Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of new patients/clients/enrolments	P	Number / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	579.00	600.00	A target of 600 (approximately 50 new clients per month) was selected based on 9 months of actual attachment data from 2025/26, during which Langs attached 579 new clients at an average of 64 per month. A conservative floor of 50 per month was chosen to account for seasonal variation (December 2025 was 40) and the completion of the funded attachment initiative that contributed to higher volumes earlier in the year. Langs currently has no active waitlist and is accepting new clients through Health Care Connect and OHT Care Connectors. The OHT stabilization clinic for unattached patients is in development and may increase referral volumes mid-year, but has not been factored into this target given the uncertainty of timing. A target of 600 is achievable under steady-state conditions and will be reviewed for 2027/28 once the stabilization clinic is operational and full-year data is available.	

Change Ideas

Change Idea #1	Monitor and support new client attachment through Health Care Connect and Care Connectors, and contribute to the planning and implementation of an OHT stabilization clinic for unattached patients.		
Methods	Process measures	Target for process measure	Comments
Track the number of new clients attached at Langs each quarter using EMR/BIRT data. New clients referred through Health Care Connect and Care Connectors will be monitored to understand referral volumes and sources. In collaboration with OHT partners, Langs will support planning for a stabilization clinic model for unattached patients, with the goal that patients stabilized through the clinic will be attached to Langs or another primary care organization in the city. Progress reviewed quarterly.	Number of new clients attached at Langs each quarter	At least 150 new clients attached by end of Q1 2026/27 At least 300 new clients attached by end of Q2 2026/27	Langs surpassed its funded attachment target in 2025/26. That funding cycle is complete. Ongoing attachment continues with no active waitlist via Health Care Connect and OHT Care Connectors. Target of 600 reflects a conservative steady-state floor of 50 new clients per month, supported by 9 months of actual data. The OHT stabilization clinic is a longer-term attachment lever being tracked as it develops. Aligns with the Ontario Health Primary Care Action Plan commitment to attach 2 million more people to primary care by 2029

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring	O	% / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	69.00	79.00	Increase from last year/ baseline.	

Change Ideas

Change Idea #1 Review HbA1c monitoring data for T2DM clients. Follow up with overdue clients using a simple outreach process. Explore feasibility of a diabetes vitals clinic to support vitals checks, blood work, and interdisciplinary care.

Methods	Process measures	Target for process measure	Comments
(1) Review and stratify HbA1c data by DEP vs. non-DEP clients. (2) Use a simple process to identify overdue clients and support outreach. (3) Explore feasibility of a diabetes vitals clinic (staffing, workflow, blood work, interdisciplinary care). Progress reviewed quarterly.	% T2DM clients (DEP) with current HbA1c, per quarter % T2DM clients (non-DEP) with current HbA1c, per quarter Vitals clinic feasibility review completed by Q4 2026/27	Monitoring review maintained: Q2 2026/27 Follow-up process in place: Q3 2026/27 Vitals clinic feasibility review complete: Q4 2026/27	Carry-forward. Baseline complete. Focus this year: maintain review process, introduce a follow-up approach for overdue clients, and explore a vitals clinic model.

Measure - Dimension: Efficient

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Staff Reporting Satisfaction with Technology Training and Access to Resources	C	% / Staff	Staff survey / April - March	75.00	85.00	Increase by 10% seems feasible once we have the intranet fully updated and things like the P2P network up and running.	

Change Ideas

Change Idea #1 Maintain and update the digital training repository to keep technology support resources accessible for staff.

Methods	Process measures	Target for process measure	Comments
Review the repository, add or update resources as needed, and make minor improvements based on staff feedback.	Number of repository reviews or updates completed during 2026/27 Number of new or updated training resources added during 2026/27	2+ repository reviews completed during 2026/27 5+ resources added or updated during 2026/27	This keeps the work practical and focused on maintaining what already exists rather than building something new.

Change Idea #2 Implement a simple peer support approach that helps staff identify peer supports for common technology questions.

Methods	Process measures	Target for process measure	Comments
Maintain a list of peer supports and a simple way for staff to request help (e.g. Microsoft Forms, email, or shared file). Reviewed during the year for usage and adjustments	Number of peer supports identified by Q3 2026/27 Number of peer support requests or connections made during 2026/27	Peer support process in place: Q3 2026/27 5+ connections documented by fiscal year-end 2026/27	Keep this intentionally low-tech and light.

