

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	P	Number / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	0.00	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 decreased slightly last fiscal year due to one of our physicians preparing to retire. Numbers will be reported to the lead quarterly to report to the Board and Providers.

Change Idea #2 Providers will be given list of patients presently not rostered to ensure these patients get registered if appropriate.

Methods	Process measures	Target for process measure	Comments
Researcher to give lists to Physicians.	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 FHT has a number of patients who are not rostered but continue to have our physician as their main provider.

Change Idea #3 Researcher will go through present day roster lists of all physicians and ensure accuracy in computer.

Methods	Process measures	Target for process measure	Comments
Researcher will go through roster capitation lists of all providers and compare to EMR for accuracy. FHN/FHO forms will be mailed to patients for whom we assumed were rostered but were missed.	Number of discrepancies will be noted and FHN/FHO forms will be followed up to ensure they are completed	100 % of roster lists will be checked and completed during this fiscal year	We have not done a complete and thorough check of roster lists in a couple of years so this will be very effective.

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 or our current HbA1c stat for next year which according to Primary Care Practice Reports Nov 2025 (data to Mar 31, 2025) - this is 75%. The LHIN average was 57.5% and Ontario average was 54.1%. Our FHT is much higher. We would like to maintain our numbers.	

Change Ideas**Change Idea #1 Biannual searches and reminder report**

Methods	Process measures	Target for process measure	Comments
Researcher will do a biannual 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. A reminder report has been created in EMR and will remain so providers are aware when looking at patient's chart.	A reminder report will be done biannually and presented to the LEAD as well a quarterly search will be done by the researcher to ensure we are maintaining our percentage.	100% of all patients included in reminder report will be highlighted and given to provider to follow up on biannually. Maintain % and if drops more than 1 %, Lead will be notified. Board will be presented with stats.	Our physicians are doing well with this important metric so we will continue to analyze and attempt to maintain or improve our numbers.

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	P	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	83.60	100.00	The target 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. Our office does random calculations for access as well third next available appointments are calculated weekly and numbers are given to the Lead Physician to review quarterly.	

Change Ideas

Change Idea #1 Our FHT will collect 1200 surveys again this year in attempts to increase the validity of the data.

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 quarte	

Change Idea #2 Collection of data for same day next day appointments at front desk on random days.

Methods	Process measures	Target for process measure	Comments
Front desk staff will be given sheets to tabulate same day/next day/ no appt can be offered on three random days/per month.	Percentage of appointments given same day/next day vs no appointment available will be calculated	95% of patients who call should be able to get a same day/next day appointment.	Our front desk supervisor will roll a dice and will do these data collections on 3 random days per month.

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 ELIGIBLE PATIENTS 50-74, DATA WILL BE COLLECTED EMR CHART REVIEW 2026/27	EMR/Chart Review / Q2 2025 (covering 2 years of participation for FIT and 10 years of participation for flexible sigmoidoscopy or colonoscopy up to September 2025)	79.40	80.00	Our EMR data suggests higher rates but we continue to use Primary Care Reports to maintain consistent reporting. Although we didn't reach our target for 25/26 [80.1%] we were only less than 1% less. Our current 79.4 % screened eligible patients is higher than LHIN [63.9%] and the Provincial average [60.5%] on PCP reports as of March 2025 data (Nov 2025 report). But we strive always to do better and increase screening percentages for better prevention of disease.	

Change Ideas

Change Idea #1 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 on top 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 list of 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 if they have a reminder in their EMR that they are not up to date for colon cancer screening. 3) Remind 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%) by March 31, 2027. 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, 2027. (80%)	

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 ELIGIBLE PATIENTS 25-69, DATA WILL BE COLLECTED EMR CHART REVIEW 2026/27	EMR/Chart Review / Q2 2025 (covering 42 months of participation for cytology (Pap) testing, and 66 months of participation for HPV testing up to September 2025)	71.30	75.00	Primary Care Reports Nov 2025 (data to March 2025) at 71.3% for patients 21-69. Our EMR search as of Mar1/26 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 75%. With the changes that were made to cervical screening recently, we feel there was a period of adjustment. We are hopeful that our percentage can be maintained or slightly improve. Our EMR search for 25-69 eligible patients screened as of Feb 23/26 is 84.9%.	

