AOP Part A: 2021-2022 Annual Report

Please complete this form no later than **5 p.m. on Friday, May 27, 2022.**

The form does not permit saving changes part-way through the completion process; you **must complete the form in one session**. In that regard, you may wish to refer to the Annual Operating Plan submission documents that were provided in pdf format to prepare your responses in advance.

Upon completion, you are encouraged to print or save a pdf copy of your completed submission for your records.

Once you have submitted the completed form, a message at the end will confirm that your response has been submitted and will provide the option to ***Print or get PDF of answers.*** You can then send the form to a printer or save it as a pdf file.

1.0 Access

Increasing access to comprehensive primary care has been a key priority of Ontario's interprofessional programs. Considerable progress has been made in attaching patients to a family health care provider. Access is about providing the right care, at the right time, in the right place and by the right provider, through activities such as offering timely appointments, providing services close to home, after-hours availability, and a compassionate approach to bringing on new patients.

1. Family Health Team Name *

Barrie & Community Family Health Team

1.1 Patient Enrollment

2. What is the FHT's Target Patient Enrollment for March 31, 2022 *

149,000

3. What is the FHT's Actual Patient Enrollment for March 31, 2022 *

150,860

4. If the target was not met, please explain why and outline your plan to meet this target: *

The target was exceeded.

5. Are physicians enrolling new patients? *

- (●) Yes
- ( ) No

6. What is the number of physicians accepting new patients. *

One

7. Please estimate the FHT's capacity to accept new patients (specify # of patients) *

2500

8. Additional details (optional)

Enter your answer

1.2 Patient Enrolment - Access for New Patients in 2021-2022

9. Please complete the below *

	YES	NO
Were patients who contacted the FHT directly (self-referrals) enrolled?	○	○
Were any new patients referred by Health Care Connect (HCC)?	○	○
Were patients from other sources enrolled? (e.g., hospital, home care, other physicians/specialists)	○	○

1.3 Non-Enrolled Patients

Where resources are available, FHTs are encouraged to offer interprofessional programs and services to both enrolled and non-enrolled patients. If the FHT serves a specific non-enrolled patient population, describe the target population, services required, method used to estimate the number of patients served by the organization, and why the patients are not enrolled.

10. Please provide an estimate of non-enrolled patients served in 2021-22. *

The Prenatal and Well Baby (PNWB) Program

Prenatal and Well Baby: 3906 patient visits (1247 patients)
Breastfeeding: 780 patient visits (506 patients)

The PNWB Program provides routine prenatal and well-baby care for women and children (up to the age of 6 years), without a family doctor in the Barrie area, along with lactation consultant services. The goal is to improve health outcomes for individuals in the maternal child population by providing access to health care, lactation support, routine childhood vaccinations, education, as well as referrals and links to community supports as appropriate. Care is provided by a team of physicians, 1 RN, 2 part-time NPs and 2 part-time Lactation Consultants. Breastfeeding services are provided by a Lactation Consultant within the PNWB program, for all women (FHT and non-FHT) in the Barrie area. Some PNWB program patients have been successfully rostered to a family doctor within the FHT. Some patients continue to remain non-enrolled because physicians are at maximum capacity or these patients have recently moved into the community. A specialist (Pediatrician) is available in the PNWB program to provide increased, timely access to care for frenulectomy procedures and other pediatric consults as needed.

The PNWB program delivers the following:
- Routine prenatal care (initial and follow up appointments, up to 28 weeks gestation)
- Routine newborn care
- Well-baby checkups, including immunizations
- Lactation Consultant appointments
- Breastfeeding information and support
- Links to community supports, as needed
- Access to SW supports, as needed

Breastfeeding services at the BCFHT are available to all childbearing families in the community, including non-rostered patients.

Breastfeeding support is provided by an International Board Certified Lactation Consultant (IBCLC), in addition to RN support from the SMDHU for a total of 5 days per week.

The BCFHT strives to promote, protect and support breastfeeding in our community in the following ways:
- Offer breastfeeding support (1:1 Appointments) to all childbearing families in our community.
- Collaboration of Lactation Consultant with other BCFHT team members, including Family Practice office staff, as needed.
- Link with community partners, as appropriate, around breastfeeding issues.

