Access and Flow

Measure - Dimension: Timely

Indicator #7	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	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	47.00	49.00	Persist in striving to achieve our 2023/2024 target of 49%, surpassing the provincial average of 33.7% (HQO Primary Care System Performance Report 2022).	

Change Ideas

Change Idea #1 Enhance Access and Communication through Optimized Telephone Systems

Methods	Process measures	Target for process measure	Comments
Implement a queue system on the telephone lines to inform patients of their position in line and estimated wait time before connecting with a representative. Include a message in the queue encouraging patients to explore online appointment booking alternatives.	Call queque and OAB message implemented on CHC telephone lines.	Call queque and OAB message implemented on CHC telephone phone lines by June 30th, 2024.	

Change Idea #2 Expand OAB System for Enhanced Patient Access

Methods	Process measures	Target for process measure	Comments
1) Increase Online Appointment Types: Broaden the range of online bookable appointments through the Ocean platform. 2) Enhance OAB Communications: Monitor and adjust the existing communication methods of the Ocean platform to improve interaction between patients and providers.	1) Increase in Online Appointments 2) Reduce No-show Rates	1) Achieve a growth in the number of appointments booked online compared to the previous year by March 31, 2025. 2) Decrease the percentage of appointment no-shows specifically for appointments booked through the OAB system by March 31, 2025.	

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of rostered patients with type 1 or type 2 diabetes receiving multidisciplinary care.	C	% / patients with diabetes, aged 18 or older	EMR/Chart Review / April 2024- March 2025	85.00	95.00	MSAA set target.	

Change Ideas

Change Idea #1 Enhance the diabetes care indicator by addressing documentation gaps and documenting instances of service refusal.

Methods	Process measures	Target for process measure	Comments
1) Perform an audit on patients within the missing percentage to pinpoint variations or gaps in documentation causing discrepancies in the indicator. 2) Develop a systematic approach to document instances when patients refuse, decline, or do not necessitate encounters.	Aim to reach the target corridor of 85% in the multidisciplinary diabetes care indicator.	Ensure that 85% of rostered patients with type 1/type 2 diabetes receive multidisciplinary care by March 31, 2025.	

Measure - Dimension: Timely

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screening eligible clients who received or were offered a mammogram int he previous two years.	C	% / PC organization population eligible for screening	EMR/Chart Review / April 2024 - March 2025	82.00	50.00	MSAA set target.	Cambridge North Dumfries OHT

Change Ideas

Change Idea #1 To Identify patients who are overdue for mammogram testing

Methods	Process measures	Target for process measure	Comments
1. A list of patients who are overdue for mammogram testing will be pulled from EMR quarterly 2. MOA or nurses will be educated on how to find mammogram results in PSS, screening guidelines and eligibility for testing. 3. A Provider Champion will be available to answer questions when they arise about eligibility. 4. When result for Mammogram testing returns providers will send postdated message to medical reception to repeat testing in 2 years.	Quarterly reports will be run in April, July and October and January. Increase in number of eligible women who accept mammogram will increase We will record patients who decline to do mammogram testing for breast cancer in a way that can be tracked	List created and pulled quarterly for dissemnation.	

Change Idea #2 To increase number of patients offered mammogram testing

Methods	Process measures	Target for process measure	Comments
1. Assign a MOA or nurse to contact patients over due for mammogram. 2. MOA or nurse call to offer testing and OBSP information to patient 3. MOA or nurse records mammogram accepted and declined with MSAA tracking button in PSS	Increase in number of patients offered mammogram testing increase in number of mammograms refused recorded in EMR Improve our current performance in Mammogram screening.	Number of clients identified from lists reached out to.	

Measure - Dimension: Timely

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screening eligible clients who received or were offered a PAP test in the previous three years either at or outside the CHC.	C	% / PC organization population eligible for screening	EMR/Chart Review / April 2024-March 2025	78.00	70.00	MSAA set target.	Cambridge North Dumfries OHT, Waterloo Region NPLC, Kinbridge Community Association, Region of Waterloo

Change Ideas

Change Idea #1 Identify patients who are overdue for Cervical Screening in our practice

Methods	Process measures	Target for process measure	Comments
1. Run quarterly list of patients overdue for screening by location. medical receptionists will be educated to review chart for testing results, changing report categories as needed, and how to record MSAA care in EMR. 2. MOA or nurse will contact and offer PAP testing to patients who are due and book appointments when accepted and chart refusals if patient declines. 3. Each location will have a Provider Champion to answer questions when they arise, when result for PAP testing returns providers will send postdated message to medical reception to repeat testing in 3 years.	Number of quarterly reports run per year increase in number of Pap tests offered Increase in % of PAP tests completed.	MSAA screening lists will be run in April, July, Oct, and January. Increase in % of patients with up to date PAP testing.	