Measure - Dimension: Efficient

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Staff Satisfied with Organization-Wide Internal Communications	C	% / Staff	Staff survey / April-March	70.00	80.00	Increase by 10% seems feasible.	

Change Ideas

Change Idea #1 Create and share a monthly departmental data spotlight highlighting key data, trends, or achievements from one department at a time using existing internal communication channels.

Methods	Process measures	Target for process measure	Comments
Develop a simple monthly spotlight format. One department featured at a time via existing channels. Builds on the data eblast work already underway. Format and sequencing reviewed throughout the year based on feedback.	# of data spotlights shared during 2026/27 # of departments featured during 2026/27	Spotlight format developed: Q2 2026/27 At least 8 spotlights shared by fiscal year-end 2026/27	This builds on the data eblast work already underway and shifts it into a more structured monthly spotlight approach that can be continued and refined over time.

Measure - Dimension: Timely

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Patient/client perception of timely access to care: percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted	P	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	59.00	65.00	Target of 65% reflects a modest, achievable increase from 59%. This is a patient-reported measure influenced by individual expectations and perceptions of urgency, making a large jump unrealistic. A 6-point increase supports meaningful improvement while staying realistic.	

Change Ideas

Change Idea #1 Refine the timely access survey questions and dissemination approach to improve data quality, accessibility, and usefulness of results.

Methods	Process measures	Target for process measure	Comments
Survey working group (with PFAC input where feasible) will finalize survey wording, response options, and dissemination methods. Updated survey rolled out across available channels. Response volume reviewed to assess effectiveness.	Number of timely access survey questions reviewed and finalized by Q2 2026/27 Number of survey responses received during 2026/27	Survey finalized: Q2 2026/27 Response volume maintained or improved vs. prior cycle by fiscal year-end 2026/27	This work is already underway, so the focus is on finalizing and using what has already been developed.

Change Idea #2	Review how Online Appointment Booking is currently being used, including the reasons available for booking, appropriateness of those reasons, lead time to online booking, and opportunities to expand or improve the patient booking experience.		
Methods	Process measures	Target for process measure	Comments
(1) Review and assess OAB booking reasons for appropriateness and gaps. (2) Review online booking lead time. (3) Explore whether co-booking or expanded OAB features can be trialed. Findings shared internally.	Completion of a review of Online Appointment Booking reasons and appropriateness by Q3 2026/27 Completion of a review of online booking lead time by Q3 2026/27 Completion of an assessment or trial decision related to co-booking or expanded Online Appointment Booking features by Q4 2026/27	OAB reasons and lead time review complete: Q3 2026/27 Decision on co-booking or expanded OAB features made: Q4 2026/27	All clinicians are already set up for OAB, so this year's focus is less about implementation and more about optimizing how the tool is configured and used.

Measure - Dimension: Timely

Indicator #13	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen-eligible people who are up to date with colorectal tests	O	% / PC organization population eligible for screening	EMR/Chart Review / Q2 2025 (covering 2 years of participation for FIT and 10 years of participation for flexible sigmoidoscopy or colonoscopy up to September 2025)	64.93	70.00	Increase from last year.	

Change Ideas

Change Idea #1 Use automated outreach to identify patients overdue for colorectal cancer screening and support follow-up through an established outreach process.

Methods	Process measures	Target for process measure	Comments
Maintain the current automated outreach process to identify patients overdue for colorectal screening. Outreach activity will be reviewed quarterly to monitor whether flagged patients are being contacted and to identify any follow-up needs.	Percentage of patients identified as overdue for colorectal cancer screening who receive automated or documented outreach each quarter	At least 75% of patients identified as overdue for colorectal cancer screening will receive automated or documented outreach by Q3 2026/27	Carry-forward item. Focus is on maintaining the current outreach process rather than introducing new complexity.

Measure - Dimension: Timely

Indicator #14	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen-eligible people who are up to date with cervical screening	O	% / PC organization population eligible for screening	EMR/Chart Review / Q2 2025 (covering 42 months of participation for cytology (Pap) testing, and 66 months of participation for HPV testing up to September 2025)	66.34	70.00	Increase from last year.	

