Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of new patients/clients/enrolments	O	Number / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	10.00	10.00	Our FHT is currently not accepting new patients (but we will accept new babies and family members). We already are over our target population set by the MOH (on our quarterly FHT reports that are submitted).	

Change Ideas

Change Idea #1 continue with change idea -Track new roster patient numbers and derostered numbers.

Methods	Process measures	Target for process measure	Comments
Researcher to calculate monthly via capitation reports.	Number of newly rostered patients minus derostered patients done monthly for all physicians in our FHT.	100% of time the difference will be zero or positive.	Our numbers fluctuate due to a large number of rostered patients in LTC. Deaths are frequent, especially at specific times of the year. (Winter/ flu season/covid)

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring	O	% / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	82.00	82.00	we would like to maintain our current HbA1c stat for next year which according to Primary Care Practice Reports nov 2024 (data to Mar 2024) - this is in the 75th percentile of all FHT's who have signed up to use Primary Care Reports. The LHIN average was 55.7% and Ontario average was 52.6%. We would like to maintain our numbers.	

Change Ideas

Change Idea #1 Searches quarterly

Methods	Process measures	Target for process measure	Comments
Researcher will do a quarterly search for patients who should have their HbA1c done twice in the last 12 months. This list will be given to providers to look over.	observe % of diabetics who have their HbA1c adequately checked.	maintain % and if drops more than 1 %, Lead will be notified. Board will be presented with stats.	

Change Idea #2 Reminder report

Methods	Process measures	Target for process measure	Comments
A reminder report has been created in EMR so providers are aware when looking at patient's chart.	A reminder report will be done biannually and presented to the LEAD.	100% of all patients included in reminder report will be highlighted and given to provider to follow up on biannually.	

Measure - Dimension: Timely

Indicator #13	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Patient/client perception of timely access to care: percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	87.00	100.00	The target corridor set by the Alliance for Healthier Communities is between 85% and 100%. We are committed to providing our patients with access 100% of the time. Most of our practitioners utilize a form of advanced access booking, which involves leaving a portion of appointments open for same-day bookings. This approach allows providers to accommodate patients as needed. Additionally, our office has a designated overflow doctor or nurse practitioner (NP) who provides same-day visits, as well as an "illness clinic" dedicated to symptomatic or infectious patients, which is also booked on the same day. To further improve our access percentage, we will review vacation scheduling and overflow demands over the coming year.	

Change Ideas

Change Idea #1 We will attempt to gather 300 surveys per quarter this fiscal year. This will improve the accuracy of this metric.

Methods	Process measures	Target for process measure	Comments
Researcher will send out surveys to each patient who has had an in- person visit through our ocean portal.	Number of surveys answered will be calculated quarterly and reported to Lead.	300 surveys per quarter	

Measure - Dimension: Timely

Indicator #14	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen-eligible people who are up to date with colorectal tests	O	% / PC organization population eligible for screening	EMR/Chart Review / Most recent information available	80.10	80.10	Our target reached [80.1%] is in the top 25th percentile of all FHT's. Our 80.1 % screened eligible patients is higher than LHIN [64.6%] and the Provincial average [60.9%] on PCP reports as of March 2024 data (Nov 2024 report). But we strive always to do better and increase screening percentages for better prevention of disease.	

Change Ideas

Change Idea #1	Continue with current change idea-1) Increase the percentage of patients, who are up to date with colorectal screening when in the office for other reasons. 2)Increase the percentage of patients, who are up to date with colorectal cancer screening by calling to inform. 3)Increase the percentage of patients who are up to date with colorectal cancer screening through the SAR report.