BCFHT is actively involved in system integration and coordination to increase access to breastfeeding services. An agreement is in place with the local Public Health Unit, which provides the services of a Public Health Nurse, one day every week, in the breastfeeding clinic.

11. Were FHT programs available to members of the broader community? Please explain. *

Supported by Lung Health, CREs provided COVID@Home program for both FHT and non-rostered patients afflicted with COVID. The program reduced ED visits and supported earlier discharge from hospital for individuals still requiring oxygen. The key elements of the program involved a simple monitoring template, home pulse oximeter, and daily telephone monitoring support to assist in rapid detection for any deterioration. Patients entered the program via referral from ED, primary care and assessment centres.

A primary focus this year was continuing to support COVID efforts while maintaining primary care. We supported a local assessment centre with scheduling staff to work in the clinic, including leadership, admin, RNs, IHPs, NPs, IT support and medical supplies. The BCFHT also supported our local health unit's (SMDHU) mass immunization effort with HR support. In addition, the BCFHT planned and operated 10 immunization clinics for community members and staff between May 2021 - Jan 2022. We served 389 unique patients and provided a total of 595 doses (a combination of 1st, 2nd, and 3rd doses). Many patients were not enrolled and came from as far away as Toronto. Various roles and programs at the FHT provided support including RNs, NPs, physicians, IHPs, leadership and admin.
The BCFHT supported the SMDHU to develop a process where they could refer unattached children to PNWB clinic to access routine childhood vaccines, ensuring childhood vaccination remained a priority throughout the pandemic.

The Telemedicine Program increased local access to specialists by FHT and non-FHT patients in the community. 439 patients have been seen in the program from April 2021 to March 2022, for a total of 568 clinical telemedicine encounters (provider to patient consultation). The following specialists were accessed: mental health/psychiatry, dermatology/wound care, neurology, respirology and others (including allergy, gastro-enterology, hematology, orthopaedic surgery, genetics, general surgery, endocrinology, paediatrics, and others). The Telemedicine Program addressed the restricted access to specialist care caused by the COVID by encouraging providers to use eConsult. From April 2021 – March 2022 600 eConsults were completed, therefore providing increased access to a wide range of specialist care.

Non-rostered PNWB patients can be seen in other FHT programs including LINKS, Social Work and Nutrition Services. PNWB provides pap tests for unattached local patients being directed from Cancer Care Ontario. Breastfeeding services are available to all childbearing families in our community, including non-rostered patients. Breastfeeding support is provided by an IIBCLC; SMDHU supports this program with an additional 1 day/week IBCLC RN for a total of 5 days per week IBCLC support.

The School Success Program provides care for FHT rostered and non-FHT elementary school-aged students in the Barrie Community. The program targets students experiencing a physical or mental health challenge affecting their success at school, including learning, development, social, emotional and behavioural issues. The program connects all parties including students/families, health care team, education system and community resources to ensure a seamless and timely approach to care. The School Success Program provides Paediatrician consultation (initial and follow-up appointments) and allied health care support; including OT, SW, system navigation by RN and connection with appropriate resources and supports.

The BCFHT's affiliated FHO supports two extended-hours clinics. In these clinics, patients who are non-enrolled or unattached can receive care. The majority of patients receive acute episodic care, a few receive some degree of chronic disease management. From April 1, 2021-March 31

1.4 French Language Services

12. Did the FHT provide programs and/or services in French for patients whose mother tongue is French, or patients who are more comfortable speaking French? *

- (●) Yes
- ( ) No

13. If yes, provide an estimate of how many patients accessed programs and/or received services in French. *

A small minority, less than 2%

1.5 Accessibility to Cultural and Language Services

14. Did the FHT address the linguistic and cultural needs of the population being served, where possible? Please explain. *

