Access and Flow | Timely | Optional Indicator

	Last Year		This Year		
Indicator #9 Percentage of screen-eligible people who are up to date with colorectal tests (Southlake FHT)	**75.40** Performance (2025/26)	**80** Target (2025/26)	**74.80** Performance (2026/27)	**-0.80%** Percentage Improvement (2026/27)	**76** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Expand the Weight Management Program to include a workflow stream to book preventative screening appointments with their primary care physician.

Process measure

- Number of patients who accept a preventative care follow up appointment after being offered one

Target for process measure

- 100% of patients enrolled in the weight management program who are overdue for colorectal cancer screening will be offered a preventative screening appointment with their primary care physician.

Lessons Learned

Using a template from the Central Cancer Regional Program, we create customized letters for patients who are overdue for screening and direct them to our website for instructions on obtaining a FIT kit. This information is also included in the Weight Management welcome package, and physicians emphasize the importance of screening during the initial assessment, particularly for higher risk groups such as individuals with obesity.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Expand the Weight Management Program to include a resources and education materials related to cancer screening and prevention

Process measure

- Percentage of eligible patients who receive cancer screening education materials during weight management program intake

Target for process measure

- 100% of eligible patients receive educational materials before their first follow up appointment with the weight management specialist in the Weight Management Program

Lessons Learned

We are currently assessing the effectiveness of including the screening letter in the welcome package. Our next PDSA cycle will incorporate additional educational materials to further support patient understanding of screening.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Update all preventative screening forms and tools in the EMR system with current guidelines

Process measure

- Percentage of preventative screening forms and tools reviewed and updated to align with current clinical guidelines

Target for process measure

- 100% of preventative screening forms and tools reviewed and updated by Q2

Lessons Learned

Our preventative toolbars and EMR queries have been updated with the latest guidelines.

Change Idea #4 ☐ Implemented ☑ Not Implemented ☐ In Progress

Use cancer screening dashboards to engage providers with cancer screening initiative

Process measure

- Percentage of providers that accessed their SAR report in the last 6 months. Percentage of physicians signed up for Physician Linked Correspondence (PLC) and percentage of physicians without an assigned delegate

Target for process measure

- 100% of providers will access their SAR report, sign up for PLC and have an assigned delegate by the end of Q4 2025-2026 fiscal year

Lessons Learned

This change is no longer within the scope of our initiative. We will instead focus exclusively on individuals with obesity and those enrolled in the Weight Management program.

Change Idea #5 ☑ Implemented ☐ Not Implemented ☐ In Progress

Design a survey to gather data on potential barriers to screening among patients with obesity

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

With support from a student volunteer and a patient partner, we developed a survey for patients with obesity who are overdue for cancer screening. The survey helped identify key reasons for delayed screening, including access related barriers, which will be the focus of our improvement efforts next year

Comment

We have recruited a student volunteer to follow up with patients enrolled in the Weight Management program who received the initial screening letter in their welcome package. The student will contact these patients to determine whether they have arranged for recommended preventive screening.

Indicator #8

Percentage of screen-eligible people who are up to date with cervical screening (Southlake FHT)

Last Year		This Year		
71.50	**75**	**66.90**	**-6.43%**	**68**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Expand the Weight Management Program to include a workflow stream to book preventative screening appointments with their primary care physician.

Process measure

- Number of patients who accept a preventative care follow up appointment after being offered one.

Target for process measure

- 100% of patients enrolled in the weight management program who are overdue for cervical cancer screening will be offered a preventative screening appointment with their primary care physician.

Lessons Learned

Using a template provided by the Central Cancer Regional Program, we create customized letters for patients who are overdue for screening and includes a link to book online with our nursing team for cervical screening. This information is also incorporated into the Weight Management welcome package, and physicians reinforce the importance of screening during the initial assessment, particularly for higher-risk populations such as individuals with obesity.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Expand the Weight Management Program to include a resources and education materials related to cancer screening and prevention

Process measure

- Percentage of eligible patients who receive cancer screening education materials during weight management program intake.

Target for process measure

- 100% of eligible patients receive educational materials before their first follow up appointment with the weight management specialist in the Weight Management Program.

Lessons Learned

We are currently assessing the effectiveness of including the screening letter in the welcome package. Our next PDSA cycle will incorporate additional educational materials to further support patient understanding of screening.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Update all preventative screening forms and tools in the EMR system with current guidelines

Process measure

- Percentage of preventative screening forms and tools reviewed and updated to align with current clinical guidelines.

Target for process measure

- 100% of preventative screening forms and tools reviewed and updated by Q2

Lessons Learned

Our preventative toolbars and EMR queries have been updated with the latest guidelines.

