lead physician are part of the local Marathon Seniors Supportive Housing project, in collaboration with other key stakeholders such as NOSH, Town of Marathon and local industry and resident representatives.

Access to the Right Level of Care - Addressing ALC Issues

Marathon Family Health Team (MFHT) has encountered some issues with regard to patient access to the right level of care, when it comes to palliative - end of life care and community nursing care.

In 2016, the communities of Marathon, Biigtigong First Nation and Mobert First Nation reserves lost the community nursing service provider as contracted with the North West Community Care Access Center. In an effort to provide some community nursing services, the MFHT and North of Superior Hospital - Wilson Memorial General (NOSH-WMGH) collaborated to provide a community nursing service program. During the week, between the hours of 8:30 am and 6:00 pm, MFHT nursing staff are able to provide community nursing services either on-site at the Marathon Family Health Team clinic, and at the patient home if the patient resides in the town of Marathon. During evenings and weekends, the North of Superior Hospital - Wilson Memorial General nursing staff are able to provide community nursing services on-site at the hospital.

This collaboration works very well between the two agencies, but it is not a 100% guaranteed service provision. The program is not able to work for those patients who need continuous home nursing care services during the evening and on weekends or statutory holidays. Therefore, if a patient is in hospital, and can be discharged home because they no longer need tertiary care treatment, they are often not discharged home because CCAC supports are not available. In addition, if the patient is palliative and/or end-of-life stage and their wish is to die at home, their wish cannot be supported because again, CCAC supports are not available.

Sometimes palliative patients can have a dramatic change in their functional status over a period of a few days and CCAC supports need to be put in place quickly in order to keep the patient in their home, as might be their wish for end of life treatment. Without an identified CCAC service provider for Marathon, Biigtigong and Mobert First Nation reserves, these community nursing care services and home care supports are just not available.

MFHT has endeavored, along with NOSH - WMGH to obtain the NW CCAC service provider contract and with it the assigned financial resources, in order for both facilities to hire the appropriate level of nursing staff to address this service gap. The service provider contract as written is not feasible for MFHT use and attempts to arrange a differently worded contract or arrange for a MOU agreement have been unsuccessful to-date, however, both MFHT and NOSH-WMGH remain committed to resolving the issue in fiscal 2017-2018.

Unfortunately, in the interim, residents of all three communities are affected by this huge gap in service and hospital beds continue to be occupied instead.

Engagement of Clinicians, Leadership & Staff

The QIP process is largely generated through the QI committee with the epidemiologist playing a key role. Input for the QI plan is received from clinicians, providers and leadership through a variety of ways as follows:

- Quality Improvement Plan – prepared annually by ED and Epidemiologist, and due to Ontario Health Quality Council (OHQC) on April 1st each year.
- QI indicators aligned with strategic directions. Allied health providers also develop QI indicators specific to the health programs they are providing.
- At the beginning of each fiscal year – April 1st – the QI Plan summary is routed to all staff and posted in prominent areas of the clinic for patient review.
- Students are hired in May of each fiscal year, to complete QI tasks related to updating the OSCAR EMR. The Epidemiologist meets with each student in May to provide training with regard to information retrieval process and data input. The ED manages the scheduling of the students to allow for sufficient time to complete QIP targets/objectives.
- At committee meetings during the 1st quarter of each fiscal year (April, May and June), allied health providers are advised of specific indicators/targets that relate to their individual programs and services, and the Epidemiologist reviews individually with each allied health professional the plan to accomplishing set targets.
- At the end of each quarter – (July-Q1, Oct-Q2, Jan-Q3 and April-Q4), the ED and Epidemiologist prepare the statistical analysis and run charts associated with each QI target to determine the % of completion, and report the data back to the MOHLTC as part of the Ministry reporting requirements.
- At the end of each quarter, allied health providers and physicians are advised of the status and current statistics related to their specific set indicators/targets. If necessary, a strategy to improve on statistical percentage is discussed, between the Epidemiologist and all the allied health providers and physicians at individual meetings arranged by the Epidemiologist.
- Bi-annually (Oct and Feb), the ED and Epidemiologist prepare a six-month statistical analysis and run charts associated with each QI target to determine the % of completion, and report the data back to the MFHT Board.
- During the bi-annual report back, the Epidemiologist will indicate if a target indicator will not be met, and will make recommendations as to next steps for the Board to consider, e.g. delete indicator, mark as incomplete with rationale stated, step-up efforts to improve outcomes, etc.
- In November of each fiscal year, the Epidemiologist and ED start to develop the next fiscal year QI Plan. A progress report is developed for current fiscal year targets by the Epidemiologist. The ED begins the next fiscal year QI narrative. The ED and Epidemiologist meet to discuss the next fiscal year targets/initiatives in order to create the QI Workplan.
- In February of each fiscal year, the ED and Epidemiologist meet to review the next fiscal year QI Plan in development and routes a copy to all Board Directors for input. Board members are invited at the February Board meeting to present their recommendations for edit of the document.
- In March of each fiscal year, by mid-month, the ED and Epidemiologist prepare the final draft of the QI Plan, incorporate any suggestions from Board Directors and forward a copy of the Final draft for Board approval to the Lead Physician.
- On or before April 1st of each fiscal year, the QIP is submitted to HQC of Ontario. A copy of the QIP is also sent to the LHIN, the MOHLTC and AFHTO.