Our PNWB program services non-FHT patients. We have several doctors in this program that speak other languages, supporting this culturally diverse patient population, including: Spanish, Cantonese, Africaan's and Dutch.
The BCFHT collaborates with the North Simcoe Muskoka Trans Health Program, by providing a safe space for individuals within the Barrie community to obtain access to care locally. The Trans Health program practitioners work on-site at the main BCFHT campus on a monthly basis to ensure those unable to travel to Orillia have access to the program.
Some physician offices also offered appointments in other languages. The following languages are provided in some FHT Physician offices:
Afrikaans, Arabic, Cantonese, Chinese (Mandarin), Farsi, Gujarat, Hindi, Hungarian, Konkani, Polish, Punjabi, Romanian, Russian, Sinjala, Spanish, Ukranian, Urdu, and Yoruba (Nigerian).

1.6 Regular and Extended Hours

15. What are your regular hours of operation when patients can access Interdisciplinary Health Providers (IHP) services?
Ex.: Mon: 9am-5pm, Tues: 8am-4pm, etc. *

Hours of operation:

Mon: 8 am – 4 pm
Tues: 8 am – 4 pm
Wed: 8 am – 4 pm
Thurs: 8 am – 4 pm
Fri: 8 am – 4 pm
Sat: Closed
Sun: Closed

Mental Health Services are Monday to Friday 9 am -5pm

16. When are IHP services available after hours?
Ex.: Mon: 5pm-8pm, Tues: 5pm-9pm, etc. *

Extended hours:

Mon: 4 pm -6 pm
Tues: 4 pm -6 pm
Wed: 4 pm -6 pm
Thurs: 4 pm -6 pm
Fri: 4 pm -5 pm
Sat: Closed
Sun: Closed

17. Identify which programs are offered after hours: *

Registered Dietitians: 7:30 am on Fridays
Lung Health: 7:30am Monday to Friday

OTN until 5pm daily as needed
Pharmacists until 5pm

Diabetes until 4:30 pm Monday, Tuesday, Wednesday, Friday

LINKS until 430pm daily as needed.

AWC until 430pm.

18. Additional Information:

Registered Dietitians run programs in the evening. The Weight Loss Surgery Group runs Tuesdays from 6-730pm. All other previously run evening RD programs are currently on hold or have moved to Zoom during the day during COVID.

1.7 Timely Access to Care

Please provide information on how appointments were scheduled in 2021-2022.

19. Did the FHT schedule appointments on the same day or next day (within 24 to 48 hours)? *

- (●) Yes
- ( ) No

20. If yes, what percentage of total enrolled patients was able to see a practitioner on the same day or next day, when needed? *(Please indicate with an asterisk "*" if the value entered is an estimate)* *

98% *as per physician survey responses

1.8 Other Access Measures

Please provide information on other types of access measures provided in 2021-2022.

21. Percentage of FHT practitioners who provided home visits? *

7%

22. Which types of IHPs perform home visits? *

NPs, RNs, Social Workers, Occupational Therapists

23. Number of home visits performed by IHPs in 2021-2022 *

47

24. Did the FHT deliver care virtually in 2021-2022? *

- (●) Yes
- ( ) No

25. If yes, was virtual care provided via telephone? *

- (●) Yes
- ( ) No

26. If yes, was virtual care provided via video? *

- (●) Yes
- ( ) No

27. What percentage of IHP services were provided virtually (e.g. telephone/video/online)? *

100%

Emergency Department (ED) Diversion

28. Did the FHT have a strategy to divert enrolled patients from the ED (**aside from physician contractual requirements for after hours**)? *

- (●) Yes
- ( ) No

29. Please describe the strategy: (Examples: NP after-hour clinics, ED Reports (CTAS 4, 5), triaging, patient awareness procedures (phone calls, posters, website, reminders), hospital discharge follow-up, outside use reports follow up) *

Supported by our Lung Health Program, Certified Respiratory Educators provided the COVID@Home program for both FHT and Non rostered community patients afflicted with COVID 19. The program provided both a positive impact on reducing ED visits and supported earlier discharge from hospital for individuals still requiring Oxygen. The Key elements of the program involved an easily accessible evidence-based pathway, simple monitoring template, home pulse oximeter , and daily telephone monitoring support to assist in rapid detection for any deterioration. Patients entered the program via referral from ED, Primary care and community Assessment Centres.