Change Idea #4 ☐ Implemented ☑ Not Implemented ☐ In Progress

Use cancer screening dashboards to engage providers with cancer screening initiative

Process measure

- Percentage of providers that accessed their SAR report in the last 6 months. Percentage of physicians signed up for Physician Linked Correspondence (PLC) and percentage of physicians without an assigned delegate

Target for process measure

- 100% of providers will access their SAR report, sign up for PLC and have an assigned delegate by the end of Q4 2025-2026 fiscal year

Lessons Learned

This change is no longer within the scope of our initiative. We will instead focus exclusively on individuals with obesity and those enrolled in the Weight Management program.

Change Idea #5 ☑ Implemented ☐ Not Implemented ☐ In Progress

Design a survey to gather data on potential barriers to screening among patients with obesity.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

With support from a student volunteer and a patient partner, we developed a survey for patients with obesity who are overdue for cancer screening. The survey helped identify key reasons for delayed screening, including access related barriers, which will be the focus of our improvement efforts next year

Comment

We have recruited a student volunteer to follow up with patients enrolled in the Weight Management program who received the initial screening letter in their welcome package. The student will contact these patients to determine whether they have arranged for recommended preventive screening.

Indicator #7

Percentage of screen-eligible people who are up to date with breast screening (Southlake FHT)

Last Year		This Year		
69.70	**73**	**68.80**	**-1.29%**	**70**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Expand the Weight Management Program to include a workflow stream to book preventative screening appointments with their primary care physician.

Process measure

- Number of patients who accept a preventative care follow up appointment after being offered one

Target for process measure

- 100% of patients enrolled in the weight management program who are overdue for breast screening will be offered a preventative screening appointment with their primary care physician.

Lessons Learned

Using a template provided by the Central Cancer Regional Program, we create customized letters for patients who are overdue for screening and include the Ontario Breast Screening Program's direct booking number. This information is also incorporated into the Weight Management welcome package, and physicians reinforce the importance of screening during the initial assessment, particularly for higher-risk populations such as individuals with obesity.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Expand the Weight Management Program to include a resources and education materials related to cancer screening and prevention

Process measure

- Percentage of eligible patients who receive cancer screening education materials during weight management program intake

Target for process measure

- 100% of eligible patients receive educational materials before their first follow up appointment with the weight management specialist in the Weight Management Program

Lessons Learned

We are currently assessing the effectiveness of including the screening letter in the welcome package. Our next PDSA cycle will incorporate additional educational materials to further support patient understanding of screening.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Update all preventative screening forms and tools in the EMR system with current guidelines

Process measure

- Percentage of preventative screening forms and tools reviewed and updated to align with current clinical guidelines.

Target for process measure

- 100% of preventative screening forms and tools reviewed and updated by Q2

Lessons Learned

Our preventative toolbars and EMR queries have been updated with the latest guidelines.

Change Idea #4 ☐ Implemented ☑ Not Implemented ☐ In Progress

Use cancer screening dashboards to engage providers with cancer screening initiative

Process measure

- Percentage of providers that accessed their SAR report in the last 6 months. Percentage of physicians signed up for Physician Linked Correspondence (PLC) and percentage of physicians without an assigned delegate.

Target for process measure

- 100% of providers will access their SAR report, sign up for PLC and have an assigned delegate by the end of Q4 2025-2026 fiscal year.

Lessons Learned

This change is no longer within the scope of our initiative. We will instead focus exclusively on individuals with obesity and those enrolled in the Weight Management program.

Change Idea #5 ☑ Implemented ☐ Not Implemented ☐ In Progress

Design a survey to gather data on potential barriers to screening among patients with obesity.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

With support from a student volunteer and a patient partner, we developed a survey for patients with obesity who are overdue for cancer screening. The survey helped identify key reasons for delayed screening, including access related barriers, which will be the focus of our improvement efforts next year

Comment

We have recruited a student volunteer to follow up with patients enrolled in the Weight Management program who received the initial screening letter in their welcome package. The student will contact these patients to determine whether they have arranged for recommended preventive screening.

Access and Flow | Timely | Custom Indicator

Indicator #1

In the last 12 months, patients that were sick and urgently needed care at Southlake Academic Family Health Team, describe the length of time it took between making the urgent care appointment and receiving care as satisfactory. (Southlake FHT)

Last Year		This Year		
64.00	70	68.20	--	NA
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Optimize the allocation of call center resources to effectively manage call volumes during peak times.

Process measure

- Percentage of peak call times adequately staffed and percentage of calls that reach a busy signal during peak call times.

