Ontario

FHT AOP Part A: 2022-2023 Annual Report

Please complete this form no later than **5 p.m. on Friday, May 26, 2023.**

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 Word 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 and Community Family Health Team

1.1 Patient Enrollment

2. What is the FHT's Target Patient Enrollment for March 31, 2023 *

149,000

3. What is the FHT's Actual Patient Enrollment for March 31, 2023 *

148,763

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

Recently there have been many physicians retiring, with new physicians taking over the practice. Some are still currently in the process of re-rostering patients under the new provider. Also, many physicians continue to see fee-for-service patients, and we are unable to accurately collect those numbers.

5. Are affiliated physicians enrolling new patients? *

- (●) Yes
- ( ) No

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

1

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

2000

8. Additional details (optional) e.g. prioritized accepting patients with high needs, chronic illness, etc.:

One physician is expected to join the Barrie & Community Family Health Team (BCFHT) and start a new practice locally. Physicians continue to join the FHT throughout the year, some take over retiring physicians and some start new practices. Throughout the year, physicians continue to accept new patients as their roster changes.

1.2 Patient Enrolment - Access for New Patients in 2022-2023

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,	◉	○

	Yes	No
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 2022-23. *

Prenatal and Well Baby: 3836 patient visits (1272 patients)
Breastfeeding: 1021 patient visits (646 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 consulting physicians, RNs, NPs and 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 frenotomy 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 available

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 Simcoe Muskoka District Health Unit (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

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

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. This program supported 36 patients over the last year during 125 visits. The program reduced ED visits and supported earlier discharge from hospital for individuals still requiring Oxygen. Patients entered the program via referral from ED and primary care.

The FHT Telemedicine Program continues to successfully increase local access to specialists by patients in the community (both FHT and non-FHT patients). 404 patients have been seen in the program from April 2022 to March 2023, for a total of 1169 clinical telemedicine encounters (provider to patient consultation). The following specialists were accessed during those visits: mental health/psychiatry, dermatology/wound care, neurology, respirology and others. **Others include visits such as allergy, gastro-enterology, hematology, orthopaedic surgery, genetics, general surgery, endocrinology, paediatrics, etc. The telemedicine program addressed the restricted access to specialist care caused by the COVID by encouraging providers to use eConsult. Telemedicine staff also act as delegates for providers performing this service on their behalf. From April 2022 – March 2023 821 eConsults were completed.

Non-rostered patients of the PNWB program can be referred to and can be seen in other FHT programs including LINKS, Social Work (as available) and Nutrition Services. The PNWB program provides pap tests for unattached local patients being directed from Cancer Care Ontario.
Breastfeeding services at the BCFHT are available to ALL childbearing families in our community, including non-rostered patients. The BCFHT Breastfeeding Services began in October 2010 in response to a community need for additional breastfeeding services to support childbearing families in our community. Breastfeeding support is provided by an International Board-Certified Lactation Consultant (IBCLC); the SMDHU supports this program with an additional 1 day per 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 who are experiencing a physical or mental health challenge that is affecting their success at school. This includes learning, development, social, emotional, and behavioural issues. The program aims to connect all involved parties including students/families, health care team, education system and community resources to ensure a more seamless and timely approach to care. Care is provided by a team including Paediatricians, Registered Nurses, Registered Psychotherapist, Social Worker, Occupational Therapist and Administrative support.

Mental Health- In collaboration with CMHA Simcoe County Branch we offered two Dialectical Behavioural Therapy groups to both FHT and CMHA clients in

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 estimated at 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 who speak other languages, supporting this culturally diverse patient population, including Cantonese, Afrikaans 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, Ukrainian, Urdu, and Yoruba (Nigerian).
Bridge Translation services are accessed as needed to support interpretation and translation when required.

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.

Regular hours of operation:

Mon: 8am - 4 pm
Tues: 8am - 4pm
Wed: 8am - 4pm
Thurs: 8am - 4pm
Fri: 8am - 4pm

Mental Health: Monday to Friday, 9am - 5pm

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

Mon: 7:30-8am / 4-5 pm
Tues: 7:30-8 am /4-5 pm
Wed: 7:30-8 am / 4-5 pm '
Thurs:7:30-8 am /4-5 pm
Fri: 7:30-8 am /4-5 pm

Mental Health - Hours vary based on client need

17. Identify which programs are offered after hours: *

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

OTN until 5pm daily as needed

Pharmacists until 5pm

Diabetes until 430pm Mon, Tues, Thurs, Fri

LINKS until 430 pm daily as needed.

Aging Well Clinic until 430 pm.

Mental Health- 90 extended hours provided in 2022/23

18. Additional Information: *

RDs run programs in the evening – Weight Loss Surgery Group runs Tuesdays 6-7:30pm

1.7 Timely Access to Care

Please provide information on how appointments were scheduled in 2022-2023.

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 an IHP on the same day or next day, when needed? *(Please indicate with an asterisk "*" if the value entered is an estimate)* *

50%*

1.8 Other Access Measures

Please provide information on other types of access measures provided in 2022-2023.

