Theme I: Timely and Efficient Transitions

Measure

Dimension: Timely

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen eligible female patients aged 52 to 69 years who had a mammogram within the past two years.	A	% / PC organization population eligible for screening	OHIP,RPDB, CCO-OCR,CIHI, SDS / April 2020 – March 2021	77.00	78.00	Provincial target is 72%, performance in 20-21 as 68% due to COVID, performance in 21-22 is 77%, marginal increase in target, effort is to maintain	

Change Ideas

Change Idea #1 To ensure eligible clients are aware and following through with mammograms.

Methods	Process measures	Target for process measure	Comments
Process, workflow reviewed and revised with an emphasis on addressing barriers to accessing mammograms.	Workflow reviewed and revised for mammograms. Investigate options with providers about how best to ask about access issues for those who do not get mammograms.	1 recall list workflow reviewed and revised for mammograms. 1 tool created to remind providers to ask about access issues for those who do not get mammograms.	

Measure

Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of female patients aged 23 to 69 years who had a Pap test within the previous three years.	A	% / PC organization population eligible for screening	OHIP,RPDB, CCO-OCR,CIHI, SDS / April 2020 – March 2021	78.00	79.00	Performance data in 20-21 was lower (67 %) due to COVID. Current performance is meeting target. As we resume normal operations we will target to maintain and potentially exceed target.	

Change Ideas

Change Idea #1 Ensure timely and efficient delivery of PAP tests for clients.

Methods	Process measures	Target for process measure	Comments
Refine recall lists for PAP and develop strategies to promote efficient PAP delivery.	Recall system for PAP reviewed and revised if necessary. Investigate efficient delivery of PAP tests for clients.	1 workflow reviewed, revised if necessary and approved by Quality Committee. 1 strategy developed for efficient delivery of PAP tests for clients. (ie. promote PAP month, PAP clinic days etc.)	

Measure **Dimension:** Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen eligible patients aged 52 to 74 years who had a FOBT/FIT within the past two years, other investigations (i.e., flexible sigmoidoscopy) or colonoscopy within the past 10 years.	A	% / PC organization population eligible for screening	OHIP,RPDB, CCO-OCR,CIHI, SDS / April 2020 – March 2021	80.00	62.00	Provincial target is 62%, performance in 20-21 was 70% during COVID, 21-22 performance was 80%	

Change Ideas

Change Idea #1 Ensure eligible clients are up-to-date with colorectal screening.

Methods	Process measures	Target for process measure	Comments
Review and revise recall workflow process, EMR documentation process as necessary.	Workflow reviewed and revised with a focus on EMR documentation to accurately capture client status with colorectal screening.	1 revised workflow created	

Measure **Dimension:** Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of hospital discharges where the client was seen by a primary care provider within 7 days. (CHC specific data)	C	% / Clients	Other / Organizational fiscal year	57.70	60.00	Data is collected by IC/ES for the Alliance. Our data (57%) should be interpreted with caution according to the most recent practice profile.	

Change Ideas

Change Idea #1 Provide staff with a reminder on the process that will support timely 7 day follow up when client is discharged from hospital.

Methods	Process measures	Target for process measure	Comments
Provide reminders to all primary care staff in primary care meeting and using other communication tools.	Quality Committee staff assigned to reminder/training update at primary care meeting.	1 reminder/presentation to primary care staff regarding process for follow up of clients within 7 days of hospital discharge.	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) involve them as much as they want to be in decisions about their care and treatment	P	% / PC organization population (surveyed sample)	In-house survey / April 2021 – March 2022	98.04	99.00	moderate improvement as score is already high	

Change Ideas

Change Idea #1 To maintain the client centered service approach with a focus on including clients in the decision making regarding their care and treatment.

Methods	Process measures	Target for process measure	Comments
Education and communication to staff about client centered care.	Develop and implement an efficient and creative way to remind staff about client centered care/involvement in decision making.	1 strategy for education about client centered care developed and implemented.	Total Surveys Initiated: 51

Measure

Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of clients who respond positively to the client survey question" "Would you recommend this organization to a family or friend."	C	% / Clients	In-house survey / Will follow organization fiscal year	98.00	100.00	This is an indicator that all members of the Durham OHT are asked to collect and has been a standard on our client experience survey	Durham OHT

Change Ideas

Change Idea #1 Ensure this indicator is part of the client experience survey issued twice per year.

Methods	Process measures	Target for process measure	Comments
Implement client experience survey 2 times per year including the question...Would you recommend this service to friends and family.	Refreshed survey delivered twice yearly to the appropriate number of clients to meet accreditation standards.	2 survey periods delivered.	