Change Idea #2 Contact patients who are eligible and overdue for Cervical screening.

Methods	Process measures	Target for process measure	Comments
Assign a MOA or nurse to contact patients over due for PAP and offer appointment 2. Record PAP test accepted OR declined with MSAA tracking button in PSS 3. Ensure providers use MSAA button to record PAP testing when complete 4.Plan "Pap clinic " day when appropriate	Increase in % of completed PAP tests Increase in patients contacted to arrange PAP testing Patients who decline PAP testing will be recorded in chart in a way it can be captured	Number of clients identified from list and reached out to.	

Measure - Dimension: Timely

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage screening eligible clients who received or were offered a FOBT/FIT in the previous two years.	C	% / PC organization population eligible for screening ongoing primary care CHC clients aged 50 to 74	EMR/Chart Review / April 2024-March 2025	79.00	60.00	MSAA set target.	Cambridge North Dumfries OHT

Change Ideas

Change Idea #1 To Identify patients who are overdue for FOBT/FIT

Methods	Process measures	Target for process measure	Comments
1) Adapt the role of medical receptionists to review lists, review charts, and contact patients to offer colon screening. 2) MOA or nurse contacts the provider through messaging for a requisition for FIT when accepted, confirming healthcare and address details with the patient. 3) Provider tracks the acceptance of FIT testing with the MSAA tracking button and in the Encounter form. MOA or nurse will record the refusal of screening with the MSAA tracking button.	Lists will be pulled and reviewed over each quarter Increased number of patients offered screening increased % of patients with up to date colon screening.	Number of clients identified from lists reached out to quarterly.	

Measure - Dimension: Timely

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of target panel size achieved.	C	% / PC patients/clients	EMR/Chart Review / April 2024 - March 2025	86.00	95.00	MSAA set target.	

Change Ideas

Change Idea #1 Run a list of patients who are overdue (has had no encounter in the last 3 years) as per the panel size calculation and have nurse call patient to schedule an appointment.

Methods	Process measures	Target for process measure	Comments
Run list of patients overdue for an encounter. Provide list to nursing staff and have them call clients to reach out for check in and offer an appointment.	Increase in panel size percentage to achieve target corridor.	Increase panel size percentage to hit target corridor of 85% by March 31, 2025.	

Equity

Measure - Dimension: Equitable

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Completion of sociodemographic data collection	O	% / Patients % of ongoing primary care clients at CHC	EMR/Chart Review / Most recent consecutive 12-month period	44.00	75.00	Target set by the Alliance to have the completeness and quality of data recorded in your EMR for five key sociodemographic variables: income, education, racial/ethnic origin, gender identity, and sexual orientation with a goal of all member organizations having a 75% data completion rate by 2024.	

Change Ideas

Change Idea #1 Review and standardize process of collecting sociodemographic data in EMR.

Methods	Process measures	Target for process measure	Comments
Continue work from the Rapid Access Learning Initiative (RALI) for Sociodemographic forms. 1) Implement and sustain new process at North Dumfries site expand to all clinicians and multiple days a week. Use Ocean to automatically send out the forms. 2) Spreading and pilot the initiative at Langs main site - start with one med sec and one to two clinicians. Med sec to automatically send out forms during pilot.	Track the completion rate of sociodemographic forms and aim for a sustained increase in the run chart, indicating a positive shift in the completion trend.	Achieve a consistent upward trend in sociodemographic form completions, surpassing the average daily completion rate, as reflected in the run chart by September 30, 2024.	We anticipate several challenges as we update the sociodemographic form to incorporate new Alliance questions while ensuring a balance in vacancies within medical secretary roles, which are crucial to this process. Additionally, we continue to encounter resistance from community service participants who might not see the relevance of these questions to the program they are attending.

