



THEME AWARD:

Data & Digital: Enabling Connected, Coordinated, Team-Based Care

Organization	Initiative	Contact Information
Summerville Family Health Team	From Documentation to Decision-Making: Transforming EMR Data into Reliable Primary Care Information for Better Care Today and Stronger Expansion Tomorrow	Andrea Stevens Executive Director
Woodbridge Medical Centre Family Health Team	From Clicks to Care: A One-Stop Digital Workflow That Strengthened Team-Based Diabetes Management	Tiziana Piccinni Executive Director





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NOMINEE(S): Summerville Family Health Team

INITIATIVE: From Documentation to Decision-Making: Transforming EMR Data into Reliable Primary Care Information for Better Care Today and Stronger Expansion Tomorrow

AT A GLANCE

Better data starts long before the dashboard. Summerville Family Health Team is tackling the less-visible work of standardizing how information is entered, coded and reported across six sites, turning its shared EMR into a more reliable source for patient care, quality improvement and future system planning.

THE OPPORTUNITY

Summerville Family Health Team, established in 2007 as one of Ontario's first Family Health Teams, provides care to approximately 50,000 enrolled patients and 7,000 non-enrolled people attached to our physicians. Our patients come from more than 60 cities, primarily Mississauga and Etobicoke, and receive care across six locations connected through one shared EMR, Accuro.

Over the past three years, Summerville Family Health Team has led continuous initiative to improve the accuracy, consistency, and usefulness of clinical and operational information in Accuro. Teams cannot coordinate care effectively, evaluate performance confidently, or plan for population needs if the underlying EMR data are inconsistent. In a configurable EMR such as Accuro, meaningful digital improvement requires more than simply using the

system—it requires shaping data-entry structures, coding practices, workflows, and reporting logic so that information becomes dependable across providers and sites.

WHAT WE DID

Summerville Family Health Team serves a large and diverse population across six clinical sites. To care for this population effectively, teams need accurate information to identify

This work was driven by a critical need: if we want to monitor the quality of our service delivery, advance our quality improvement initiatives, and compare our internal information with Ministry of Health and Ontario Health reporting, then the data in our EMR must be reliable, standardized, and fit for use.

care gaps, track preventive and chronic disease needs, understand sociodemographic patterns, monitor service quality, and coordinate follow-up across providers and locations. Based on our experience, there is also a broader sector issue: a lack of consistent approaches and shared guidelines for data standardization across Family Health Teams, even among organizations using the same EMR. This creates challenges not only within organizations, but across the broader primary care system when teams try to compare performance, share learning, or contribute reliable information to system planning. •

- Reviewed numerous internal reports and examined the underlying data inputs to identify inconsistencies, documentation gaps, and reporting weaknesses in Accuro.
- Worked through multiple groups focused on preventive care, diabetes, sociodemographic data, and information management.
- Reported this work through the Quality Improvement Committee, which includes representatives from all sites, a variety of service providers, management, and Quality Improvement/Decision Support expertise
- Provided quarterly reports to the Board of Directors and 9–11 monthly reports to the working groups and Quality Improvement Committee, elevating data quality as an organizational and governance priority.
- Leveraged strong collaboration between the Family Health Team and Family Health Organization to support alignment and implementation across teams.
- Created standard drop-down menus, standardized key data-entry fields, introduced consistent custom coding guidelines, and limited selected interventions in the data-entry structure to reduce variation and improve reliability.
- Used Excel formulas and Power Query to overcome reporting limitations in Accuro and produce more accurate internal reports that could be compared more meaningfully with Ontario Health and Ministry of Health reporting.
- Developed presentations, training materials, and briefing resources for existing staff, new physicians, locums, and Family Medicine residents to support sustained consistency in documentation. They also highlighted a broader lesson for the sector:

as Ontario expands team-based care and moves toward a more connected primary care digital environment, EMR data standardization within Family Health Teams should be treated as a foundational capability, not only a local workaround.

THE IMPACT

This achievement improved the reliability and consistency of information in Accuro and strengthened Summerville Family Health Team's ability to use primary care data as a meaningful source of truth for care delivery, quality improvement, and accountability.

- Teams now have greater confidence in the data extracted from Accuro for operational planning and quality improvement activities.
- Standardized fields, menus, and custom coding guidelines have reduced variation in how key information is documented across sites and providers.
- Internal reports are more credible and more comparable with Ontario Health and Ministry of Health reporting.
- The initiative has improved the organization's ability to monitor the quality of service delivery and assess quality improvement initiatives with more reliable information.
- Presentations, training, and briefing materials have strengthened shared understanding among staff, physicians, locums, and residents of why documentation quality matters to patient care and system performance.
- Quarterly reporting to the Board and 9–11 monthly reports to working groups and the Quality Improvement Committee have increased organizational accountability for data quality and data stewardship.

