Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of screen eligible rostered CHC clients aged 50 to 74 years who were offered or received a fecal occult blood test in the previous 2 years, colonoscopy in the last 10 years, sigmoidoscopy within the last 5 years or a double contrast barium enema within the last 5 years.	C	% / Patients	EMR/Chart Review / April 1, 2022- Sep 30, 2022	86.00	74.00	Although we are doing very well with the end results of this indicator we do not have planned, sustainable or long term processes in place to be proactive throughout the year.	

Change Ideas

Change Idea #1 SGBCHC will be focusing on creating process and procedures that will guide the team in the timely execution of tasks that will ensure a sustained year long effort in achieving the goals of this indicator

Methods	Process measures	Target for process measure	Comments
Create a sub committee that will review and analyze the FOBT Screening processes. The Sub Committee will create a formal FOBT screening process/procedure. Procedure will determine what tasks need to be defined, when to be executed and by who. Our goal will be to achieve a steady rate of CRC screening throughout the year while negating the sudden periodic peaks of activity that have happened prior to deadlines. Milestones will be set up to measure attainment of goals. Define the quarterly # of Screening calls, Tests Booked, Test Completed prorated to the QTR and YE targets for this Indicator. Train staff on QIP Indicator definition and Process requirements.	Clinical Team to review milestones quarterly throughout the year for # calls made each month, # of Tests booked, # of Test completed etc. Generate quarterly Reporting on results of milestones. Create Gantt chart or similar project management tool to keep everyone informed and on track. Clinical team to review results quarterly to see if procedure is working as planned. Tweak plan if not achieving desired results.	Create a short term sub committee, comprising of a cross section of Clinical, Admin and Management by end of April 2023. Create formal FOBT Screening Procedure by end of June 2023. Gantt/PM tool in place by end June 2023. 100% of quarterly Milestone # of Calls, tests booked and tests completed.	

Measure

Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
10% of primary health care appointments will be booked online (compared to analog method of appointment booking).	C	% / Patients	EMR/Chart Review / April 2023- June 2023	CB	CB	SGBCHC recently implemented an online booking system for 1:1 Primary Health care appointments so we will need to collect baseline data for this new indicator	

Change Ideas

Change Idea #1 SGBCHC is in the process of implementing an online booking tool so that clients have better access to booking an appointment at any time during the day that they wish.

Methods	Process measures	Target for process measure	Comments
1) Extract data from EMR appointments to identify the volume of online appointments booked 2) Monitor supply/demand data for appointments available/booked online at our website	Increase % of on-line booking Promote on-line bookings usage and monitor adoption rate.	10% of SGBCHC appointments will be made using the online booking tool in 2023-2024	

Change Idea #2 Determine client satisfaction with on-line bookings

Methods	Process measures	Target for process measure	Comments
Survey Clients to gauge degree of satisfaction with their On-line booking experience	1) How easy is it to make the appointments on-line 2) Quantify % 0f appointments made on-line outside of regular CHC business hours	1) Achieve approval rating of 75% 2) 10-20% of on-line bookings made outside CHC open hours	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #3	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 2022 - March 2023	96.55	97.00	Although we have had good past performance (Fall 2021) there has not been a Client Satisfaction survey done since then. Despite doing well with the end results of this indicator we do not have planned, sustainable or long term processes in place to be proactive throughout the year.	South Georgian Bay OHT

Change Ideas

Change Idea #1 SGBCHC will be focusing on creating process and procedures that will guide the team in the timely execution of tasks that will ensure a sustained year long effort in achieving the goals of this indicator

Methods	Process measures	Target for process measure	Comments
Create a sub committee that will review and analyze the Client Satisfaction Survey processes. The Sub Committee will create a formal process/procedure relating to Client Satisfaction Survey. Procedure will determine what tasks need to be defined, when to be executed and by who. Our goal will be to achieve a steady rate of Survey processing throughout the year while negating the sudden periodic peaks of activity that have happened prior to deadlines. Milestones will be set up to measure attainment of goals. Define the quarterly # Survey results prorated to the QTR and YE targets for this Indicator. Train staff on QIP Indicator definition and Process requirements.	Review milestones quarterly throughout the year for # Survey results completed. Generate QTR Reporting on results of milestones. Create Gantt chart or similar project management tool to keep everyone informed and on track. Committee to review results quarterly. Clinical manager will Review to see if procedure is working as planned. Tweak plan if not achieving desired results.	Create sub committee , comprising of a cross section of Clinical, Admin and Management by end of May 2023. Create formal Client Survey Procedure by end of June 2023. Gantt/PM tool in place by end July 2023.	Total Surveys Initiated: 118

Measure

Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Inter-professional Diabetes Care Rate. Patients receiving care from 2 or more providers in last 2 years	C	% / Patients	EMR/Chart Review / April 2022- Oct 2022	80.00	88.00	Will create the opportunity to schedule more appointments for Diabetes patients with more Non-GP/NP providers	South Georgian Bay OHT

Change Ideas

Change Idea #1 Improve the data quality extracted from the EMR to include all approved combinations of 2 or more diabetes related professionals.

Methods	Process measures	Target for process measure	Comments
Create a working group to identify the gaps in current data entry practices, data extraction capabilities along with the root cause barriers to good data interpretation. Create a clearly defined process and data cleaning strategy.	Working group will be identified and have met by end of May 2023. The working group will identify appointment codes required. The SGBCHC DMC will develop a data model and method of extracting client:practitioner appointments by end of Q2. Ensure data is cleaned monthly. Provide staff training on coding.	Percent of no codes and mismatched codes will be reduced by 50% by Q4 2024.	

Theme III: Safe and Effective Care

Measure

Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of female patients aged 21 to 69 years who had or were offered a Pap test within the previous three years.	C	% / Patients	EMR/Chart Review / April 1 2022-Sept 30 2022	89.00	94.00	Although we are doing very well with the end results of this indicator we do not have planned, sustainable or long term processes in place to be proactive throughout the year.	South Georgian Bay OHT

Change Ideas

Change Idea #1 SGBCHC will be focusing on creating process and procedures that will guide the team in the timely execution of tasks that will ensure a sustained year long effort in achieving the goals of this indicator

Methods	Process measures	Target for process measure	Comments
Create a sub committee that will review and analyze the PAP Screening processes. The Sub Committee will create a formal PAP screening process/procedure. Procedure will determine what tasks need to be defined, when to be executed and by who. Our goal will be to achieve a steady rate of PAP screening throughout the year while negating the sudden periodic peaks of activity that have happened prior to deadlines. Milestones will be set up to measure attainment of goals. Define the monthly # of Screening calls, Tests Booked, Test Completed prorated to the QTR and YE targets for this Indicator. Train staff on QIP Indicator definition and Process requirements.	Review milestones monthly throughout the year for # calls made each month, # of Tests booked, # of Test completed etc. Generate Monthly Reporting on results of milestones. Create Gantt chart or similar project management tool to keep everyone informed and on track. Committee to review results monthly. Committee will Review to see if procedure is working as planned. Tweak plan if not achieving desired results.	Create a working group, comprising of a cross section of Clinical, Admin and Management by end of may 2023. Create formal FOBT Screening Procedure by end of June 2023. Gantt/PM tool in place by end July 2023. 100% of Monthly Milestone # of Calls, tests booked and tests completed.	