Target for process measure

- Achieve a 30% reduction in busy signals by ensuring the call center is adequately staffed at least 90% of peak times.

Lessons Learned

Our Office Manager introduced a call-centre overflow process to reduce patient wait times. Each reception pod now has additional phones with call-centre login capability, allowing administrative staff to support incoming calls during peak periods. This flexible staffing model is designed to improve responsiveness, balances workload across the team, and strengthens the patient experience while longer-term staffing plans are developed.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Train staff on efficient phone call handling practices

Process measure

- Percentage of staff members that complete assigned digital training modules

Target for process measure

- All administrators will have completed training modules assigned to them by the beginning of Q2 2025-2026 fiscal year

Lessons Learned

The Office Manager has launched weekly “Admin Elevate” training sessions, providing ongoing refreshers across key administrative processes, including call-centre workflows. These sessions help strengthen consistency, confidence, and overall service quality.

Change Idea #3 ☐ Implemented ☑ Not Implemented ☐ In Progress

Improve Advanced Access for primary care providers with long wait times, as indicated by high third-next-available appointment metrics

Process measure

- Third next available appointments for providers interested in applying advanced access principles.

Target for process measure

- Providers who apply advanced access to their schedules will have a 30% reduction in third next available appointments

Lessons Learned

Distribution of advanced access data sets, including Third Next Available metrics, was paused shortly after Q1 due to resource constraints. The team has since shifted its efforts toward evaluating same-day and next-day appointment slot utilization, with a focus on understanding the effectiveness and efficiency of these slots. These insights will be shared with providers to guide decisions informed by patient booking patterns. Data collection and analysis will remain a priority and will be further developed as part of the 2026–2027 QIP.

Change Idea #4 ☐ Implemented ☐ Not Implemented ☑ In Progress

Enhance urgent care booking and utilization

Process measure

- Percentage of administrative staff across all sites who completed the digital e-learning module for urgent care booking

Target for process measure

- 100% of administrative staff across all sites complete the digital e-learning module for urgent care booking by the end of Q3 in the 2025-2026 fiscal year.

Lessons Learned

Our 2024–2025 QIP introduced an urgent care triage tool to strengthen administrative decision-making and improve booking efficiency. Over the past year, we tracked and flagged appointments that either fell outside the tool's guidance or revealed situations where the tool did not direct patients to the most appropriate provider. These insights will guide refinements to the tool and inform targeted administrative training for the coming year.

Change Idea #5 ☑ Implemented ☐ Not Implemented ☐ In Progress

Align physician preference for appointment types

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

To streamline phone and in-person bookings for our administrative team, we consolidated all provider-specific scheduling preferences into a single, easy-to-use chart. We also aligned these preferences within the EMR so each provider's appointment types and rules are clearly reflected in the system. This improves consistency, supports smoother scheduling, and reduces the learning curve for new staff who book across multiple providers.

Comment

Our team has expanded its phone-traffic analysis to include a broader data set, giving us a clearer view of call patterns and demand. Weekdays average 425 calls, with consistent peak volumes on Mondays and Tuesdays at 9:00 a.m. and shortly after 1:00 p.m. This provides a strong foundation for informed staffing and workflow planning.

We are also tracking average call duration by agent to better align staffing levels with demand and ensure resources are allocated appropriately during high-volume periods. This data-driven approach helps us identify capacity gaps and develop sustainable staffing models rather than relying on reactive adjustments.

To strengthen internal communication, the team is transitioning from PSS instant messaging to MS Teams Channels. Teams now serves as a centralized space for knowledge sharing, group discussions, peer support, quick-reference materials, and team recognition. This shift has improved issue resolution and reduced delays that can extend call times.

Equity | Equitable | Custom Indicator

	Last Year		This Year		
Indicator #3 Percentage of patients that use social assistance with standardized documentation of income status within the electronic medical system (EMR). (Southlake FHT)	**25.00**	**50**	**40.60**	**--**	**NA**
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Increase adoption of the TELUS Health Equity Questionnaire (HEQ) to help capture social assistance and income status in the EMR

Process measure

- Percentage of patients using social assistance with income status documented in the EMR

Target for process measure

- 50% patients using social assistance will have income status documented in the EMR

Lessons Learned

Over 180 responses have been collected this year through email outreach and self-check-in kiosks.

Comment

Our team took part in the University of Toronto DFCM community of practice on the SPARK Tool, a provincial framework for standardized sociodemographic data collection in primary care. The experience strengthened our understanding of how structured equity data can shape strategic priorities, program design, and performance monitoring. We also collaborated with DeepEnd Canada to reinforce leadership alignment, clarify data governance, and establish sustainable training supports. We are now examining whether implementing the SPARK Tool would improve alignment with provincial standards and advance our long-term equity objectives.