The BCFHT's primary focus in this past year was continuing to support our community in the COVID 19 effort while maintaining primary care. Acknowledging that early assessment and immunization efforts can help reduce the burden of illness on a person, community and population this work likely reduced visits to our local ED. We were proud to collaborate and support our local COVID Assessment Centre with assistance in scheduling a variety of staff to work in the clinic. This included leadership team members, admin, RNs, IHPs and NPs. The BCFHT also worked to support our local health unit's (SMDHU) mass immunization effort with human resource support of leadership team members, admin, RNs, IHPs and NPs at a variety of sites throughout the region.

In addition to supporting the SMDHU mass immunization clinics, the BCFHT planned and operated 10 Moderna immunization clinics, for community members and staff, at our site between May 2021 and Jan 2022.

The LINKS Team accepts patients who are high users of the emergency department, as well as high users of the healthcare system in general.

The FHT looks after a large population of women and children in this community who do not have a primary care provider. By providing routine prenatal and well-baby care, as well as breastfeeding support and some acute care to more than 1613 patients last year, the program likely prevented these patients from accessing care through walk-in clinics and/or emergency rooms.

The Lung Health team receives notice of FHT patient visits to ED or admission for either new enrollment or continued follow up in the program. Patients are encouraged to enroll and participate in the BCFHT Pulmonary Rehab Core and Maintenance programs where appropriate to gain knowledge and resources to assist in self-management strategies and action plans to reduce hospitalizations.

The BCFHT, through a partnership with the Barrie and Community Family Medicine Clinics, is initiating a public awareness campaign to help patients make educated decisions as to where and when they need to access care. One of the intended outcomes of this is to divert CTAS 4 and 5 to our walk-in clinics if that is the most appropriate place of care.

The BFHO after-hour clinics see enrolled (and unenrolled) patients and are open for hours that

30. How are patients made aware of hours of operation? (Examples: visible clinic signage, voicemail, patient pamphlets, FHT website or other means) *

Hours of operation are posted on the BCFHT website, are on a screen in the lobby of the main building and are posted in waiting rooms.

This information is also available on the FHT Facebook and Twitter accounts.

2.0 Integration and Collaboration

Collaboration with community partners is a key priority for FHTs. As the entry point to the health care system for many Ontarians, primary health care providers need to partner with other health and social service organizations in the communities they serve.

These partnerships can improve patient navigation, expand the suite of supports available to patients, and facilitate seamless transitions in all steps of the patient's journey. Meanwhile, care providers benefit from more efficient and coordinated service delivery.

2.1 Service Integration and Collaboration with Other Agencies

31. For those agencies that you are either collaborating or integrated with, please check the appropriate box if you have coordinated care plans, memorandums of understanding, shared programs and services, or shared governance. *

	Coordinated Care Plan	Memorandums of Understanding	Shared Programs and Services	Shared Governance	N/A
Children's Services	◉	○	○	○	○
Ontario Health - Home and Community Care	○	○	○	○	◉
Community Health Centre	○	○	○	○	◉
Community Support Services	○	○	○	○	◉
Developmental Services	○	○	○	○	◉
Diabetes Education Centre	○	○	○	○	◉
Local Hospital	○	○	○	○	◉
Mental Health and Addiction Services	○	◉	○	○	○

Public Health Unit	○	●	○	○	○
Senior Centre/Service	○	○	○	○	●
FHT	○	○	○	○	●
Long-Term Care Homes	○	○	○	○	●

32. Please provide any additional comments, as needed.

Home & Community Care Coordinators all have access to EMR to read notes and use the messenger tasking functions. LINKS team members have access to CHRIS HPG to start and amend coordinated care plans

BCFHT is collaborating with BCHC to support physiotherapy services within current FHT programming at the Aging Well Clinic. BCHC provides physician support to the Clinic. The BCHC physician (who holds an advanced competency in care of the elderly) works collaboratively with clinic IHPs to diagnose, treat and manage patients referred with concerns re: cognitive impairment &/or multiple complex medical conditions.

