# Access and Flow

## Measure - Dimension: Efficient

| Indicator #3 | 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 | CB | CB | CB | |

### Change Ideas

Change Idea #1 Assess baseline HbA1c monitoring rates among clients with type 2 diabetes, stratified by those engaged with the Diabetes Education Program (DEP) and those not. Identify and address barriers for clients not meeting the indicator, with a focus on OPPC clients not connected to DEP.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Pull a report of all Langs clients with T2DM and HbA1c data from the past 12 months. Stratify data by DEP involvement vs. non-DEP (OPPC) clients. Identify individuals overdue for HbA1c testing. Engage primary care and chronic disease staff to explore barriers and referral opportunities. | % of T2DM clients in DEP who are up to date with HbA1c % of T2DM clients not in DEP who are up to date with HbA1c | Complete baseline stratification by June 2025 Contact 20+ overdue OPPC clients by Q3 | This initiative focuses on understanding internal variation and promoting equity in diabetes care. Although Langs performs well overall on this indicator, this work aims to close potential gaps for clients not currently engaged in structured diabetes education and monitoring support. |

## Measure - Dimension: Timely

| Indicator #15 | 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)<br><br>Active, Ongoing Primary Care Clients | In-house survey / Most recent consecutive 12-month period | 56.09 | 57.00 | While Langs is currently performing above the provincial average at 56%, this indicator is based on patient perception, which can be influenced by individual expectations and understanding of what constitutes an "urgent" need. As such, it can be challenging to drive substantial improvement through system-level changes alone.<br><br>We recognize that some patients may expect same-day appointments for non-urgent concerns, or may be unaware of alternative care options (e.g., phone visits, health advice lines). Therefore, instead of setting an unrealistic target, we aim to sustain or moderately improve our performance through education, better communication, and expanded access options.<br><br>We also review this indicator alongside satisfaction with the appointment time actually received, which helps us better understand access in context and focus improvement efforts where they will be most meaningful for patients. | |

## Change Ideas

| Change Idea #1 | Advance the work of the internal survey working group to improve the accuracy and inclusiveness of timely access data by refining survey questions and optimizing dissemination strategies across Langs sites. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Engage the survey working group to review and revise current survey questions related to timely access. Pilot new survey questions internally and with patient-facing staff for clarity and relevance. Update dissemination plan to increase reach, including mixed methods (in-person, digital, phone). Promote participation across diverse client groups to improve representativeness. | Completion of revised timely access questions. Completion of updated dissemination plan. Total number of client survey responses received. | Achieve a 50% increase in completed survey responses compared to baseline, reaching at least 600 responses by the end of fiscal year 2025/2026. | Survey work is ongoing through the QI survey working group. |

Change Idea #2 Continue to expand OAB System for Enhanced Patient Access

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Expand OAB functionality to the Diabetes Education Program (DEP) and Social Work (SW) teams now that additional Ocean licenses have been secured. Collaborate with clinicians and support staff to identify additional visit types suitable for online booking across teams. Use a placement student to conduct a review of current online booking usage and analyze the reasons patients are selecting for appointments, with the goal of streamlining and standardizing booking options. Update communication channels (e.g., posters, portal banners, front desk scripts) to promote OAB availability. Monitor booking patterns and no-show trends, adjusting offerings as needed. | Number of distinct appointment types available for online booking % of total appointments booked online Completion of review and analysis of online booking reasons # of communication channels updated to promote OAB | Add at least 3 new appointment types to the OAB system (including DEP and SW) by March 31, 2025 Increase % of appointments booked online by 10% over previous year Complete analysis of booking reasons and share findings with teams by end of Q3 Update 4+ communication touchpoints to support OAB promotion | This initiative builds on prior year efforts by expanding OAB to additional teams and using real-time insights from appointment booking data to enhance clarity and efficiency for both clients and staff. Improved access through OAB supports client-centred care and helps reduce avoidable delays in service. |

## Measure - Dimension: Timely

| Indicator #16 | 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 / Most recent information available | 67.68 | 72.00 | While piloting the Poppy Bot - goal to see ~ 5% increase in colorectal cancer screening rates. | |

### Change Ideas

Change Idea #1 Leverage the Poppy Bot tool from the eHealth Centre of Excellence (eCE) to identify patients due for colorectal cancer screening and automate the outreach and follow-up process.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Work with the eHealth Centre of Excellence to implement the Poppy Bot for automated cancer screening follow-up | % of flagged patients contacted through automated outreach | Reach 75% of eligible patients due for colorectal cancer screening via Poppy Bot automation by Q3 | We are above CHC provincial average for screening but seeing if using the Poppy bot can increase rates as well as perhaps reduce admin burden. |