Change Ideas

Change Idea #1 Use automated outreach to identify patients overdue for cervical cancer screening and support follow-up through an established outreach process.

Methods	Process measures	Target for process measure	Comments
Maintain the current automated outreach process to identify patients overdue for cervical screening. Outreach activity will be reviewed quarterly to monitor whether flagged patients are being contacted and to identify follow-up needs.	Percentage of patients identified as overdue for cervical cancer screening who receive automated or documented outreach each quarter	At least 75% of patients identified as overdue for cervical cancer screening will receive automated or documented outreach by Q3 2026/27	Carry-forward item. This should remain a maintenance-focused screening indicator

Measure - Dimension: Timely

Indicator #15	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen-eligible people who are up to date with breast screening	O	% / PC organization population eligible for screening	EMR/Chart Review / Q2 2025 (covering 2 years of participation for mammography up to September 2025)	64.04	70.00	Increase from last year.	

Change Ideas

Change Idea #1 Use automated outreach to identify patients overdue for breast cancer screening and support follow-up through an established outreach process.

Methods	Process measures	Target for process measure	Comments
Maintain the current automated outreach process to identify patients overdue for breast screening. Outreach activity will be reviewed quarterly to monitor whether flagged patients are being contacted and to identify follow-up needs.	Percentage of patients identified as overdue for breast cancer screening who receive automated or documented outreach each quarter	At least 75% of patients identified as overdue for breast cancer screening will receive automated or documented outreach by Q3 2026/27	Carry-forward item. Focus remains on maintaining the existing automated outreach process.

Measure - Dimension: Timely

Indicator #16	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of eligible patients up to date with lung cancer screening	C	% / PC organization population eligible for screening	EMR/Chart Review / April - March	CB	CB	This is a new indicator for Langs. No reliable local data exists yet. Year 1 focus is on establishing a baseline for offered rate and screened rate. A meaningful target will be set once baseline is known and compared to provincial performance.	

Change Ideas

Change Idea #1 Establish a baseline for lung cancer screening offered rate and screened rate, implement EMR documentation for offered/declined, and develop a simple follow-up process for eligible patients.

Methods	Process measures	Target for process measure	Comments
Complete an EMR chart review to identify eligible patients and establish baseline offered and screened rates. A consistent EMR documentation approach will be implemented for recording when screening is offered and when a patient declines. In collaboration with the new local screening partner, a simple referral or outreach process will be developed. Progress reviewed quarterly.	% of eligible patients with documented screened status, per quarter EMR documentation process for offered/declined in place by Q2 2026/27	EMR documentation approach implemented: Q2 2026/27 Baseline offered rate and screened rate established: Q3 2026/27 Quarterly monitoring in place by Q4 2026/27	New indicator. Year 1 is baseline only — no performance target. Aligns with the health promotion and prevention strategic pillar and a new local screening partnership. Documenting offered/declined protects providers from repeated flagging. Target and improvement focus to be confirmed in 2027/28.

Measure - Dimension: Timely

Indicator #17	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of eligible patients up to date with AAA screening	C	% / PC organization population eligible for screening	EMR/Chart Review / April - March	CB	CB	This is a new indicator for Langs. No reliable local data exists yet. Year 1 focus is on understanding current eligible patient volumes and screened rates before setting a target. Target approach in 2027/28 will depend on baseline: if most eligible patients are already screened, a maintenance target is appropriate; if screened rates are low, a time-limited improvement project will be initiated.	

Change Ideas

Change Idea #1	Establish a baseline for AAA screening offered rate and screened rate, implement EMR documentation for offered/declined, and align with Ministry outreach to support eligible patient follow-up.		
Methods	Process measures	Target for process measure	Comments
Complete an EMR chart review to identify eligible patients and establish baseline offered and screened rates. A consistent EMR documentation approach will be implemented for recording when screening is offered and when a patient declines. The team will review Ministry letter outreach timing and coordinate any internal follow-up where feasible. Eligible patient demographics will be tracked to monitor equity in screening rates. Progress reviewed quarterly.	% of eligible patients with documented screening offered status, per quarter % of eligible patients with documented screened status, per quarter EMR documentation process for offered/declined in place by Q2 2026/27	EMR documentation approach implemented: Q2 2026/27 Baseline offered rate and screened rate established: Q3 2026/27	New indicator. Year 1 is baseline only — no performance target. Ministry outreach to eligible patients is already underway, making this a good time to begin monitoring. Documenting offered/declined protects providers from repeated flagging and supports accurate data. Target and improvement approach to be confirmed in 2027/28 based on baseline volume and screened rate.