By improving the reliability, consistency, and comparability of information in Accuro, Summerville Family Health Team created a stronger foundation for coordinated care, quality improvement, and the future digital maturity of team-based primary care in Ontario.

SUSTAINING AND ADVANCING THE WORK

This is a continuous initiative that began with a stronger organizational focus on data accuracy approximately three years ago and continues to evolve. The initiative is sustainable because it is built on repeatable structures rather than one-time cleanup: agreed-upon coding standards, standardized data-entry fields and menus, defined intervention controls within the EMR structure, routine reporting to working groups, the Quality Improvement Committee, and the Board of Directors, and presentations, training resources, and briefing materials to support onboarding and practice consistency over time. By reporting quarterly to the Board and 9–11 times per year to working groups and the Quality Improvement Committee, the initiative remains visible, measurable, and accountable across clinical, operational, and governance levels.

WHAT OTHERS CAN LEARN

This achievement offers significant learning for other Family Health Teams and primary care organizations. Based on our experience, one of the sector's key gaps is the lack of

consistent approaches and shared guidelines for data standardization across organizations, even among teams using the same EMR. Summerville Family Health Team's work offers a practical model that others can adapt: review reports and underlying data inputs to identify inconsistencies; engage interdisciplinary working groups to understand workflow and documentation issues; standardize coding, fields, menus, and data-entry structures; use practical analytics tools such as Excel formulas and Power Query to improve extraction accuracy; sustain adoption through training, presentations, and onboarding resources; and embed the work in governance structures so data quality becomes part of quality improvement and strategic oversight. This initiative also offers a message for the sector: EMR data standardization within Family Health Teams can serve as an entry point for improving primary care data reliability across Ontario. As the province expands Family Health Teams and builds a more connected digital infrastructure, consistency in how primary care data are entered, structured, and interpreted will become even more important for future planning, evaluation, and accountability.

SPREAD / KNOWLEDGE SHARING

Summerville Family Health Team has already spread this achievement broadly within the organization through presentations, training materials, and briefing resources for existing staff, new physicians, locums, and Family Medicine residents. The initiative was also reviewed and advanced through multiple working groups, the Quality Improvement Committee, and the Board of Directors, creating strong internal spread across sites, roles, and organizational levels. Interprofessional Health Providers (IHPs) have also played a key role in spreading the initiative by reinforcing and communicating documentation standards within the EMR, supporting consistent practices across disciplines, and promoting accurate data entry as part of routine clinical workflows.

In addition, 9–11 monthly reports to working groups and the Quality Improvement Committee have enabled repeated discussion, refinement, and adoption across operational and clinical teams. Because there is no consistently applied approach to EMR data standardization across Family Health Teams—even among teams using the same EMR—Summerville Family Health Team can help lead by sharing practical lessons, approaches, and tools with others. This includes our experience with coding guidance, standardized data-entry fields, governance structures, and practical reporting solutions that improve reliability within a configurable EMR environment. Higher-level organizations, sector leaders, and Family Health Team management need to recognize the importance of the FHT EMR itself as a reliable source of information—not rely only on external sources such as hospital, lab, and OHIP billing data.



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NOMINEE(S): Woodbridge Medical Centre Family Health Team

INITIATIVE: From Clicks to Care: A One-Stop Digital Workflow That Strengthened Team-Based Diabetes Management

AT A GLANCE

Connecting care means making information usable across the team. This initiative uses digital tools and redesigned workflows to strengthen how patient information is captured, shared and acted on, helping providers coordinate care more effectively while reducing friction in day-to-day clinical work.

THE OPPORTUNITY

Woodbridge Medical Centre Family Health Team (WMCFHT) demonstrates effective interprofessional collaboration through the design and use of a shared digital diabetes workflow that supports coordinated action across clinical aids, physicians, billing agent, interprofessional healthcare providers (IHPs), and committee leadership. Rather than building a tool for a single role, the team intentionally designed a

JavaScript-powered PS Suite custom form that reflects the real work of multiple team members and creates a team-based diabetes care workflow. For example, clinical aids needed a standardized way to complete and document foot ulcer risk screening, physicians were manually checking and adding ICD-9 code 250 in the cumulative patient profile (CPP)

The solution was developed as a shared digital infrastructure that gives each role the information and actions they need at the point of care

and spending more time in submitting Q040 bills due to the lack of immediate visibility into K030 and Q040 history.

The broader team was working across disconnected documentation processes.

The solution was developed as a shared digital infrastructure that gives each role the information and actions they need at the point of care. Clinical aids can insert a standardized foot ulcer risk screening and documentation tool in one click. Physicians receive an automatic prompt when ICD-9 coding is missing and can update individualized A1C targets directly within the same workflow. Real-time local EMR data generated through this workflow now informs quarterly performance review and clinical program planning through both the Diabetes Care Committee and the Quality Improvement Committee.

This means the initiative functions not only as a clinical tool, but also as a team-based governance mechanism that supports accountability, learning, and continuous improvement.