The LINKS team coordinates with DSO and locally Catulpa for shared patients to ensure navigation through the health and social services systems.

The Barrie & Area Diabetes Collaborative is a community partnership of key stakeholders and programs involved in the provision of diabetes care, that work together to ensure that all diabetes patients in the community are seen in the 'right place, by the right provider, at the right time'. Coordination of diabetes services, improved access to care and improved efficiency of health care delivery involving diabetes are some of the main goals. The primary agencies involved include BCFHT, BCHC, RVH and LMC Diabetes and Endocrinology.

The BCFHT Diabetes and Lung Health programs are integrated with RVH. Lung Health Program now accepts direct referrals from RVH for COPD patients being discharged from the hospital to ensure prompt follow up and seamless transition of care. The Diabetes team accepts direct referrals from the RVH Diabetes Program.

BCFHT Registered Dietitians accept pediatric feeding referrals from RVH's SLP in order to decrease patient wait times. BCFHT RD's also have partnered with RVH RD's to develop a protocol for malnutrition screening and follow up to help improve outcomes and reduce hospital re-admissions. BCFHT RD's collaborate with RVH's out patient Mental health program by presenting regularly in the addictions and recovery program – was on hold due to COVID, will restart.

The Aging Well Clinic accepts direct referrals from RVH for inpatients being discharged back to the community and for at-risk seniors assessed in the ER . RVH's Outpatient Geriatric Clinic diverts referrals for FHT patients to the Aging Well Clinic.

The BCFHT worked with the CMHA Simcoe County Branch to develop a MOU to support both OTN programs. This understanding allows both parties to maintain communication to make timely, necessary improvements to serve FHT patients in Barrie and Innisfil. The triages care to the CMHA Innisfil site to ensure FHT patients receive OTN care closer to home if residing south of Barrie. The CMHA OTN coordinator provides vacation coverage for the BCFHT OTN Coordinator. With a large patient load and only one provider at the BCFHT OTN program, this coverage is important and ensures that triaging, booking and patient visits can continue in their absence. Both parties work together to support, educate and outreach FHT physicians and staff, increasing telemedicine referrals.

The SMDHU and the BCFHT have a formal written agreement supporting one Public Health Nurse to work out of the PNWB Clinic supporting Lactation services and frenulectomy one day per week. This is a donation in kind offered to the FHT by the Simcoe Muskoka District Health

Unit, which helps improve access issues for women requiring support with breastfeeding and

2.2 Local Planning and Community Engagement

33. What process/mechanism did the FHT have in place to include input from the Ontario Health Region and other community partners into program and service planning, including health human resources planning? *

The FHT ED and Leadership Team members communicates and meets regularly with community partners to collaborate on program and service planning for the following clinical areas in our community: COVID-19 community response, seniors care, diabetes, palliative care, Lung Health, and Prenatal and Well baby care, including immunizations.
In development of the School Success program, the BCFHT worked closely in conjunction with the Simcoe Muskoka District School Board and continues to engage the Board in service planning. The School Success program leads meet bi-annually and as needed with representatives from the School Board Special Education as well as the Couchiching FHT to review processes and programs to ensure community deliverables are being met and in order to identify gaps in service and areas for development.
The Simcoe Muskoka District Health Unit and the BCFHT have a formal written agreement (MOU) supporting one Public Health Nurse to work in the PNWB Clinic supporting Lactation services and frenulectomy one full day per week. This is an in-kind donation offered to the FHT by the Simcoe Muskoka District Health Unit, which helps improve access issues for patients requiring this.
The Canadian Mental Health Association – Simcoe County Branch and the BCFHT have a formal MOU supporting telemedicine care for Innisfil area patients and working together, via physician and provider education and outreach, to increase access to telemedicine for all FHT patients.