Methods	Process measures	Target for process measure	Comments
1)Utilizing reminders in EMR to keep ontop of screening required by physicians. 2)Utilizing EMR chart review to assess which patients are due for colorectal cancer screening. 3)Access Cancer Care Ontario Screening Activity Reports (SARs). The SAR report will give us a listof patients due for a screening or needing follow-up with their screening. Providers will be given a list biannually to ensure they are aware of patients who are due for screening.	1)The Research Assistant will continue to call and follow up with patients to encourage them to follow up on their colon cancer screening. 2) Physicians will remind patients during office visits ifthey have a reminder in their EMR that they are not up to date for colon cancerscreening 3) Reminding staff to check reminders in their EMR and keep updated. 4)Percentage of patients up to date with colorectal cancer screening will be compared to our EMR searches to ensure all patients are being accounted for. Maintain the percentage of patients up to date with screening (80.1%) by March 31, 2026. We will be making calls in follow-up to the letter mailed out by CCO/MOHLTC.	Maintain or improve the percentage of patients up to date with screening to over 80% by March 31, 2026. (80.1%)	

Measure - Dimension: Timely

Indicator #15	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen-eligible people who are up to date with cervical screening	O	% / PC organization population eligible for screening	EMR/Chart Review / Most recent information available	74.70	78.00	We are in the top 25th percentile of all FHT's per Primary Care Reports Nov 2024 (data to March 2024) at 74.7%. Our EMR search as of Mar1/25 is more accurate and an up-to-date representation since it takes into account patients who have never been sexually active and therefore do not require screening. We feel this is an achievable and sustainable average and will strive to increase to 78%. With the new changes to cervical screening, we feel there will be a period of adjustment and are hopeful that our percentage can be maintained or slightly improve.	

Change Ideas

Change Idea #1	continue with change ideas- Increase the percentage of patients who are up to date with cervical cancer screening by calling to inform them. 2)Increase the percentage of patients, who are up to date with cervical cancer screening when in office for other reasons. 3)Increase the percentage of patients who are up to date with cervical cancer screening through the SAR report. 4)The research assistant will continue to call and follow up with patients to encourage them to follow up on their cervical cancer screening. 5) Physicians will remind patients during office visits if they have a reminder in their EMR that they are not up to date for cervical cancer screening.

Methods	Process measures	Target for process measure	Comments
The researcher will scan the CCO SAR reports monthly to see who is coming due/overdue for screening. The researcher will look at the percentages of eligible patients screened and evaluate them quarterly. This will be given to each provider semi-annually as a reminder.	The percentages of patients screened will be compared to the previous quarter to see if improves	Increase the percentage of patients up to date with screening to our goal of 78% by March 31, 2026. Since we are in the top 25th percentile, we feel we should attempt to maintain our target.	

Measure - Dimension: Timely

Indicator #16	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen-eligible people who are up to date with breast screening	O	% / PC organization population eligible for screening	EMR/Chart Review / Most recent information available	76.40	76.40	Our stats reflect that we are already in the top 25th percentile of all FHT's and therefore we are going to strive to maintain our target.We have set a target of 76.4. We are using data from Primary Care Practice reports (Report will be issued Nov 2025)to report our performance, but we also compare these numbers with the current up-to-date records in our EMR. Our EMR numbers are more accurate but we feel we should use PCP report numbers as a guide. Last year, Nov 2024 report, our target reached [76.4] is already higher than LHIN [59.1%]and Provincial average [58%] on PCP reports as of March 2024 data. But we strive always to do better and increase screening percentages for better prevention of disease. Our EMR data suggests screening rate of 83 % in eligible patients for fiscal year Apr 1/24- March 1/25.	

Change Ideas

Change Idea #1 cont as last QIP-#1 Use CCO SAR, reminders and Target reports reviewing eligible patients who have not been screened.