## Measure - Dimension: Timely

| Indicator #17 | 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 / Most recent information available | 70.84 | 75.00 | While piloting the Poppy Bot - goal to see ~ 5% increase in cervical cancer screening rates. May be difficult this year with changes from PAP to HPV test creating data pull inconsistencies. | |

### Change Ideas

Change Idea #1 Leverage the Poppy Bot tool from the eHealth Centre of Excellence (eCE) to identify patients due for cervical cancer screening and automate the outreach and follow-up process.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Work with the eHealth Centre of Excellence to implement the Poppy Bot for automated cancer screening follow-up | % of flagged patients contacted through automated outreach | Reach 75% of eligible patients due for cervical cancer screening via Poppy Bot automation by Q3 | We are above CHC provincial average for screening but seeing if using the Poppy bot can increase rates as well as perhaps reduce admin burden. |

## Measure - Dimension: Timely

| Indicator #18 | 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 / Most recent information available | 60.18 | 65.00 | While piloting the Poppy Bot - goal to see ~ 5% increase in breast cancer screening. | |

### Change Ideas

Change Idea #1 Leverage the Poppy Bot tool from the eHealth Centre of Excellence (eCE) to identify patients due for breast cancer screening and automate the outreach and follow-up process.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Work with the eHealth Centre of Excellence to implement the Poppy Bot for automated cancer screening follow-up | % of flagged patients contacted through automated outreach | Reach 75% of eligible patients due for breast cancer screening via Poppy Bot automation by Q3. | Focusing more so on this indicator because we are below Ontario CHC average for screening rates. |

## Measure - Dimension: Timely

| Indicator #19 | 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 2025- March 2026 | 71.00 | 95.00 | Target set through MSAA's. | |

### Change Ideas

**Change Idea #1** Continue outreach to clients who are overdue for care (no encounter in the last 3 years) as part of the strategy to improve panel size accuracy and re-engage inactive patients.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Run EMR reports to identify clients with no visit in the past 3 years Provide lists to nursing staff or admin team Call clients to offer check-ins and encourage re-engagement with their provider Track appointment uptake and panel updates | Number of clients identified as overdue Number of clients contacted and reached | Increase panel size percentage by 10% by March 31, 2026. (81%) | This approach builds on last year's strategy to reconnect with inactive clients and supports ongoing improvements to roster accuracy and access. |

**Change Idea #2** In response to new expansion funding, balance the intake of new clients from the waitlist with provider availability, ensuring timely intake appointments while maintaining access for follow-ups and same-day needs.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Review and prioritize waitlists regularly based on clinical need Stagger onboarding to align with provider capacity Schedule timely first "meet and greet" appointments with assigned providers after intake | Number of new clients onboarded from the waitlist | Onboard 100+ new clients by fiscal year-end. | This change idea helps operationalize recent expansion funding while ensuring access remains timely and balanced across client types and clinical needs. |

# 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 | EMR/Chart Review / Most recent consecutive 12-month period | 54.00 | 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 Continue to expand and standardize the collection of sociodemographic data across Langs sites using the updated Health Equity Questionnaire (HEQ) form. This year's focus includes a combined approach of targeted email campaigns and proactive in-person collection to capture clients who may be missed electronically.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Deploy periodic email "blitzes" using Ocean to prompt clients to complete the updated HEQ form Implement a standardized process at both Langs and North Dumfries sites for medical secretaries to check HEQ form status at check-in | Both Langs and North Dumfries sites have a documented and active process in place for medical secretaries to check HEQ form status and offer completion via email, tablet, or paper Number of HEQ forms completed via email and in person % of patient charts with completed sociodemographic data | Standardized process implemented at both sites by Q2 Achieve a 21% increase in completed sociodemographic forms compared to baseline by March 31, 2026 to reach the target of 75% in the identified areas (gender, orientation, education, race, income) Offer HEQ form completion to 100% of clients without completed data at intake or check-in | |

## 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 | 81.20 | 100.00 | A target of 100% is achievable, as all staff are expected to complete the required training within the reporting period. Processes are in place to support compliance, including automatic enrollment during onboarding and multiple training offerings throughout the year. | |