Equity

Measure - Dimension: Equitable

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Completion of sociodemographic data collection	O	% / Patients	EMR/Chart Review / Most recent consecutive 12-month period	77.40	80.00	Increase from last year.	

Change Ideas

Change Idea #1 Maintain standardized collection of sociodemographic data through the Health Equity Questionnaire at intake, check-in, and targeted email outreach, with a focus on achieving the Alliance target for completion in the 5 core areas of income, gender identity, sexual orientation, race/ethnicity, and education for OPPC clients aged 13+ seen in the last 3 years.

Methods	Process measures	Target for process measure	Comments
Front-line staff offer HEQ at intake and check-in. Quality Coordinator coordinates periodic email outreach. Completion rates for all 5 core fields reviewed quarterly for OPPC clients aged 13+ seen in the last 3 years. Follow-up or reminders provided for lower-completion fields.	Percentage of OPPC clients aged 13+ seen in the last 3 years with completed income data each quarter Percentage of OPPC clients aged 13+ seen in the last 3 years with completed gender identity data each quarter Percentage of OPPC clients aged 13+ seen in the last 3 years with completed sexual orientation data each quarter Percentage of OPPC clients aged 13+ seen in the last 3 years with completed race/ethnicity data each quarter Percentage of OPPC clients aged 13+ seen in the last 3 years with completed education data each quarter	75% completion in each of the 5 core sociodemographic fields for OPPC clients aged 13+ seen in the last 3 years by March 31, 2027	This aligns the work more clearly with the Alliance target. Focus for this year is on maintaining the collection process and improving completion in the 5 core areas.

Measure - Dimension: Equitable

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	81.95	100.00	It is mandatory for all staff.	

Change Ideas

Change Idea #1 Maintain mandatory IDEA-related education through onboarding and annual training opportunities to support staff knowledge and organizational commitments.

Methods	Process measures	Target for process measure	Comments
Track completion of required IDEA training through onboarding and ongoing education. Reviewed quarterly; reminders sent where needed.	Percentage of staff who have completed or are registered for required IDEA-related training each quarter Number of IDEA-related education sessions offered during 2026/27	100% of staff completed or registered for IDEA training by March 31, 2027 4+ IDEA education sessions offered during 2026/27	Straightforward carry-forward item. Current approach can continue with limited change.

Experience

Measure - Dimension: Patient-centred

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Do patients/clients feel comfortable and welcome at their primary care office?	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	90.54	91.00	Maintain this high percentage.	

Change Ideas

Change Idea #1 Continue translation-related work by identifying priority patient-facing materials for translation and reviewing which languages should be prioritized to better support accessible and welcoming care.

Methods	Process measures	Target for process measure	Comments
Review commonly used patient-facing materials and identify priority items for translation. Existing interpreter usage data will inform which languages to prioritize. Progress reviewed during the year.	Number of patient-facing materials reviewed for translation suitability by Q3 2026/27 Number of priority materials identified for translation by Q4 2026/27 Number of languages identified for prioritization by Q4 2026/27	5+ materials reviewed for translation: Q3 2026/27 3+ priority materials and 3+ priority languages identified: Q4 2026/27	This keeps the work simple and actionable for the year while building on earlier language access and interpreter-related work.

Safety

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of faxes sent per 1,000 rostered patients	P	Number of faxes / PC patients/clients	/ Most recent quarter of data available (consecutive 3-month period)	1685.10	1516.59	Try for a 10% decrease in first year of actions.	

Change Ideas

Change Idea #1 Maintain fax volume tracking and promote digital alternatives such as eFax and eReferral to support gradual reduction in fax use.

Methods	Process measures	Target for process measure	Comments
Review outgoing fax volume data, identify high-use areas, and provide guidance on digital alternatives (eFax, eReferral). Progress reviewed during the year.	Number of staff or teams provided with eFax or eReferral guidance during 2026/27 Number of faxes sent per 1,000 rostered patients each quarter	Fax volume tracked all 4 quarters of 2026/27 Digital workflow guidance provided to high-use teams as feasible during 2026/27	Because tracking remains manual and workflow change takes time, this should remain a monitoring and support item rather than a high-pressure reduction target.