The challenge for development of the QIP annually is identifying and setting realistic goals for change that can be accomplished during a fiscal year; there are many ideas for change and a limited amount of time and human resources that can be devoted to moving forward with these change ideas while maintaining regular clinical duties and access.
This challenge can also be exacerbated by issues MFHT faces with regard to recruitment and retention of health care providers. For some health care

positions, it has been difficult to recruit for the role, i.e. Nurse Practitioner (+4 years prior to hire in 2016) and Registered Dietitian (only part-time employee for +10 years), while for other positions retention has been the challenge, i.e. Registered Nurse and Social Worker positions. As healthcare provider positions remain vacant, the ability to provide continuity of established programs and healthcare services becomes an issue and in some instances the program itself is cancelled completely.

Overall the QIP development and reporting has proved to be very valuable to MFHT in providing a structure for outlining where we are going, how we will get there and how we have progressed to-date.

Other methods for engaging leadership, clinicians and staff are:

1. Bi-monthly team meetings with all providers and staff.
2. Monthly Board of Directors meetings.
2. Communicating results of annual patient surveys to all providers and staff for awareness of MFHT strengths and areas for improvement. Facilitation of discussion to help address areas for improvement.
3. Posting of QI target and initiative summaries for each fiscal year at all staff workstations and key clinic locations such as exam and patient waiting rooms.
4. Updates to all providers and staff about QI targets and initiatives during fiscal year at bi-monthly provider and staff meetings for awareness of progress to-date.
5. Review of other local health care agencies strategic plans such as North of Superior Hospital and the NW LHIN as well as the Town of Marathon strategic plan to help align the MFHT strategic plan to their identified strategic directions.
6. Review and discussion with the MFHT Board and staff of MOHLTC reports such as the Price Report, Patients First Act, Northwest LHIN Health Services Blueprint and the Rural Health Hubs Framework for Ontario report to align MFHT strategic directions with Provincial initiatives around primary health care.

Resident, Patient, Client Engagement

Over the past fiscal year patient engagement has been achieved in a number of ways as follows:

* Community information sessions or focus groups for Marathon, Biigtigong First Nation and Mobert First Nation with regard to soliciting feedback on the Addictions & Chronic Pain program, indoor walking program, 10,000 steps community challenge and Mindfulness Based Therapy program.

* Experience-based review session of the Addictions & Chronic Pain program with collaborative partner North of Superior Hospital staff, for improvement of the administration of this program as a result of patient and staff feedback.

* Annual general patient survey, conducted in January 2017, final report February 2017. The survey contains items related to the MFHT strategic directions of Addiction & Chronic Pain Management, Health Promotion, Access, Governance and Human Resource management.

* Other patient surveys generated throughout the fiscal year have been administered to acquire feedback about new patient programs and/or services as well as health promotion topics and informative health messages on the waiting room TV.

* The MFHT Lead Physician began the process in fiscal 2016-2017 to develop and implement a joint local patient and family advisory committee with the North of Superior Hospital. A final decision should be made in fiscal 2017-2018 as to how this advisory committee will function and a subsequent assessment will then be made to determine if this is the right direction to implement for engaging meaningful input from patients in order to improve the quality of our local health care programs and services.

* Patients utilize the MFHT website to provide ongoing feedback and recommendations under the contact us section and by writing comments and suggestions on paper and placing those in our waiting room comment box.

* Implementation of patient self-management programs such as; Mindfulness Based Therapy and Chronic Pain Self Management. Employee training and educational courses re patient self-management programs - Motivational Interviewing, Mindfulness, and Chronic Pain Self Management.

Patient engagement has influenced development of the MFHT quality improvement plan in terms of providing us with the information necessary to help us outline strategic directions and to inform us as to how well we are doing and where we need to focus in order to facilitate improvement. With patient feedback, we are able to view system patterns in the health care programs and services we provide through a local primary health care lens. This enables us to be more responsive to our community health needs at the local level, as well as improve efficiency and access to care.

Staff Safety & Workplace Violence

The Marathon Family Health Team (MFHT) is committed to providing and maintaining a working environment that is based on respect for the dignity and rights of everyone in the organization. It is the goal of MFHT to provide a healthy and safe work environment that is free of any form of harassment or violence.

The MFHT Respect in the Workplace Policy was approved in 2010, and all staff receive annual training with regard to the policy. New staff discuss this policy with the HR supervisor during their orientation. All staff are required to sign off on the policy annually, indicating they understand their responsibility to address concerns about and to not condone, workplace harassment/violence.

MFHT has a formal and in-formal procedure for resolving and investigating workplace violence and harassment complaints, that includes investigative procedures and corrective action measures. Within the policy, there is a protection from retaliation clause as well as a promise to keep all complaints confidential to the extent MFHT is able to do so.

MFHT also has a Professional Code of Conduct Policy for all staff, and it is the responsibility of all staff to sign off on the policy annually indicating they understand their responsibility to conduct themselves in accordance with the policy.

MFHT posts a Workplace Harassment Policy statement and Workplace Violence Policy statement in every examination room, in the patient waiting room, and at the Front reception workstation, so staff and visitors to the facility will conduct and behave themselves accordingly.

Contact Information

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Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair
Quality Committee Chair or delegate
Executive Director / Administrative Lead
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)