Equity | Equitable | Custom Indicator

Indicator #1

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. (Brock Community Health Centre)

Last Year		This Year	
CB	**65**	**51.60**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ensure updated socio demographic information is in each active clients chart.

Target for process measure

- 65% of active client demographics data is updated. 100 % of primary care staff are aware of the required demographic updates.

Lessons Learned

All new patients have completed demographics.
During COVID updating demographics was difficult due to paper based model.
Investigating electronic demographic collection through PS Suites and Ocean using secure messaging. Focus would be on those without email capacity and how to update their files.

Comment

All new patients have completed demographics.
During COVID updating demographics was difficult due to paper based model.
Investigating electronic demographic collection through PS Suites and Ocean using secure messaging. Focus would be on those without email capacity and how to update their files.

Indicator #10

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%) (Brock Community Health Centre)

Last Year		This Year	
CB	**10**	**X**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

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%)

Target for process measure

- 1 Report generated annually and submitted to the Alliance for Healthier Communities.

Lessons Learned

Data for this indicator is too low for accuracy. The Alliance for Healthier Communities is attempting to create a report in BIRT to assist with this indicator.

Theme I: Timely and Efficient Transitions | Timely | Custom Indicator

Indicator #8

Percentage of hospital discharges where the client was seen by a primary care provider within 7 days. (CHC specific data) (Brock Community Health Centre)

Last Year		This Year	
57.70	**60**	**57.50**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

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

Target for process measure

- 1 reminder/presentation to primary care staff regarding process for follow up of clients within 7 days of hospital discharge.

Lessons Learned

Workflow is in use for appropriate. Timely notification is an issue from all of the hospitals that our clients utilize.

Theme I: Timely and Efficient Transitions | Timely | Additional Indicator

Indicator #11	Last Year		This Year	
Percentage of screen eligible female patients aged 52 to 69 years who had a mammogram within the past two years. (Brock Community Health Centre)	**77** Performance (2022/23)	**78** Target (2022/23)	**91.14** Performance (2023/24)	**--** Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To ensure eligible clients are aware and following through with mammograms.

Target for process measure

- 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.

Lessons Learned

Q3 Data 2022-2023. Workflow created.

Indicator #7

Percentage of female patients aged 23 to 69 years who had a Pap test within the previous three years. (Brock Community Health Centre)

Last Year		This Year	
78	**79**	**87.23**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

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

Ensure timely and efficient delivery of PAP tests for clients.

Target for process measure

- 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.)

Lessons Learned

Q3 data for 2022-2023. Pap recall lists were created and utilized.

Indicator #12

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. (Brock Community Health Centre)

Last Year		This Year	
80	**62**	**92.43**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

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

Ensure eligible clients are up-to-date with colorectal screening.

Target for process measure

- 1 revised workflow created

Lessons Learned

Q3 data 2022-2023.

Theme II: Service Excellence | Patient-centred | Custom Indicator

Indicator #5	Last Year		This Year	
Percentage of clients who respond positively to the client survey question" "Would you recommend this organization to a family or friend." (Brock Community Health Centre)	**98** Performance (2022/23)	**100** Target (2022/23)	**98.88** Performance (2023/24)	**--** Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ensure this indicator is part of the client experience survey issued twice per year.

Target for process measure

- 2 survey periods delivered.

Lessons Learned

Data submitted to Durham Ontario Health Team for the collaborative QIP 2022.

	Last Year		This Year	
Indicator #6	**98**	**90**	**100**	**--**
Percentage of clients who respond positively to the question: "Do you feel comfortable and welcome at the CHC?" (Brock Community Health Centre)	**Performance (2022/23)**	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

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

Ensure this indicator is part of the client experience survey issued twice per year.

Target for process measure

- 2 Survey periods delivered.

Lessons Learned

Question is part of our annual Client Experience Survey.

Theme II: Service Excellence | Patient-centred | Priority Indicator

Indicator #2

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 (Brock Community Health Centre)

Last Year		This Year	
98.04	**99**	**99**	**99**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

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

Target for process measure

- 1 strategy for education about client centered care developed and implemented.

Lessons Learned

Primary care staff are overwhelmed with the state of health care and patient complexity. We did not want to add more to their plate at this time as they met the 99% target.

Theme III: Safe and Effective Care | Safe | Priority Indicator

Indicator #9

Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system. (Brock Community Health Centre)

Last Year		This Year	
4.40	**4.20**	**4**	**4**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

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

Target for process measure

- 1 chart audit tool and process created. I test chart audit administered.

Lessons Learned

Data is from Alliance for Healthier Communities Practice Profile. We internally audit for compliance to our best practice.

Theme III: Safe and Effective Care | Safe | Custom Indicator

Indicator #3

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. (Brock Community Health Centre)

Last Year		This Year	
CB	**75**	**NA**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

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

Target for process measure

- 75% of client charts show evidence of quality of care (as outlined in the audit tool)

Lessons Learned

Audit tool has been created and will be implemented tested in the spring of 2023.

Indicator #4

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. (Brock Community Health Centre)

Last Year		This Year	
66	**85**	**88.76**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

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

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.

Target for process measure

- 1 review report created, summarized, with recommendations 1 plan created to implement recommended change.

Lessons Learned

Changes were made to primary care provider schedules to ensure urgent spots were available. RPN role was utilized to accommodate urgent patients.