Change Idea #2 Review referral types currently sent by fax, identify which are available through eReferral, and update EMR referral workflows to reduce reliance on custom fax-based forms.

Methods	Process measures	Target for process measure	Comments
(1) Identify commonly used referral types available through eReferral. (2) Review and update or remove custom EMR fax referral forms. (3) Replace fax-based forms with EMR messaging directing staff to eReferral. Progress reviewed during the year	Number of referral types reviewed for eReferral availability by Q3 2026/27 Number of EMR custom referral forms removed or updated to direct staff to eReferral by Q4 2026/27	10+ referral types reviewed for eReferral availability: Q3 2026/27 5+ EMR custom referral forms removed or updated: Q4 2026/27	This supports fax reduction by aligning EMR workflows with preferred digital referral pathways and reducing reliance on legacy fax-based forms.

Measure - Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
eReferral: Percentage of clinicians within the primary care practice utilizing this provincial digital solution	O	% / Staff	Local data collection / Most recent information available	73.00	90.00	Target of 90% reflects meaningful improvement from 73%. Based on active clinician use, not just tool availability. 90% allows focused follow-up with non-users while recognizing workflow variation.	

Change Ideas

Change Idea #1 Review clinician-level eReferral utilization data and provide follow-up support to clinicians not yet using the tool.

Methods	Process measures	Target for process measure	Comments
Review clinician-level eReferral data quarterly. Non-users identified and offered support (workflow help, training, troubleshooting). Progress reviewed quarterly.	Percentage of clinicians with documented utilization of eReferral each quarter Number of clinicians identified as non-users who are contacted with follow-up support by Q3 2026/27	All clinicians' eReferral status reviewed: Q2 2026/27 100% of non-users receive follow-up support: Q3 2026/27	Carry-forward digital adoption item. Focus is on monitoring and targeted support.

Measure - Dimension: Safe

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
eConsult: Percentage of clinicians within the primary care practice utilizing this provincial digital solution	O	% / Staff	Local data collection / Most recent information available	73.00	90.00	Target of 90% reflects meaningful improvement from 73%. Based on active clinician use, not just tool availability. A 100% target is not realistic given variation in workflow and clinical need. 90% allows focused follow-up with non-users.	

Change Ideas

Change Idea #1 Review clinician-level eConsult utilization data and provide follow-up support to clinicians not yet using the tool.

Methods	Process measures	Target for process measure	Comments
Review clinician-level eConsult data quarterly. Non-users identified and offered support (workflow help, training, troubleshooting). Progress reviewed quarterly.	Percentage of clinicians with documented utilization of eConsult each quarter Number of clinicians identified as non-users who are contacted with follow-up support by Q3 2026/27	All clinicians' eConsult status reviewed: Q2 2026/27 100% of non-users receive follow-up support: Q3 2026/27	Carry-forward digital adoption item. Keep simple and support-focused.

Measure - Dimension: Safe

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
AI Scribe: Percentage of clinicians in the primary care practice utilizing this provincial digital solution	O	% / Staff	Local data collection / Most recent information available	CB	CB	CB	

Change Ideas

Change Idea #1 Review AI Scribe utilization patterns, including high users and low users, to support sustainability planning, change management, and continued advocacy for the tool.

Methods	Process measures	Target for process measure	Comments
(1) Review clinician-level utilization quarterly. (2) Identify high and low users to understand workflow fit and barriers. (3) Use pilot survey findings to inform sustainability and change management planning. (4) Review paid vs. free options based on usage and need.	Percentage of clinicians with documented AI Scribe utilization each quarter Number of clinicians identified as high users and low users reviewed by Q3 2026/27 Completion of a change management or sustainability review for AI Scribe by Q4 2026/27	100% of clinicians will have AI Scribe utilization status reviewed by Q2 2026/27 High and low user review will be completed by Q3 2026/27 A change management and sustainability review will be completed by Q4 2026/27	New indicator. The primary focus this year is sustainability and funding planning, informed by pilot survey findings, utilization patterns, and continued advocacy for the tool.