May 11, 2021

Attendees: Dominic Noel & Lyndsay Suurna

## 1. Find new paths in health promotion and disease prevention.

-By 2020, devising tools to measure improvement in patient's health literacy and quality of life after attendance to one of the programs- *Pain management group was established- other groups were put on hold due to the pandemic (currently having virtual meetings)* 

By 2021, enable self-scheduling and promote it to have at least 30% utilization by patients-New EMR has possibility for self-scheduling – consideration cost analysis by end of 2022complete feasibility assessment of self-schedule

By 2020, implement a walking program- on hold due to COVID

## 2. Increase accessibility through innovation.

By the end of 2019, transition to a new EMR- fall of 2019

By 2020, create a task force to assess feasibility of home visits- Complete feasibility assessment of home visits by 2022

By the end of 2019, offer in house phlebotomy services for our patients- *Phlebotomy-review post pandemic for end of 2022 review with life labs* 

Ensure completion of physical space expansion to provide comprehensive care by 2021

- Expansion of space by end of 2023

## 3. Foster growth and development

Find 2 opportunities to expand interdisciplinary team to broaden our services by 2020 By 2020, explore 1 annual opportunity to partner in programs/initiatives in the community to expand services – have made connection on hold with COVID - Creation of program with interdisciplinary effort- arthritis society collaboration

By 2021, continue to build patient roster to about 2600 - Actively take part in the discussions on the implementation of the upcoming health care structure changes in Sault Ste. Marie - Latest patients stats March 2022 to achieve 2600 currently approx. 2100

Measure corporate patient complexity- Patient complexity- new study primary care reform study to start in end of spring collaborating using alliance

By 2021, organize quarterly team development activities – *on hold due to COVID* By 2020, use our website as an effective, up to date educational communication tool- New Website development goal end of June 2021 to be live

## 4. Provide quality comprehensive primary care

By 2021, devise QIP indicators that will inform us on our ability to improve health and quality of life--health indicators tracking

By 2020, all NPs will have hospital privileges- All NP have current have Hospital privileges expect one on maternity leave

By 2019, participate in a community QIP indicator - Participation ongoing at OHT level- *Quality* improvement call- main work is transition between hospitals and Primary Care QIP indicators- focusing on preventative measures- tobacco cessation counselling

Recommended to duration extend current Strategic Plan to 2023 as goals are important with updates

Would recommend another facilitator former Nurse works with NPLC – Gisele Guenard with VisonarEase from Sudbury