Experience | Patient-centred | Custom Indicator

Indicator #6

Percentage of providers who report improved efficiency, clarity, and confidence in referring patients to FHT programs and services over the last 12 months. (Southlake FHT)

Last Year		This Year		
CB	**CB**	**CB**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☑ **Not Implemented** ☐ In Progress

Improve adoption and confidence in use of the FHT Program Navigation Toolbar

Process measure

- Percentage of providers who have used the FHT Program and Services Navigation Tool at least once in the past 12 months

Target for process measure

- 90% of providers will adopt the FHT Navigation Toolbar.

Lessons Learned

The initiative was not implemented this year because stakeholder consultations highlighted the need to reassess the program's overall structure, including its delivery model and referral pathways.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ **In Progress**

Improve time from referral to first appointment for the Mental Health Program

Process measure

- Average number of days between provider referral and the first patient visit

Target for process measure

- Decrease referral wait times for our Mental Health Program by 18% (or equivalent to 1.5 months) by the end of Q3 of 2025-2026 fiscal year.

Lessons Learned

Following our recent QI retreat with the mental health team, we developed a logic model to identify program factors contributing to referral wait times. Our discussion focused on refining referral criteria, exploring alternative care delivery models, and clarifying desired patient outcomes.

Comment

Next year, our efforts will focus on restructuring the program to better address referral volume, clarify discharge criteria, refine care delivery models, define program outcomes, and streamline referral pathways.

Safety | Safe | Custom Indicator

Indicator #5

Percentage of people with Heart Failure (HF) with reduced ejection fraction (HFrEF) and New York Heart Association (NYHA) class II to IV symptoms who are prescribed quadruple therapy (Southlake FHT)

Last Year		This Year		
25.00	**38**	**25.00**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☑ Not Implemented ☐ In Progress

Automate tracking and reduce manual data collection

Process measure

- Percentage of HFrEF patients coded using E2P for heart failure tracking

Target for process measure

- 50% of HFrEF patients are coded using E2P for heart failure tracking

Lessons Learned

We did not implement this change this year. Instead, we concentrated on strengthening engagement with key partners, including our local hospital, the heart function clinic, and FHT providers.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Improve primary care-cardiology coordination

Process measure

- Percentage of patients with HFrEF (NYHA II-IV) managed by cardiologist or seen in heart function clinic that have a appointment with their primary care provider in 12 months

Target for process measure

- 90% of patients with HFrEF (NYHA II-IV) managed by cardiologist or seen in heart function clinic that have a appointment with their primary care provider in 12 months

Lessons Learned

Many heart failure patients under primary care are not on optimal therapy despite having cardiologist oversight. Primary care physicians often defer medication management entirely to cardiologists, who in turn encounter challenges with medication titration due to infrequent follow-ups.

Change Idea #3 ☐ Implemented ☑ **Not Implemented** ☐ In Progress

Enhance provider education and engagement

Process measure

- Percentage of primary care providers attending education sessions

Target for process measure

- 70% of providers complete training and education sessions by the end of Q4 of 2025-2026 fiscal year.

Lessons Learned

We did not implement this change this year. Instead, we concentrated on strengthening engagement with key partners, including our local hospital, the heart function clinic, and FHT providers.

Comment

According to Ontario Health's 2024–2025 NYSS OHT eReport Dashboard, Southlake Health accounts for 53.3% of heart failure–related hospital admissions in the Central region, and our FHT catchment area includes some of the highest utilization rates.

In response, we are collaborating with Southlake, the Ontario Health Team, and the local Heart Function Clinic to address gaps in primary care integration. While the clinic was designed for rapid post-discharge follow-up, challenges have emerged: stabilized patients without a primary care provider remain attached without clear transition plans, some cardiologists continue routine follow-up care, and patients often present with non–heart failure concerns due to limited primary care access.

We are currently collecting aggregate data with key partners to inform the development of a new, integrated heart failure care model and are engaging our local Interdisciplinary Primary Care Team to design a sustainable, team-based approach.

Indicator #4

Percentage of patients with documented POA/SDM who had their decision-maker involved in a care planning discussion or major medical decision (Southlake FHT)

Last Year		This Year		
CB	**CB**	**CB**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☑ **Not Implemented** ☐ In Progress

Increase adoption of the Substitute Decision Maker Toolbar

Process measure

- Percentage of patients with cognitive impairment who have discussed POA/SDM arrangements with their provider

Target for process measure

- 50% of patients with cognitive impairment who have discussed POA/SDM arrangements with their provider

Lessons Learned

We did not implement this change this year. Instead, we are working with our resident physicians on integrating these conversations into routine care and strengthening their approach to Advance Care Planning, including discussions about POA and substitute decision-makers.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ **In Progress**

Develop a easily accessible POA/SDM and advanced care planning resources in the EMR

Process measure

- Percentage of providers trained or informed on the Substitute Decision Maker Toolbar and EMR resources.