Measure - Dimension: Equitable

Indicator #5	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	76.92	100.00	Seeing that IDEA 101 and Spectrum Rainbow training are mandatory for all staff and Indigenous cultural competency training is mandatory for all leadership, goal of 100% is feasible.	

Change Ideas

Change Idea #1 Continue IDEA (Inclusion, Diversity, Equity and Access) workshops and training offerings

Methods	Process measures	Target for process measure	Comments
Continue to keep mandatory the IDEA 101 and Spectrum Rainbow Diversity training for all staff and Indigenous Cultural Competency training for leadership. Continue to develop and offer workshops for staff such as Microaggressions and Power and Privilege. Continue to review and modify images and language in public-facing materials and those displayed in the primary care office are inclusive and representative of the population.	Percentage of all staff who have completed or are signed up to complete the mandatory trainings. Number of workshops run.	100% of all staff will have completed or be registered to attend the mandatory trainings. We will run 6 rounds of workshops by March 25, 2024.	

Experience

Measure - Dimension: Patient-centred

Indicator #6	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) All clients coming into a Langs site	In-house survey / Most recent consecutive 12-month period	CB	CB	Previous performance and target set at 91%. It is important to note that this survey question was only pulled from community services and not the clinical experience survey as the question was not being collected. Added the question to our client experience survey for CHC mid year to get a better sense of this indicator organization wide. Will continue to roll up CHC and CST data.	

Change Ideas

Change Idea #1 Continue work of the IDEA committee.

Methods	Process measures	Target for process measure	Comments
Make IDEA 101 and Spectrum Rainbow Diversity training mandatory for all staff. Continue to increase patient awareness of IDEA work through website/ patient facing notice and action plan. Continue to develop and offer workshops for staff such as Microaggressions and Power and Privilege. Continue to review and modify images and language in public-facing materials and those displayed in the primary care office are inclusive and representative of the population.	% of staff trained in IDEA 101 and Spectrum Rainbow Diversity foundations. Number of hits on IDEA webpage. Number of workshops conducted.	100% of all staff have been trained or are signed up for mandatory training by March 31, 2025. Increase IDEA webpage by 10% by March 31, 2025. Conduct 6 rounds of IDEA workshops my March 31, 2025.	

Change Idea #2 Promote organization wide using phone and video interpreting services for patients whose preferred language is not English and investigate providing health information in the language of the patient's choice, where possible.

Methods	Process measures	Target for process measure	Comments
Hold a demonstration between Voyce and RIO translation and interpreter services. Choose one services for Langs organizationally.	Demo of both services and how they work to stakeholders who are interested in these services or would benefit from these services. Selection of a vendor for these services.	Hold a demonstration meeting of the two platforms by April 30, 2024. Successfully selection of vendor and hosting of organizational training before September 30, 2024.	

Change Idea #3 Revamp and reintroduce the community survey, now named the Community Connections Survey, organization-wide (previously Your Ticket to Comment).

Methods	Process measures	Target for process measure	Comments
Assemble a working group to refine survey questions, with a specific focus on incorporating questions related to welcome/comfortability and beliefs, traditions, and cultures. Implement the survey through various channels, including paper copies, a website button, tablets at front reception, and QR codes on posters.	Track the total number of completed surveys.	Aim to collect 300 completed surveys by March 31, 2025.	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff who report favourably to the psychological safety section (being comfortable reporting to their manager to say I don’t know, I made a mistake, I disagree, I might be wrong, I have a concern, I have an idea)	C	% / Survey respondents	Staff survey / April 2024-March 2025	79.00	84.00	Align with Health Workforce Innovation Challenge (HWIC) deadline of June 2024 - set a practical and achievable targeting increasing form baseline.	

Change Ideas

Change Idea #1 Provide leadership training on psychological health and safety and assess its impact.

Methods	Process measures	Target for process measure	Comments
1) Schedule and execute training sessions. 2) Evaluate the effectiveness of the training.	1) Achieve 100% leadership attendance at a psychological health and safety webinar/education event. 2) Ensure 100% of leadership staff can identify at least one actionable key takeaway post-training, inspiring effective team leadership.	By June 30, 2024, attain 100% leadership attendance at the psychological health and safety training and 100% of leadership staff can identify actionable takeaways from their workshops.	This work aligns with Health Excellence Canada's Healthy Workforce Innovation Challenge as well as our strategic wellness vision.