34. Please describe FHT involvement in Ontario Health initiatives *

The BCFHT has been fully engaged in the development of the Barrie Area OHT (BAOHT). The FHT ED is one of the Co-Chairs of the BAOHT and has dedicated many hours of work into the OHT planning and development with community partners. This year we continued to engage community partners and have finalized our CDMA as a result of multiple planning sessions led by a facilitator; we have developed our funding plan, worked together on our collaborative QIP, initiated several digital funding opportunities in primary care, completed the healthcare

35. Public Engagement Strategy: What was the process/mechanism that the FHT had in place to include patient and community input into FHT planning and priorities? *

Patient surveys were used to gather feedback from patients for planning. This year, we surveyed patients about virtual care in order to plan for the future delivery of our programs and services. Based on patient feedback gathered, we have planned to offer at least some patient care appointments using virtual care methods

36. Ontario Health Team (OHT) Involvement: Is the FHT involved in any activities related to the development of Ontario Health Teams? Please describe the extent of the FHT's participation in OHT implementation as applicable. *

The BCFHT has been fully engaged in the development of the Barrie Area OHT (BAOHT). The BCFHT ED is one of the Co-Chairs of the BAOHT and dedicates many hours of work into the OHT planning and development with community partners on a weekly basis. The ED actively participates regular OHT meetings, including the BAOHT Governance Action Team, OHT RISE sessions, and also leads the COVID-19 working group under the BAOHT. The FHT ED is also currently working with the other co-chairs to recruit a local project lead and an administrative support person for the BAOHT.

The FHT IT Manager has been leading the digital health working group of the BAOHT and the new digital health projects that were recently approved (virtual care and online appointment booking system), along with the FHT and FHO IT Medical Lead.

The FHT QI Coordinator Lead is taking a lead role in the cQIP planning for the BAOHT.

FHT staff and managers are involved in the working groups of the BAOHT: Seniors Strategy, Palliative Care, COVID-19 and Digital Health.

2.3 System Navigation and Care Coordination

37. How did the FHT help navigate patients through the health care system? Please provide up to three examples, i.e. referral protocols to link patients with other appropriate providers or organizations; coordination with hospital for post-discharge primary care; Ontario Health collaboration for home care supports, other follow-up care, etc. *

Home and Community Care coordinators have been embedded in FHO physician offices; HCC Care Coordinators all have access to the EMR to read notes and use the messenger tasking functions. This allows quick consults between primary care and community care, allowing patients quicker access and easy navigation of referral process for HCC services.

LINKS Team – The LINKS Team Clinicians work closely with all community agencies to ensure these complex patients have access to a variety of services within the community that will support all aspects of the patients physical, mental, and socio-economical wellness. This includes direct referrals to all community services. The team also regularly contacts government agencies (ODB, ODSP, OW) and local centres such as the David Busby Centre to assist with issues regarding housing, transportation, finances, and medication coverage. Referrals to the LINKS team come through their primary care provider and are often advocated for by community agencies, RVH and IHPs.

Aging Well Clinic - The Aging Well Clinic works closely with the local hospital and community agencies. This ensures dementia patients and medically complex/frail seniors receive specialized community based geriatric care and are connected with appropriate community services. Patient referrals are accepted from RVH hospitalists, Arthroplasty Intake Clinic, ER Dept. & local vascular surgeons. RVH's Geriatric Clinic diverts FHT patients to the Aging Well Clinic. The sharing of personal health information between the Aging Well Clinic and RVH inpatient units/RVH Geriatric Clinic facilitates appropriate medical interventions and medication reconciliation as patients transition between the community and acute care. The Aging Well Clinic provides system navigation to ensure patients have access to a variety of services within the community. This includes direct referrals to services such as OH, Alzheimer's Society, Simcoe Community Services, Simcoe Muskoka Brain Injury Services, CMHA, Waypoint, Wendat, Accessible Transportation Services and Simcoe Independent Living Services. Patients/families are linked to Lifeline, Safely Home Service, Adult Day Programs, Respite Care, CHC chronic disease & fitness programs, foot care services, private pay community support programs and community centres.