### Change Ideas

Change Idea #1 Continue to implement and monitor completion of mandatory IDEA (Inclusion, Diversity, Equity, and Access) training for all staff and leadership. This includes IDEA 101 and Spectrum Rainbow Diversity training for all staff, as well as Indigenous Cultural Competency training required for all members of the leadership team.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Maintain mandatory training requirements and track staff completion status Implement automatic enrollment in IDEA 101 and Spectrum Rainbow Diversity training for all new staff as part of onboarding Offer multiple rounds of required training throughout the year to ensure flexible access | % of staff who have completed or are registered for mandatory trainings Number of IDEA elated workshops delivered annually | 100% of staff will have completed or be registered for all required mandatory trainings by March 31, 2026 | |

## Measure - Dimension: Equitable

| Indicator #6 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Number of events and participants for traditional teaching, healing, or ceremony | O | Count / PC patients/clients | EMR/Chart Review / Most recent quarter of data available | CB | CB | CB | |

### Change Ideas

Change Idea #1 Collect baseline data on culturally relevant events and participation while continuing to grow offerings

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Establish a process for tracking traditional teachings, ceremonies, and healing events in a tracker. Work with the IDEA Committee and partners to identify opportunities for expanded programming. Continue to offer culturally grounded programs such as men's circles, smudging, drum making, and educational offerings rooted in Indigenous knowledge | A standardized tracking process is in place for documenting events and participant counts Number of traditional healing/teaching events held Number of participants attending cultural events | Establish a tracking system and begin collecting baseline data by end of Q2 Offer a minimum of 3 culturally grounded events by March 31, 2026 Engage 2+ community partners annually in event planning and delivery | This is a new indicator and we are currently in the process of establishing baseline data. Langs has a history of offering culturally appropriate programming for Indigenous clients, and this initiative will formalize our tracking while deepening partnerships with Crow Shield Lodge, Healing of the Seven Generations, and our internal IDEA Committee. The work supports ongoing commitments to reconciliation, equity, and culturally safe care. |

# 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 | 87.00 | 90.00 | Langs has set a realistic and achievable target of 90% for this indicator, building on a strong current performance of 87%. | |

### 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, 2026. Increase IDEA webpage by 10% by March 31, 2026. Conduct 4 rounds of IDEA workshops my March 31, 2026. | |

| Change Idea #2 | Implement and promote the use of RIO interpreter services across Langs to support patients whose preferred language is not English. RIO, operated by Access Alliance (a fellow CHC), offers both pre-scheduled and on-demand interpretation via phone or video. Centralizing under RIO simplifies access, supports CHC collaboration, and ensures culturally and linguistically appropriate care. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Finalize internal rollout of RIO interpreter services across all Langs sites Develop and share a staff-facing guidance document on how to access and use RIO for both pre-scheduled and on-demand interpretation Provide training sessions and SharePoint materials to increase awareness and ease of use Promote the availability of interpretation services to clients Identify priority patient education materials for future translation into commonly spoken languages | Completion and distribution of RIO usage guidance to staff Number of staff trained on RIO interpreter service RIO usage metrics across Langs programs Number of patient materials reviewed or selected for translation | RIO guidance finalized and distributed to staff by Q2 Train at least 50 staff across sites by Q3 Achieve a 10% increase in interpreter usage compared to baseline Identify 3 priority education materials for potential translation by Q4 | By continuing our partnership with Access Alliance's RIO service, Langs strengthens its commitment to culturally safe, accessible care while streamlining interpreter access for staff. This initiative ensures that language is not a barrier to care, and aligns with Langs' equity and inclusion goals. |

# Safety

## Measure - Dimension: Effective

| Indicator #1 | 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 2025 - March 2026 | 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 Expand the existing training repository by adding additional tools and improving navigation. Continue to explore integration into the Langs website or intranet for easier access by all staff.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Collaborate with IT and stakeholders to add more technology topics Finalize a user-friendly layout for easy access Track staff access and gather feedback | % of staff who accessed the repository Staff feedback on ease of access and relevance | 60% of staff will have accessed the repository by March 31, 2026 | |

Change Idea #2 Continue development of the P2P network by finalizing a directory, communication strategy, and process for staff to connect with peer supporters.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Finalize and distribute a guide/map of peer champions Clarify how staff can request support (e.g., email, call list, booking link) Use this year to test and refine the model | Number of peer supporters listed Number of support connections made through the network | 10 peer champions identified and directory shared by September 2025 System for requesting support implemented and communicated by Q3 | |