Target for process measure

- 100% Percentage of providers trained or informed on the Substitute Decision Maker Toolbar and EMR resources by the end of Q4 of 2025-2026 fiscal year.

Lessons Learned

We are working with our resident physicians on integrating these conversations into routine care and strengthening their approach to Advance Care Planning, including discussions about POA and substitute decision-makers.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ **In Progress**

Allow patients to easily communicate POA/SDM information to the clinic

Process measure

- Number of records of POA/SDM information submitted via patient-initiated digital entries.

Target for process measure

- 80% of patients living with Dementia that have standardized SDM or POA documented on file

Lessons Learned

We are working with our resident physicians on integrating these conversations into routine care and strengthening their approach to Advance Care Planning, including discussions about POA and substitute decision-makers.

Comment

We plan to strengthen POA/SDM practices by creating or adopting a standardized documentation tool, developing consistent discussion resources, and integrating POA/SDM conversations into routine workflows such as CPX forms. This work includes reviewing existing tools, gathering clinician and stakeholder input, updating forms to include all relevant screenings, and establishing clear processes for implementation. We also aim to enable patients to update their POA/SDM information through the self-check-in kiosk and reminder system, supported by workflow design, system testing, and feedback from patients and clinicians.

Indicator #2

Percentage of failed faxes that are identified and resent within 24 hours (Southlake FHT)

	Last Year		This Year		
	80.00	**100**	**82.10**	**--**	**NA**
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Increase the utilization of provincial digital solutions as alternatives to fax

Process measure

- Number of clinicians in the primary care organization who are using eReferral, eConsult OLIS, HRM, e-prescribing

Target for process measure

- 100% of eligible clinicians will have access to provincial digital solutions

Lessons Learned

Our resident physicians are leading a quality improvement initiative to streamline onboarding and access to e-consults. Their work focuses on clarifying the steps required to obtain OTN Hub access and set up delegation. Our team has also applied for DHDR access and expressed interest in restarting e-referral onboarding.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Implement a standardized fax handling workflow

Process measure

- Time between a fax failure and corrective action. As a balance measure, we will also track the average time spent on fax troubleshooting by each designated staff member per week.

Target for process measure

- Starting in Q2, all failed faxes will have corrective action by a designated administrative team member by the end of urgent care.

Lessons Learned

We have introduced a revised workflow in which the evening urgent care receptionist requeues any failed faxes at the end of the day.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Improve monitoring and notification of fax failures

Process measure

- Number of unaddressed failed fax messages in the EMR message inbox. We will also measure the maximum number of failed fax messages in a patient's chart per week.

Target for process measure

- Our aim is to have fewer than 15 failed fax messages in the EMR message box and no more than 3 failed fax attempts per unique fax.

Lessons Learned

The IT and EMR coordinator reviews all failed fax notifications to identify any transmissions that continued to fail overnight.

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

Train staff on efficient fax management practices

Process measure

- Percentage of staff members that complete assigned digital training modules

Target for process measure

- All administrators will have completed training modules assigned to them by the beginning of Q2 2025-2026 fiscal year.

Lessons Learned

Our administrative team has been trained to use the fax control panel, including how to resend faxes, remove items from the queue, and determine next steps when a fax fails multiple times.

Comment

We have introduced a revised workflow in which the evening urgent care receptionist requeues any failed faxes at the end of the day. The following morning, the IT and EMR coordinator reviews all failed-fax notifications to identify any transmissions that continued to fail overnight. This two-step process prevents the buildup of unresolved fax issues and accelerates resolution of common problems such as incorrect fax numbers or outdated addressbook entries.

While Digital First and Patients Before Paperwork remain provincial priorities, primary care teams have limited control over the functionality, integration, and evolution of Ontario’s digital health systems. Because access and enhancements are managed provincially, our ability to optimize workflows and drive meaningful improvements at the practice level is constrained.

The discontinuation of PrescribeIT has increased reliance on fax communication, reinforcing outdated and inefficient processes. Although we continue to manage these workflows responsibly, this shift highlights the need for renewed provincial investment in modern, interoperable digital infrastructure. Clear system-level direction and sustained funding are essential to reduce administrative burden, improve care coordination, and strengthen patient safety across the health system.