The School Success Program provides resource navigation and coordination through the facilitation of referrals for students and families to services such as; New Path Youth and Family

2.4 Digital Health Resources

Clinical Management System/Electronic Medical Records

Please provide information on your EMR

38. Which EMR vendor/version is being used? *

QHR Accuro (ASP deployed). Current version is 2017.182.3

39. Please provide the level of integration for the following. *

	None	Read-only	Full integration
Ontario Health – Home and Community Care	○	◉	○
Emergency Department	◉	○	○
Hospital	○	○	◉
Laboratory Service	○	○	◉

40. If no EMR integration, are other data-sharing arrangements in place (e.g., case conferencing)?
Please provide any other comments *

HCC staff have read-only access to the FHT EMR.

Local hospital staff do not have direct access, though the FHT is working towards solutions on sharing data. Some FHO physicians have hospital privileges and they have EMR access while at the hospital.

41. Were you able to electronically exchange patient clinical summaries and/or laboratory and diagnostic test results with other doctors outside of the practice? *

◉ Yes

○ No

42. Were you able to generate the following patient information with the current medical records system: *

	Yes	No
Lists of patients by diagnosis	◉	○

(e.g., diabetes, cancer)		
Lists of patients by laboratory results (e.g., HbA1C<9.0)		
Lists of patients who are due or overdue for tests or preventative care (e.g., flu vaccine, colonoscopy)		
Lists of all medications taken by an individual patient (including those ordered by other doctors)		
Lists of all patients taking a particular medication		
Lists of all laboratory results for an individual patient (including those ordered by other doctors)		
Provide patients with clinical summaries for each visit		

43. Did FHT patients have access to the following patient-facing online services? *

	Yes	No
Email communication with the FHT		
Request prescription refills/renewals		
Book appointments with Family Health Team providers		

44. Did the FHT have a data sharing agreement with the affiliated physician group(s)? *

- (●) Yes
- ( ) No

45. Please explain how the EMR was used for tabulating patient statistics, identifying and anticipating patient needs, planning programs and services, etc. *

The BCFHT Lung Health program continues to use the patient tools we developed on the Oceans Tablet format and are successfully using them for every patient visit to ensure accurate, up to date patient demographics and improved quality data collection for health indicators and reporting. Patients are identified via appointment types and if appropriate asked to complete intake questionnaires. These are automatically uploaded to the EMR and allow providers to review easily. We continue to look at other opportunities in FHT programs to use this

2.5 Data Management Support

Please provide information on any data-management support activities in 2021-2022.

46. Did your organization use the services of a QIDS Specialist or any other data management specialist? *

- (●) Yes
- ( ) No

47. If yes, how did this role help your organization with quality improvement, program planning, and performance measurement? Please describe any challenges and successes. *

The BCFHT has two members of its QIDS team that provide services to BCFHT clinics and member physicians. The QIDS team has been involved in a wide variety of initiatives and projects in 2021-22 which include, but are not limited to:

- Supporting clinical teams in the standardization of EMR tools and resources.
- Creating tools in the EMR for clinical programs that support data measurement.
- Providing research support to the FMTU Residents for their QI and Research Projects.
- Conducting BCFHT program evaluations.
- Creating, distributing and analyzing patient surveys.
- Improving EMR data quality.

3.1 Other Information and Comments

48. The Ministry of Health likes to promote the work done by FHTs. Please describe any awards, acknowledgements or achievements from 2021-2022. *

The BCFHT's primary focus in this past year was continuing to support our community in the COVID 19 effort while maintaining primary care. We were proud to collaborate and support our local COVID Assessment Centre with assistance in scheduling a variety of staff to work in the clinic. This included leadership team members, admin, RNs, IHPs and NPs. The BCHFT provided IT support and medical supplies.

The BCFHT also worked to support our local health unit's (SMDHU) mass immunization effort with human resource support of leadership team members, admin, RNs, IHPs and NPs at a variety of sites throughout the region.

In addition to supporting the SMDHU mass immunization clinics, the BCFHT planned and operated 10 Moderna immunization clinics, for community members and staff, at our site between May 2021 and Jan 2022. We were able to serve 389 unique patients and provide a total of 595 doses which were a combination of first, second and third doses. Again we had support for a variety of roles at the FHT including RNs, NPs, physicians, IHPs, leadership and admin. IT worked closely with the Clinical Manager to arrange a variety of booking methods, including phone and online, as well as website screening and reminder options.