Change Ideas

Change Idea #1 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 75% by March 31, 2027 (PCP Report data). Our EMR SEARCH as of Feb 23/26 is 84.9%. We want to maintain this %.	

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 ELIGIBLE PATIENTS 50-74, DATA WILL BE COLLECTED EMR CHART REVIEW 2026/27	EMR/Chart Review / Q2 2025 (covering 2 years of participation for mammography up to September 2025)	76.40	76.40	Our stats reflect that we are significantly better than FHT's in our LHIN and Province 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 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 2025 report (for data to Mar 31/25), our target reached [76.4] is higher than LHIN [59.6%] and Provincial average [58.8%] on PCP reports as of March 2025 data. But we strive always to do better and increase screening percentages for better prevention of disease. Our EMR data suggests screening rate of 82.1 % in eligible patients for fiscal year Apr 1/25- March 1/26.	

Change Ideas

Change Idea #1 Continue as last QIP. 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) Remind staff to check reminders in EMR and keep updated. 3) Use 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, 2026, 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
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	100.00	100.00	ALL staff and providers participated in and completed relevant equity, diversity inclusion and /or antiracism education this year.	

Change Ideas

Change Idea #1 Equity and its importance will be discussed at annual staff meeting and quarterly meetings.

Methods	Process measures	Target for process measure	Comments
Will continue to collect data using EMR to ensure compliance.	number of completed equity training modules	100% of staff completed equity training/education	

Experience

Measure - Dimension: Patient-centred

Indicator #4	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	97.90	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 #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.	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 #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of faxes sent per 1,000 rostered patients	P	Number of faxes / PC patients/clients	/ Most recent quarter of data available (consecutive 3-month period)	1201.00	1201.00	Our FHT will attempt to maintain this number of faxes, although with ePrescribe being no longer available, we anticipate that this number will go increase dramatically.	

Change Ideas

Change Idea #1 #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 1201 to maintain the same number of faxes sent by our office, despite e-Prescribe being slated to be discontinued.	

Measure - Dimension: Safe

Indicator #6	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 eReferral. We will encourage to use this more frequently and to utilize admin staff as delegates.	

Change Ideas

Change Idea #1 #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 #7	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. We will encourage to use this more frequently and to utilize admin staff as delegates.	

Change Ideas

Change Idea #1 #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 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
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	Will strive to continue to have all clinicians within the primary care practice utilizing this provincial digital solution.	

Change Ideas

Change Idea #1 #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 #9	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 #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 #10	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	Our target will remain 100% but ePrescribe is slated to end so this will no be possible.	

Change Ideas

Change Idea #1 E-Prescribe slated to be discontinued.

Methods	Process measures	Target for process measure	Comments
We will not work on this if it is discontinued	We will not work on this if it is discontinued	We will not work on this if it is discontinued	

Measure - Dimension: Safe

Indicator #11	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	100.00	100.00	All providers have Online booking available for appointments.	

Change Ideas

Change Idea #1 #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 100% (10/10) of our clinicians utilizing the online appointment booking digital platform	

Measure - Dimension: Safe

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
AI Scribe: Percentage of clinicians in the primary care practice utilizing this provincial digital solution	O	% / Staff	Local data collection / Most recent information available	63.00	63.00	7 out of 11 Providers use AI SCRIBE presently. We will encourage other providers to use this tool.	

Change Ideas

Change Idea #1 Evaluate efficiency of AI Scribe amongst providers and check-in with providers biannually. Seek out what advantages AI Scribe brings to the practice.

Methods	Process measures	Target for process measure	Comments
Researcher to develop a series of questions where providers that use AI Scribe can evaluate and score different aspects of the tool. An overall question if the provider finds value in the use of AI SCRIBE will be asked as well.	Number of providers who use AI Scribe and are asked if it is more efficient than not using it.	100% of providers who use it will be asked re efficiency.	We will evaluate the benefits of AI SCRIBE and discuss biannual in hopes of encourage more use. Office staff and time spent in application of AI Scribe, easy of use, patient comfort and cost will be evaluated.