21. Percentage of IHPs who provided home visits? *

10%

22. Which types of IHPs perform home visits? *

Social Workers, Links, Mental Health – Registered Psychotherapists

23. Number of home visits performed by IHPs in 2022-2023 *

83 including Mental Health

24. Did the FHT deliver care virtually in 2022-2023? *

- (●) 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)? *

96% of total IHP services were offered with a virtual option (including phone visits) –

Emergency Department (ED) Diversion

28. Did the FHT have a strategy to divert enrolled patients from the ED for non emergency services (CTAS 4 and 5) - (**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 and primary care.

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/episodic care to more than 1720 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 Lung Health program. Patients are encouraged to enroll and participate in the West Park virtual Pulmonary Rehab program and our 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 (BCFMC), 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 Barrie Family Health Organization (BFHO) after-hour clinics see enrolled patients and are open for hours that far exceed the MOH contractual requirements. This clearly diverts significant numbers of patients from the ED.

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	Memorandum of Understanding	Shared Programs and Services	Shared Governance	N/A	Other
Children's Services	◉	○	○	○	○	○
Ontario Health - Home and Community Care	◉	○	○	○	○	○
Community Health Centre	○	○	◉	○	○	○

	Coordinated Care Plan	Memorandum of Understanding	Shared Programs and Services	Shared Governance	N/A	Other
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	○	○	○	○	◉	○
Other	○	○	◉	○	○	○

32. Please provide any additional comments, as needed. *

The BCFHT is a partner of the FMTU through the provision of QIDS and IT support, and EMR access to the physicians and residents at the FMTU. One of the areas of largest contribution by the BCFHT is through the QIDS team. QIDS provides support to the FMTU for the residents' annual quality improvement projects and the FMTU patient survey. The QIDS Specialist is a sitting member of the Research, Education and Quality Improvement Program (REQIP), which is a committee of the shared Board of Directors between the BCFHT and the Barrie FHO.

Pharmacy and RD are involved on a consultative basis with Palliative Care Community Team Rounds at Hospice Simcoe. Leadership participates in OHT Palliative Care Working Group meetings wit Hospice Simcoe.

The CFHT Trans Health Program sees patients at the BCFHT Bayview office. BCFHT provides the space to allow patients to be seen closer to home for this specialized program.

BCFHT has formed a strong partnership with the Simcoe County District School Board and the Simcoe Muskoka Catholic District Board with the School Success Program. This program provides seamless transitions and coordinates care between the education system and healthcare system for children who are struggling in school with behavioral issues, likely due to a medical condition. Timely access to system navigation, counselling, occupational therapy, and pediatrician support are key components to support students and families in Barrie. This integration and collaboration improves the students' chance for success in school along with improved quality of life and well-being for children and their families.

BCFHT uses the Ontario Telemedicine Network (OTN) Program to ensure patients get more out of the health care system by bridging the distance of time and geography to bring more patients the care they need, where and when they need it. Using innovative technology, OTN streamlines the health care process, while also expanding the way knowledge is shared and how members of the medical community interact with each other and with patients. Referrals are accepted from all physicians and NPs in the FHT as well as outside providers. Using the Telemedicine program, patients are able to access timely health care in their local area instead of travelling long distances and incurring long wait times.

The BCFHT is represented and actively involved in the Barrie Smoking Cessation Task Force.

The LINKS team sits at the Barrie and Area Navigator Collaborative (the BANC) which is the group of natural Navigators within this community that now have a forum and formal means to connect.

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 communicate and meet 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.

Our next priority area of focus will be the Mental Health & Addictions population. Two local, in-person, collaborative council sessions were recently facilitated by external consultant Jodeme Goldhar to review successes to date and next steps.

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 three Public Health Nurses to work in the PNWB Clinic supporting Lactation services 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 service.

The Canadian Mental Health Association – Simcoe County Branch and the BCFHT

34. Please describe FHT involvement in Ontario Health initiatives *

A BCFHT Clinical Manager and the Aging Well Team Lead are involved with Barrie & Area Ontario Health Team (BAOHT) Seniors working groups. There is representation on the Seniors Ambulatory working group, the Frail Seniors working group, the Seniors Rehab working group, and the Central Intake working group. Much work has been done to identify pathways for seniors to access rehabilitation services in the community. A central intake process has been developed for referrals to seniors care in partnership with the North Simcoe Muskoka Specialized Geriatric Services, Royal Victoria Regional Health Centre, and other key community members.

We continue to grow our digital health footprint within our OHT as we expand the rollout of OAB (Online Appointment Booking) throughout our primary care groups, including our FHT and FHO. As part of the province's CWM (Central Waitlist Management) initiative, RVH is working toward integration of their Digital Imaging department workflows with OceanMD's eReferral platform. This is part of a larger "Axe the Fax" project that includes deployment of eReferral to our Primary Care Practitioners and other Specialists throughout our OHT, as well as working with our Accuro EMR vendor (QHR) on improvements to their ePrescribe services.