Measure

Dimension: Patient-centred

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of clients who respond positively to the question: "Do you feel comfortable and welcome at the CHC?"	C	% / Clients	In-house survey / Organizational fiscal year	98.00	90.00	Alliance for Healthier communities data request. Part of our ongoing client experience survey.	

Change Ideas

Change Idea #1 Ensure this indicator is part of the client experience survey issued twice per year.

Methods	Process measures	Target for process measure	Comments
Implement client experience survey 2 times per year including the question...Do you feel comfortable and welcome a the CHC?	Implement client experience survey 2 times per year to the appropriate number of clients to meet accreditation standards.	2 Survey periods delivered.	

Theme III: Safe and Effective Care

Measure

Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system.	P	% / Patients	CAPE, CIHI, OHIP, RPDB, NMS / March 31, 2021	4.40	4.20	data generated by Practice Profile of the Alliance for Healthier Communities	

Change Ideas

Change Idea #1 Ensure the Brock CHC developed best practice for opiode prescriptions is being followed by providers.

Methods	Process measures	Target for process measure	Comments
Create and administer a best practice/evidence based chart audit tool and administer chart audits based on current evidence and best practices.	Audit tool and process created and approved by committee and tested on appropriate client charts across all primary care providers.	1 chart audit tool and process created. I test chart audit administered.	

Measure

Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of client's charts that indicate our individual primary care provider's compliance with the quality of care defined by Brock CHC primary care chart audit.	C	% / Clients	EMR/Chart Review / organization fiscal year	CB	75.00	This is part of accreditation preparations.	

Change Ideas

Change Idea #1 To have a quality of care chart audit tool and process monitored by the staff quality committee.

Methods	Process measures	Target for process measure	Comments
Create a quality of care chart audit tool for all primary care providers that can be implemented consistently across the organization and be managed by the staff quality committee.	1 Quality of Care chart audit tool created. 1 Workflow created that outlines the auditing process.	75% of client charts show evidence of quality of care (as outlined in the audit tool)	Part of Canadian Centre for Accreditation indicators for organizational accreditation.

Measure **Dimension:** Safe

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of clients who reported that the last time they were sick or had a health problem, they got an appointment on the date they wanted.	C	% / Clients	In-house survey / organizational fiscal year	66.00	85.00	new indicator to QIP plan.	

Change Ideas

Change Idea #1 To ensure timely urgent/same day appointments or services for clients who are feeling ill and need to be seen by a primary care provider.

Methods	Process measures	Target for process measure	Comments
To review improved/advanced access practices of other chcs and to make recommendations and changes to our primary care schedules to ensure urgent/same day access meets client needs.	Complete a review of advanced access/urgent/same day practices within the CHC sector. Complete and present recommendations to primary care team for consideration and input and implementation.	1 review report created, summarized, with recommendations 1 plan created to implement recommended change.	

Equity

Measure Dimension: Equitable

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Completion of social demographic data collection. Percentage of active individual clients who had an encounter with the CHC within most recent year and who responded to at least one of the following four socio-demographic data questions: racial/ethnic, disability, gender identity or sexual orientation.	C	% / Clients	EMR/Chart Review / Organizational fiscal year.	CB	65.00	Quality indicator for Alliance for Healthier Communities. Demographic data in chart must be updated every 3 years or as identified by client.	

Change Ideas

Change Idea #1 Ensure updated socio demographic information is in each active clients chart.

Methods	Process measures	Target for process measure	Comments
Update client demographic information for every client seen, where appropriate, over a two year time frame.	Communicate to primary care staff the requirement to updated the social demographics information for active clients. Active client charts are reviewed for updated demographics information.	65% of active client demographics data is updated. 100 % of primary care staff are aware of the required demographic updates.	

Measure **Dimension:** Equitable

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of recommended clients who received or were offered a pap smear in the most recent three year period stratified by income and stratified by racial/ethnic group. (difference between highest and lowest group - 10%)	C	% / Clients	EMR/Chart Review / organizational fiscal year	CB	10.00	Alliance for Healthier Communities Percentage stratified by income and race, base line data collection	

Change Ideas

Change Idea #1 To be able to measure health equity/access for those in racialized groups and low income groups through a stratified data report. The report will reflect those who received or were offered a pap smear in the most recent three year period stratified come and stratified by racial/ethnic group. (difference between highest and lowest group - 10%)

Methods	Process measures	Target for process measure	Comments
Create a stratified report (income/race/ethnic) group for those who received or were offered a pap in the most recent three year period.	Create a report that stratifies by income and race/ethnic group, those who received or were offered a pap in the most recent three year period.	1 Report generated annually and submitted to the Alliance for Healthier Communities.	Alliance for Healthier Communities indicator regarding health equity.