Change Idea #3 Continue using the tech suggestion box or similar channel to identify gaps and provide responsive training.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Keep suggestion tool active and visible Review entries quarterly Respond through clinical educator, peer-to-peer support, or documentation | # of suggestions received and addressed | 100% of suggestions acted on in some way by March 31, 2026 | |

## Measure - Dimension: Effective

| Indicator #2 | 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 2025 - March 2026 | 70.00 | 80.00 | Increase by 10% seems feasible. | |

### Change Ideas

**Change Idea #1** Use this year to continue reviewing and updating the intranet, including SharePoint improvements and a review of communication content, frequency, and access.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Collect informal and survey feedback on intranet usability Update intranet with more accessible layouts, useful links, and fresh content Review at least twice annually with support from the Comms & Special Events Coordinator | Number of intranet reviews or updates completed Staff satisfaction with intranet (via feedback or survey) | Complete 2 formal reviews/updates of intranet content and layout by March 31, 2026 Increase positive responses on intranet satisfaction in annual survey | |

**Change Idea #2** Update and Relaunch Data Eblast as Part of Consolidated Newsletter

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Collaborate with stakeholders to create a single, integrated newsletter Include visuals, data highlights, and updates from operations, QI, and leadership Promote launch through All Staff and internal channels | Newsletter open rate Completion of updated format | Launch new consolidated communication format by September 30, 2025 Achieve an open rate of at least 50% in the first two editions | |

## 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 | O | Number of faxes / PC patients/clients | Other / Most recent quarter of data available (consecutive 3-month period) | CB | CB | CB | |

### Change Ideas

Change Idea #1 Begin collecting baseline data on fax volume and promote the use of digital alternatives, such as EMR-integrated eFax and Ocean eReferral, to reduce overall fax usage. Focus on educating staff and clinicians on how to send documents electronically and streamline referral workflows.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Pull baseline fax volume data for all providers (e.g., number of faxes sent per 1,000 patients) Identify departments or users with high fax volumes Provide training to staff and clinicians on how to eFax directly from the EMR Offer targeted education sessions on how to send referrals through the Ocean eReferral platform Promote tip sheets and guidance through SharePoint, staff meetings, and clinical huddles Monitor fax volume trends over time and identify areas for further support | Number of staff trained on eFax and Ocean eReferral % of clinicians actively using eReferral Total number of faxes sent per 1,000 rostered patients (baseline and follow-up) | Complete baseline fax volume analysis by Q2 Offer resources or training to at least 20 clinicians on eFax and eReferral by Q3 Reduce fax volume by 10% compared to baseline by March 31, 2026 | This change idea supports digital health modernization and aligns with provincial goals to reduce reliance on faxing. Education and improved use of existing tools like eFax and eReferral will reduce administrative burden and improve information exchange. |

## 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 | CB | CB | CB | |

### Change Ideas

Change Idea #1 Begin collecting baseline data on clinician use of provincial digital tools. Identify gaps in tool adoption and engage clinicians who are not currently using the tools. Use this baseline period to collect feedback from providers on usability, barriers, and opportunities to improve adoption and integration into workflows.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Pull usage data from each platform to establish baseline rates by clinician. Identify clinicians who are not currently using the tool. Reach out to those clinicians to support setup, training, and troubleshooting. Conduct short surveys or informal interviews to gather feedback on experience, barriers, and desired improvements. Summarize feedback and share with relevant digital health leads or working groups. | % of clinicians with usage established per platform | Complete baseline data collection and clinician gap analysis by end of Q2. Reach out to 100% of non-users with offer for support. | This is a new area of focus and baseline data is being collected in 2025/26. The initial goal is to understand current adoption, identify clinicians not yet using the tools, and gather feedback to guide future QI initiatives and support planning. |

## 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 | CB | CB | CB | |

### Change Ideas

Change Idea #1 Begin collecting baseline data on clinician use of provincial digital tools. Identify gaps in tool adoption and engage clinicians who are not currently using the tools. Use this baseline period to collect feedback from providers on usability, barriers, and opportunities to improve adoption and integration into workflows.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Pull usage data from each platform to establish baseline rates by clinician Identify clinicians who are not currently using the tool Reach out to those clinicians to support setup, training, and troubleshooting Conduct short surveys or informal interviews to gather feedback on experience, barriers, and desired improvements Summarize feedback and share with relevant digital health leads or working groups | % of clinicians with usage established per platform | Complete baseline data collection and clinician gap analysis by end of Q2 Reach out to 100% of non-users with offer for support | This is a new area of focus and baseline data is being collected in 2025/26. The initial goal is to understand current adoption, identify clinicians not yet using the tools, and gather feedback to guide future QI initiatives and support planning. |