Methods	Process measures	Target for process measure	Comments
1)Research assistant generates lists of patients due for mammogram screening and calls to inform: If agreeable, schedule an appointment with our local OBSP. 2) Reminding staff to check reminders in EMR and keep updated. 3) Using CCO SAR reports the percentage of patients up to date with mammogram screening will be compared to our EMR searches to ensure all patients are being accounted for. These measures are working to increase screening in these eligible women. Target for process measure percentage of patients up to date with screening goal is to maintain 76.4%% by March 31, 2025, on Primary Care Practice Reports (a year behind on PCPR)	The percentage of patients screened compared to the previous year will be examined monthly by Research Assistant.	We will see maintenance of the percentage screened in the PCP report percentage of this population screened at 76.4% percent by Mar 2026.	We feel maintaining our numbers at 76.4% is an appropriate goal.

Equity

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Completion of sociodemographic data collection	O	% / Patients	EMR/Chart Review / Most recent consecutive 12-month period	20.40	25.00	Currently, 1/5 of our patients have completed the Equity questionnaire. We feel 1/4 is a good target for us. In our FHT according to Primary Care Report Nov 2024 (data to Mar 2024), we have 7.4 % of our patients in the first Quintile (low income) as compared to 18.5% first Quintile (low income) in all LHIN's in Ontario.	

Change Ideas

Change Idea #1 1)Increase the number of surveys sent out to patients. 2)Educate Staff re survey importance and post information re survey in rooms.

Methods	Process measures	Target for process measure	Comments
1) Researcher will send survey to all patients who have had an appointment at the office. 2)Researcher will make and post information poster re survey in all rooms.	1) Reserchер will calculate quarterly percentage of returned surveys and inform providers if not reaching target	1) 25 % of surveys should be answered by patients 2)100% of rooms will have posters hung by April 1, 2025 and remain until Mar 31, 2026.	We are emailing our patients this survey. Some patients feel confused by the survey or can't navigate the Ocean email to retrieve and answer the questions. Also, referral emails were being ignored by some patients thinking it was the survey sent to them again. (Providers asked to pause surveys for a while last year to investigate). We will continue to keep an eye out for this and educate patients via the posters and provider education.

Measure - Dimension: Equitable

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	95.24	100.00	At BMCFHT, we are committed to building an inclusive workplace that reduces unconscious bias and promotes understanding within our team. We track staff participation in equity, diversity, and inclusion (EDI) training to improve workplace relations, reduce discrimination, and enhance collaboration. Our staff engage in training through videos and learning about proper pronouns, while our physicians complete mandatory training through Hamilton Health Sciences. Investing in comprehensive EDI education fosters a respectful, innovative, and equitable workplace.	

Change Ideas

Change Idea #1 Staff will receive continuous training in equity, diversity, inclusion, and anti-racism throughout the year.

Methods	Process measures	Target for process measure	Comments
All new staff will undergo mandatory equity, diversity, inclusion, and anti-racism training as part of their onboarding process.	Target measures will be reviewed prior to the annual staff meeting. If any measure is below 100%, either the Executive Director or Lead will be notified to ensure we maintain our goals.	BMCFHT will use a target of 100%	

Experience

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Do patients/clients feel comfortable and welcome at their primary care office?	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	97.80	100.00	We are close to our goal of 100%. We will continue to make patients feel comfortable and welcome	

Change Ideas

Change Idea #1 We will attempt to collect 300 surveys quarterly. This will allow us to collect data from 1200 patients during the year.

Methods	Process measures	Target for process measure	Comments
Researcher will send our surveys to all patients who have had an in person appointment and has an email address. Each patient will only get one survey per year.	Number of surveys collected will be calculated quarterly. If quota of 300 not met, LEAD will be notified.	1200 surveys will be collected during Fiscal year	

Safety

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of faxes sent per 1,000 rostered patients	O	Number of faxes / PC patients/clients	Other / Most recent quarter of data available (consecutive 3-month period)	CB	CB	Our goal is to investigate how many faxes per 1000 rostered patients we have this year and try to decrease the amount by the next QIP beginning April 1, 2026. We fax through SR Fax and another fax machine in house (which we will collect data on). Current baseline data (For months Dec 2024, Jan 2025, and Feb 2025) = 11172.	