WHAT WE DID

WMCFT recognized the needs of its local population by targeting two of the biggest practical barriers in primary care: fragmented diabetes management and inconsistent cancer screening follow-up. The team then addressed those needs with digital workflows that made care more coordinated, more reliable, and easier for patients to access.

In diabetes care, the team built a shared PS Suite workflow that standardized foot ulcer risk screening, flagged missing ICD-9 coding, surfaced billing history, supported A1C target documentation, and helped different team members act from the same workflow.

In cancer screening, the team implemented the Prev Care Toolbar, Ocean eForms, secure messaging, chart review, and annual EMR-to-provincial reconciliation to support colorectal, cervical, breast, and lung screening across the team.

The team also built targeted outreach for **screening-eligible, average-risk, and high-risk patients**, including self-serve booking for cervical screening and tailored outreach for lung screening.

THE IMPACT

WMCFT's digital redesign produced measurable operational gains and clearer system-level value, making the work both effective and replicable. Our team has quantitative results showing time saved, improved screening completion, better outreach efficiency, recovered missing reports, and more reliable data reconciliation.

Success:

- 2,028 minutes of annual time savings across 974 patients, or about 34 clinical hours.
- 23% of reduction in rejected Q040 bills.
- Improved physician uptake (all 12 physicians) of ICD-9 coding.
- Increased satisfaction (pre 78% vs post 97%) among clinical aids using the workflow
- 6% increase in colorectal screening completion from 2024/25 to 2025/26.
- 38% increase in cervical screening appointments from 2024/25 to 2025/26.
- 56% increase in mammograms completed from 2024/25 to 2025/26.
- 32 patients referred to an OLSP site and 141 patients screened between November 2025 and March 2026.
- 2,524 patients contacted through eForms in 2025/26.
- 28% reduction in outreach time per patient in 2025/26.
- 218 missing reports recovered through reconciliation in 2025/26.
- Average of 450 discrepancies identified per physician roster through EMR-to-SAR reconciliation in 2025/26.

SUSTAINING AND ADVANCING THE WORK

WMCFHT sustains this achievement by embedding the digital workflows into committee oversight, using ongoing data review to spot gaps, and adapting the tools as care needs evolve.

The diabetes workflow is not a one-time project; real-time EMR data now feeds quarterly performance review and planning through the Diabetes Care Committee and Quality Improvement Committee.

The cancer screening model is sustained through annual comparison of local EMR data with provincial Screening Activity Report (SAR) data, which helps identify discrepancies, chase missing reports, update the cumulative patient profile, and clean up the roster.

The team continues to use the **Prev Care Toolbar**, Ocean eForms, secure outreach, and standardized documentation across multiple screening programs, rather than treating each workflow as a separate silo.

The colorectal workflow was adapted after the decommissioning of Poppy Bot, showing that the team is able to revise the process when tools or conditions change.

The cancer screening workflow is designed as a replicable blueprint for other primary care teams, which suggests the team is intentionally packaging the model for spread and adaptation.

The team uses patient-reported data and reconciliation findings to refine outreach, improve documentation, and close gaps over time.

The lung screening workflow is still being tuned, including attention to aligning eligibility and risk assessment between primary care and hospital sites, which shows active learning rather than static implementation.

WHAT OTHERS CAN LEARN

This achievement offers significant new learning for other teams because it demonstrates how digital tools can be combined into practical, role-specific workflows that improve screening, documentation, outreach, data quality, and governance. The diabetes and cancer screening initiatives provide reusable processes, including point-of-care decision support, patient-reported digital intake, annual reconciliation, and data-driven performance review, that other primary care teams can adapt to their own settings.

- How to build role-specific workflows that fit the real work of different team members instead of forcing everyone into one generic process.
- How to use patient-reported data, secure messaging, and eForms to improve outreach, documentation, and screening follow-up.
- How to turn local workflow data into governance and planning information for committees and leadership.
- The cancer screening model built around the Prev Care Toolbar, Ocean eForms, secure outreach, and annual data reconciliation.
- The practice of redesigning workflows after disruptions, such as replacing Poppy Bot with a streamlined quarterly process.

SPREAD / KNOWLEDGE SHARING

WMCFHT has taken active steps to spread the achievement by designing the workflows as replicable models, using tools already available in primary care, and adapting the approach for other programs within the organization. The cancer screening work is presented as a blueprint for other teams, while the diabetes workflow is already being considered for expansion into the hypertension intervention program, demonstrating clear intent to scale the learning beyond the original setting.

The diabetes initiative is described as a province-ready solution that other teams can adopt using tools already available in everyday practice.

The cancer screening model spans four programs, which makes it easier to transfer the underlying approach to other chronic disease or preventive care workflows.

The team is using annual reconciliation, standardized documentation, patient-reported data, and point-of-care decision support as reusable methods that can be adapted elsewhere.