## Measure - Dimension: Safe

| Indicator #11 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| OLIS: Percentage of clinicians within 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 Begin collecting baseline data on clinician use of provincial digital tools. Identify gaps in tool adoption and engage clinicians who are not currently using the tools. Use this baseline period to collect feedback from providers on usability, barriers, and opportunities to improve adoption and integration into workflows.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Pull usage data from each platform to establish baseline rates by clinician. Identify clinicians who are not currently using the tool. Reach out to those clinicians to support setup, training, and troubleshooting. Conduct short surveys or informal interviews to gather feedback on experience, barriers, and desired improvements. Summarize feedback and share with relevant digital health leads or working groups. | % of clinicians with usage established per platform | Complete baseline data collection and clinician gap analysis by end of Q2. Reach out to 100% of non-users with offer for support. | This is a new area of focus and baseline data is being collected in 2025/26. The initial goal is to understand current adoption, identify clinicians not yet using the tools, and gather feedback to guide future QI initiatives and support planning. |

## Measure - Dimension: Safe

| Indicator #12 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| HRM: Percentage of clinicians within 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 Begin collecting baseline data on clinician use of provincial digital tools. Identify gaps in tool adoption and engage clinicians who are not currently using the tools. Use this baseline period to collect feedback from providers on usability, barriers, and opportunities to improve adoption and integration into workflows.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Pull usage data from each platform to establish baseline rates by clinician. Identify clinicians who are not currently using the tool. Reach out to those clinicians to support setup, training, and troubleshooting. Conduct short surveys or informal interviews to gather feedback on experience, barriers, and desired improvements. Summarize feedback and share with relevant digital health leads or working groups. | % of clinicians with usage established per platform | Complete baseline data collection and clinician gap analysis by end of Q2. Reach out to 100% of non-users with offer for support. | This is a new area of focus and baseline data is being collected in 2025/26. The initial goal is to understand current adoption, identify clinicians not yet using the tools, and gather feedback to guide future QI initiatives and support planning. |

## Measure - Dimension: Safe

| Indicator #13 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Electronic Prescribing: Percentage of clinicians within 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 Begin collecting baseline data on clinician use of provincial digital tools. Identify gaps in tool adoption and engage clinicians who are not currently using the tools. Use this baseline period to collect feedback from providers on usability, barriers, and opportunities to improve adoption and integration into workflows.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Pull usage data from each platform to establish baseline rates by clinician. Identify clinicians who are not currently using the tool. Reach out to those clinicians to support setup, training, and troubleshooting. Conduct short surveys or informal interviews to gather feedback on experience, barriers, and desired improvements. Summarize feedback and share with relevant digital health leads or working groups. | % of clinicians with usage established per platform | Complete baseline data collection and clinician gap analysis by end of Q2. Reach out to 100% of non-users with offer for support. | This is a new area of focus and baseline data is being collected in 2025/26. The initial goal is to understand current adoption, identify clinicians not yet using the tools, and gather feedback to guide future QI initiatives and support planning. |

## Measure - Dimension: Safe

| Indicator #14 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Online Appointment Booking: Percentage of clinicians within the primary care practice utilizing this provincial digital solution | O | % / Staff | Local data collection / Most recent information available | CB | CB | Collecting new baseline as we recently onboarded more IHPs. | |

### Change Ideas

Change Idea #1 Begin collecting baseline data on clinician use of provincial digital tools. Identify gaps in tool adoption and engage clinicians who are not currently using the tools. Use this baseline period to collect feedback from providers on usability, barriers, and opportunities to improve adoption and integration into workflows.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Pull usage data from each platform to establish baseline rates by clinician. Identify clinicians who are not currently using the tool. Reach out to those clinicians to support setup, training, and troubleshooting. Conduct short surveys or informal interviews to gather feedback on experience, barriers, and desired improvements. Summarize feedback and share with relevant digital health leads or working groups. | % of clinicians with usage established per platform | Complete baseline data collection and clinician gap analysis by end of Q2. Reach out to 100% of non-users with offer for support. | This is a new area of focus and baseline data is being collected in 2025/26. The initial goal is to understand current adoption, identify clinicians not yet using the tools, and gather feedback to guide future QI initiatives and support planning. |