The BCFHT continued to support the SMDHU by working together to develop a process where the SMDHU could refer unattached children to the PNWB clinic to access childhood vaccines, ensuring that childhood vaccination remained a priority throughout the pandemic.

The BCFHT also implemented the COVID@Home program for both FHT and Non rostered community patients afflicted with COVID 19. The program provided both a positive impact on reducing ED visits and supported earlier discharge from hospital for individuals still requiring Oxygen. The key elements of the program involved an easily accessible evidence-based

49. Is there anything else that the organization would like to communicate to the ministry regarding its activities in 2021-2022? Any challenges, opportunities and recommendations for the ministry can also be detailed in this space. *

Digital Health Funding Request - Appointment Reminders (add-on service) with QHR
Programs and patients have been requesting digital reminders for years. One program piloted it but we cannot extend this to other programs/patients due to cost. The estimated annual cost for all programs is $14,000 and would replace approximately 35,000 reminder calls. The initial pilot in PNWB was successful using the Cliniconex program via QHR. This provides automatic text, email or phone reminders for scheduled patient visits. Patients receive a timely reminder of their upcoming appointment either by phone, email or text message (most choose text). The patient can then cancel or confirm their appointment. Unfortunately, due to cost we are unable to expand this service to other programs. Estimated annual cost for BCFHT programs based on 2021/22 numbers, HST included = $13,834.59. It is our hope that we can expand this service to all BCFHT programs on a permanent basis through additional funding.

Nurse Practitioner (NP) Request: To Support our Expanding FHT/FHO and Patient Care Needs in our Community -
Due to significant growth of our FHT/FHO and the number of patients receiving care , the BCFHT is requesting an additional NP. An additional 1.0 FTE NP would better meet current patient care needs in a timely manner. Our growing FHO has created a wait list of physician offices requesting immediate NP support. Consideration for future incremental increases would provide access for a larger number of signatory physicians and their respective patients, along with enhanced care provided by NPs. The BCFHT is currently funded for 18.25 FTE NPs to support our FHT/FHO - 2.0 FTE support PNWB and Aging Well; 0.25 FTE designated NP Team Lead, remaining 15.50 FTE support patients in physician offices (the equivalent of 0.25 FTE per physician). With the limited number of NP resources, only patients of 62 physicians (out of 103 in FHO) receive the support of a NP. An inequity exists as 41 of our physicians remain unsupported by a NP. The addition of a 1.0 FTE NP would provide improved access to primary care by our patients and allow more physician practices to receive the support of an NP.

Social Work (SW)FTE Request: To Support Growing Community Needs for School Age Children and Families - BCFH requests 1.0 FTE Social Work to support the Success in Schools Program. This program provides support for school age children and their families who are struggling in class and ensures the team surrounding each student includes a complete circle of care (family, school, physicians, RNs, SWs, OTs, community supports). When referred to SW, elementary age children and their family receive counselling and support focusing on developing strategies to cope with their presenting concern, as well as to address social, emotional, or behavioural concerns. Previously SW resource was reallocated from other operating programs. With the onset of the pandemic, as well as Barrie's continued growth, the need for access for school age children for social, emotional or behavioural concerns has dramatically increased. The program saw 139 unique patient visits for SW in the 2020-21 fiscal year. As of Dec. 31, 2021, the number of unique patient visits reached 151 for the 2021-22 fiscal year and increases monthly.

Mental Health (MH) FTE Request for a Central Intake (Bachelor's Level) Clinician - In order to meet the increasing demand for MH services, we would like to request an additional Mental

Evidence of Board Approval

The ministry requires the submission of evidence that the FHT Board has approved all three parts of the submission (Part A (Annual Plan), Part B (Service Plan) and Part C (Governance and Compliance Attestation).

Upon completing the forms, please email the filled out **Board Approval Acknowledgement** document that was provided with the AOP package to your Senior Program Consultant.

The submission of **one copy** of the **Board Approval Acknowledgement** form is sufficient; there is no need to provide separate forms for each part of the AOP package.

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