A BCFHT Clinical Manager sits on the BAOHT Palliative Care working group. This group is working on providing better access to palliative care services within the community, which was a Year 1 target population strategy.
The BCFHT ED and a Clinical Manager sit on the BAOHT Lower Limb Preservation Strategy steering committee and working group. This group is working on a demonstration project to help prevent non-traumatic lower limb amputations. This group is made up of members of the BAOHT as well as partners representing the indigenous community, paramedicine, and homeless and marginalized communities.

Early identification of patients with COVID-19 and supporting these individuals at home using a structured and validated algorithm, including remote monitoring with pulse oximetry, reduced anxiety about the illness, improved adherence to self-care and support early identification of those at risk for deterioration. The COVID@Home program within our community was supported by the BCFHT Lung Health Program.

Partner organizations in Barrie & Area have come together to support the build of a COVID@Home program in our community. COVID@Home is an approach to care that aims to ensure all patients diagnosed with COVID-19 receive support commensurate with their level of severity and risk, and that all primary care

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.

About 1528 patients who accessed Registered Dietitian services were sent a survey to gather feedback and evaluate services. The results were used for planning and identifying areas of opportunity that align with our QIP indicator regarding reducing wait times to see a dietitian.

For Mental Health, the Ontario Perception of Care (OPOC) Tool is a standardized way to gather client feedback on the quality of care received. This tool was

36. Ontario Health Team (OHT) Involvement: Is the FHT involved in any activities related to the implementation 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 dedicates many hours of work into the OHT planning and development with community partners on a weekly basis. The ED actively participates in regular OHT meetings, including the BAOHT Executive Committee, Collaborative Council as well as other OHT working groups and planning meetings, and OHT RISE sessions. The FHT ED also successfully worked with the other co-chairs to recruit a local project lead and administrative support person for the BAOHT this past year.

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 and sits on an Indicator Working Group.

FHT staff and managers are involved in the working groups of the BAOHT: Seniors

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 (HCC) 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 specialised 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 and fitness programs, foot care services, private pay community support programs and community centres.

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 2017.655

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.

General hospital staff do not have access, but the teaching unit has full access.

Through OLIS, lab results directly import to the EMR.

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	(●)	( )

	Yes	No
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 QIDS team provides services to BCFHT clinics and member physicians. The QIDS team regularly uses the EMR for a wide variety of initiatives and projects in which include, supporting clinical teams in the standardization of EMR tools and resources, creating tools for clinical programs that support data measurement, providing research support to the FMTU Residents for their QI and research projects, conducting program evaluations, creating, distributing, and analyzing patient surveys, and improving data quality.

The EMR was also used to pull data on the number of patient visits and other information in every program area, including Lung Health, as well as for reports and for planning purposes regarding any needed increase in resources.

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.

2.5 Data Management Support

Please provide information on any data-management support activities in 2022-2023.

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 2022-23 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.

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 2022-2023. *

Our Prenatal and Well Baby Program was nominated for a Bright Lights award at the 2022 AFHTO conference. The PNWB team provides prenatal and well-baby care for women and children (up to the age of 6) without a family physician in the Barrie and surrounding area. The program has nurses, nurse practitioners, physicians and lactation consultants that provide care, education and referrals into community supports. The program also performs tongue tie releases and has a paediatrician available for consultation.

This year we have added Online Appointment Booking (OAB) functionality for some of our programs, allowing patients to connect to the Medeo-based service and book certain types of appointments through their phone, tablet, or computer at their convenience. Communication with the patient is conducted through a secure patient messaging system. As we progress with the project we will work to

49. Is there anything else that the organization would like to communicate to the ministry regarding its activities in 2022-2023? Any challenges, opportunities and recommendations for the ministry can also be detailed in this space. *

Organizational challenges include:

OTN Program:
- There is increased utilization of OTN services for both attached and unattached patients putting increased demands on the program.
- The funding for nursing staff in OTN is lower than that for other nursing staff.
- Lack of administrative support for the program

Other challenges include program wait times are due to limited resources, including the wait times to see a Respirologist and for Mental Health appointments.

Due to limited RD resources we continue to have an 8-10 week wait time for an initial dietitian visit. To address wait times, we have delayed and reduced follow up visits and redirected most referrals to group sessions for education/learning prior to self-selecting to book a one-on-one appointment.

Wait times for paediatrician consults in our SSP program continue to be lengthy and are currently approximately 10 months. This wait is shorter than accessing paediatricians in our community, which current takes approximately 2 years.

Cost of Living Wage Increases / Benefits - Despite significant cost of living expense increases, we have had no wage raise for several years. Multiple staff have brought this concern forward resulting in dissatisfaction among staff.

Unattached patients & lack of resources

Service gaps – women's health

Staff Leaves - Throughout our 2022/23 fiscal we have had multiple staff off on medical leave of absences.

Children & Youth Mental Health - We have one Psychotherapist within our School Success Program who sees children (up until grade 8) on a consult/limited bases.

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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