Change Idea #2 Evaluate and respond to engagement and psychological safety survey outcomes.

Methods	Process measures	Target for process measure	Comments
Establish a dedicated action group to analyze and implement decisions derived from survey findings.	Confirm the successful formation of the survey action group.	Successful creation of engagement survey action group and first meeting held by June 30, 2024.	Attain the successful establishment of the engagement survey action group, with the inaugural meeting conducted by June 30, 2024.

Measure - Dimension: Effective

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Staff reporting satisfaction with with technology training and access to resources.	C	% / Staff	Staff survey / April 2024-March 2025	CB	CB	Increase from baseline.	

Change Ideas

Change Idea #1 Centralized Tech Training Repository: Develop a centralized repository for technology-related training materials, tools, and resources accessible to all staff.

Methods	Process measures	Target for process measure	Comments
Collaborate with IT to create an organized repository, categorizing training materials for Access, Teams, PS, Clinical Connect, Info HR, and other relevant technologies	Track the number of staff accessing the repository	25% of staff will have accessed the repository by December 31, 2024.	

Change Idea #2 Tech Learning Suggestion Box: Incorporate a specific section in the suggestion box where staff can express interest in learning more about specific technologies.

Methods	Process measures	Target for process measure	Comments
Integrate the suggestion box feature into existing communication channels, making it easily accessible to all staff.	Monitor the number of tech-related learning suggestions submitted and actioned.	50% of tech-related suggestions have been action by some type of resource (training, documents, peer to peer suport, clinical educator) by June 30, 2024.	

Change Idea #3	Peer-to-Peer Support Network Guide/Map/Call List: Develop a guide or map listing proficient staff members willing to champion and support their colleagues in using specific software.		
Methods	**Process measures**	**Target for process measure**	**Comments**
Identify and approach proficient staff members to participate in the peer-to-peer support network. Create a visible guide or map for easy reference.	Number of staff members identified as peer leaders in technologies and added to a directory shared with staff.	10 staff members identified as peer leaders in technologies and added to a directory shared with staff by September 30, 2024.	

Change Idea #4	Leverage the Clinical Educator Position for Enhanced Efficiency.		
Methods	**Process measures**	**Target for process measure**	**Comments**
Provide support through the clinical educator, concentrating on refining EMR utilization and health care portal proficiency within the clinical team.	Track the count of 1:1 and group sessions conducted.	Achieve ten 1:1 and/or group sessions by March 31, 2025.	Thinking of how to track email and spontaneous interactions related to clinical education. Also how to evaluate effectiveness of the sessions.

Measure - Dimension: Effective

Indicator #3	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 2024-March 2025	CB	CB	Increase from baseline.	

Change Ideas

Change Idea #1 Investigate changing the intranet landing page: Investigate a migration from the current intranet to SharePoint, utilizing already integrated Office 365 tools.

Methods	Process measures	Target for process measure	Comments
Partner with the communications and special events coordinator during the website refresh to integrate the desired features for the intranet. Conduct surveys with staff and committees to collect input on necessary intranet functionalities.	Implement an intranet component survey for staff satisfaction.	Successfully transition from the intranet model to SharePoint by March 2025.	

Change Idea #2 Consolidated Communication Newsletter: Develop an internal newsletter for communication updates, combining content from staff eblast and data eblast.

Methods	Process measures	Target for process measure	Comments
Collaborate with the communications and special events coordinator, IT/Facilities, Data Coordinator, and Langs front reception to refresh visuals and content. Merge staff eblast and data eblast into a streamlined newsletter format for comprehensive communication.	Increase the open rate of the consolidated newsletter or integration of staff eblast and data eblast into the newsletter.	Successful creation and implementation of a communication newsletter (which includes staff and data eblasts) by September 30, 2024	

Change Idea #3 Support staff who cannot attend day of All Staff Meetings

Methods	Process measures	Target for process measure	Comments
Recognize that some staff do not work on Thursdays, leading to missed meetings. Consider recording meetings and posting recording and meeting minutes to intranet/communication site to accommodate different schedules.	Track the number of staff accessing the recorded meetings and/or minutes.	For each all staff meeting, 5% of staff will have accessed the recorded meetings and/or minutes.	