Change Ideas

Change Idea #1 collect numbers of faxes sent per rostered patients

Methods	Process measures	Target for process measure	Comments
Take tally of outgoing faxes quarterly from SR Fax and fax machine in house.	Number of faxes from machine counter and SR Fax invoice done quarterly by research assistant.	Our target will be to collect data for number of faxes sent by our office.	Researcher will collect data quarterly and present to Lead.

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
eReferral: Percentage of clinicians within the primary care practice utilizing this provincial digital solution	O	% / Staff	Local data collection / Most recent information available	100.00	100.00	100% (11/11) of our clinicians use e-referral.	

Change Ideas

Change Idea #1 All practitioners are already using eReferral, and we will continue to encourage its use over the next year

Methods	Process measures	Target for process measure	Comments
Primary care practice will continue to utilizing this provincial digital solution	Target measures will be reviewed annually	BMCFHT will continue to use a target of 100%	

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
eConsult: Percentage of clinicians within the primary care practice utilizing this provincial digital solution	O	% / Staff	Local data collection / Most recent information available	100.00	100.00	100 % (11/11) of our clinicians use eConsult.	

Change Ideas

Change Idea #1 All practitioners are already using eConsult, and we will continue to encourage its use over the next year

Methods	Process measures	Target for process measure	Comments
primary care practice will continue utilizing this provincial digital solution	Target measures will be reviewed annually	BMCFHT will continue to use a target of 100%	

Measure - Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
OLIS: Percentage of clinicians within the primary care practice utilizing this provincial digital solution	O	% / Staff	Local data collection / Most recent information available	100.00	100.00	100% (11/11) of our clinicians use OLIS.	

Change Ideas

Change Idea #1 All practitioners are already using OLIS, and we will continue to encourage its use over the next year

Methods	Process measures	Target for process measure	Comments
Primary care practice will continue to utilizing this provincial digital solution	Target measures will be reviewed annually	BMCFHT will continue to use a target of 100%	

Measure - Dimension: Safe

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
HRM: Percentage of clinicians within the primary care practice utilizing this provincial digital solution	O	% / Staff	Local data collection / Most recent information available	100.00	100.00	100% (11/11) of our clinicians use HRM.	

Change Ideas

Change Idea #1 All practitioners are already using HRM, and we will continue to encourage its use over the next year.

Methods	Process measures	Target for process measure	Comments
Primary care practice will continue to utilizing this provincial digital solution	Target measures will be reviewed annually	BMCFHT will continue to use a target of 100%	

Measure - Dimension: Safe

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Electronic Prescribing: Percentage of clinicians within the primary care practice utilizing this provincial digital solution	O	% / Staff	Local data collection / Most recent information available	100.00	100.00	100% (11/11) of our clinician use e-prescribe.	

Change Ideas

Change Idea #1 All practitioners are already using ePrescribing, and we will continue to encourage its use over the next year.

Methods	Process measures	Target for process measure	Comments
Primary care practice will continue to utilizing this provincial digital solution	Target measures will be reviewed annually	BMCFHT will continue to use a target of 100%	

Measure - Dimension: Safe

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Online Appointment Booking: Percentage of clinicians within the primary care practice utilizing this provincial digital solution	O	% / Staff	Local data collection / Most recent information available	90.90	90.90	90.9% (10/11) of our clinicians use on-line appointment booking. Our nurse practitioner is mostly used for acute, walk-in and over-flow appointments and we feel on-line booking is not necessary.	

Change Ideas

Change Idea #1 All practitioners are already using Online Appointment Booking, and we will continue to encourage its use over the next year

Methods	Process measures	Target for process measure	Comments
Our clinicians will continue to utilize the EMR on-line appointment digital platform	Target measures will be reviewed annually	BMCFHT will continue with a target of 90.9% (10/11) of our clinicians utilizing the online appointment booking digital platform	Our nurse practitioner primarily handles acute, walk-in, and overflow appointments, and we believe that online booking is not necessary.