Access and Flow | Timely | Custom Indicator

	Last Year		This Year		
Indicator #7 Percentage of patients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted. (Oxford County Community Health Centre)	**CB** Performance (2023/24)	**CB** Target (2023/24)	**93.03** Performance (2024/25)	**--** Percentage Improvement (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To achieve our goal of collecting baseline data for our client experience survey metrics, we have re-vamped our client experience survey, and our survey response collection process.

Process measure

- Number of surveys completed per blitz day.

Target for process measure

- 25 surveys completed per blitz day.

Lessons Learned

~20. 203 survey completions in total.
Our idea of doing singular days worked so well that we decided to extend them to week long blitzes (twice), each of which yielded approximately 100 survey completions.

Comment

Our new "blitz" strategy for collecting baseline client experience survey data was incredibly successful. This was paired with a shorter survey to allow for ease of completion (with available support form our staff as necessary). On 'blitz days' medical reception staff handed out surveys to each person who presented to reception - they completed the surveys and deposited them confidentially into our survey box in the waiting area.

Results

Equity | Equitable | Custom Indicator

	Last Year		This Year		
Indicator #3 Percentage of eligible clients who received or were offered a pap smear in the most recent 3-year period, stratified by income & racial/ethnic group. More specifically, the % difference in screening rates between highest and lowest performing groups. (Oxford County Community Health Centre)	**9.30** Performance (2023/24)	**10** Target (2023/24)	**9.30** Performance (2024/25)	**--** Percentage Improvement (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Given the data for 2021-22, we are already meeting the expected standard of less than 10% for this common-QIP indicator. We intend to continue to monitor our performance on this key equity metric to ensure our performance is stable.

Process measure

- Fidelity to quarterly performance monitoring.

Target for process measure

- review and discuss at the end of 4/4 quarters this fiscal year.

Lessons Learned

Providers

Change Idea #2 ☑ Implemented ☐ Not Implemented

Some of our Primary Care Providers trialed downloading lists of their rostered clients (by mining our EMR) who were overdue for a Pap Smear test.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

This resulted in an organized, low-barrier method for calling and offering such tests to clients requiring them. Our hope is that this will support those who experience barriers to care, to access the care they need.

Comment

This year we are considering ubiquitous adoption of the quarterly outstanding list change idea.

	Last Year		This Year		
	27.60	**40**	**NA**	**--**	**NA**
	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Percentage Improvement (2024/25)	Target (2024/25)

Indicator #1

Completion of sociodemographic data collection (% of clients 13+ years old who had an individual encounter with the CHC within the most recent 1-year period who responded to at least one of the four specified sociodemographic questions: racial/ethnic group, disability, gender identity, sexual orientation) (Oxford County Community Health Centre)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1) we have created an extended demographics collection plan

Process measure

- We will check with our providers monthly at all staff meetings to determine how many of them are actively giving the demographic survey to clients.

Target for process measure

- We will aim for 50% to endorse giving out the survey regularly.

Lessons Learned

Uptake by primary care providers was poor, despite reminders. We decided this idea was not working, and that implementing our second change idea would be better.

Change Idea #2 ☐ Implemented ☑ Not Implemented

2) if change idea 1 is unsuccessful, we will have our medical reception staff attempt to collect the information.

Process measure

- We will ensure that 10 scheduled "blitz days" are completed, with at least 25 surveys being completed each day.

Target for process measure

- We will ensure that 10 scheduled "blitz days" are completed, with at least 25 surveys being completed each day.

Lessons Learned

We failed to move beyond the first change idea in the past fiscal year.

Change Idea #3 ☐ Implemented ☑ **Not Implemented**

3) self-serve sociodemographic data collection in our waiting room

Process measure

- Number of surveys completed per month.

Target for process measure

- 25 surveys completed per month.

Lessons Learned

N/A

Comment

We have not yet received our Q4 Sociodemographic Placemat.

Experience | Patient-centred | Custom Indicator

Indicator #6

Percentage of patients who rate their overall experience at our centre as "excellent" or "very good" (5 point likert scale = excellent - very good - good - fair - poor) (Oxford County Community Health Centre)

	Last Year		This Year		
	CB	**CB**	**94.12**	**--**	**NA**
	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Percentage Improvement (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To achieve our goal of collecting baseline data for our client experience survey metrics, we have re-vamped our client experience survey, and our survey response collect

Process measure

- Number of surveys completed per blitz day.

Target for process measure

- 25 surveys completed per blitz day.

Lessons Learned

~20. 203 survey completions in total.
Our idea of doing singular days worked so well that we decided to extend them to week long blitzes (twice), each of which yielded approximately 100 survey completions.

Comment

Our new "blitz" strategy for collecting baseline client experience survey data was incredibly successful. This was paired with a shorter survey to allow for ease of completion (with available support form our staff as necessary). On 'blitz days' medical reception staff handed out surveys to each person who presented to reception - they completed the surveys and deposited them confidentially into our survey box in the waiting area.

Results

	Last Year		This Year		
Indicator #5 Percentage of patients who always feel comfortable and welcome (yes/no) at our centre. (Oxford County Community Health Centre)	**CB** Performance (2023/24)	**CB** Target (2023/24)	**96.57** Performance (2024/25)	**--** Percentage Improvement (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To achieve our goal of collecting baseline data for our client experience survey metrics, we have re-vamped our client experience survey, and our survey response collect

Process measure

- Number of surveys completed per blitz day.

Target for process measure

- 25 surveys completed per blitz day.

Lessons Learned

~20. 203 survey completions in total.
Our idea of doing singular days worked so well that we decided to extend them to week long blitzes (twice), each of which yielded approximately 100 survey completions.

Comment

Our new "blitz" strategy for collecting baseline client experience survey data was incredibly successful. This was paired with a shorter survey to allow for ease of completion (with available support form our staff as necessary). On 'blitz days' medical reception staff handed out surveys to each person who presented to reception - they completed the surveys and deposited them confidentially into our survey box in the waiting area.

Results

Experience | Patient-centred | Priority Indicator

	Last Year		This Year		
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 (Oxford County Community Health Centre)	**CB** Performance (2023/24)	**90** Target (2023/24)	**88.56** Performance (2024/25)	**--** Percentage Improvement (2024/25)	**90** Target (2024/25)

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

To achieve our goal of collecting baseline data for our client experience survey metrics, we have re-vamped our client experience survey, and our survey response collection process.

Process measure

- Number of surveys completed per blitz day.

Target for process measure

- 25 surveys completed per blitz day.

Lessons Learned

~20. 203 survey completions in total.
Our idea of doing singular days worked so well that we decided to extend them to week long blitzes (twice), each of which yielded approximately 100 survey completions.

Comment

We narrowly missed our goal for this performance measure. Our new "blitz" strategy for collecting baseline client experience survey data was incredibly successful. This was paired with a shorter survey to allow for ease of completion (with available support form our staff as necessary). On 'blitz days' medical reception staff handed out surveys to each person who presented to reception - they completed the surveys and deposited them confidentially into our survey box in the waiting area.

Results

Safety | Safe | Priority Indicator

	Last Year		This Year		
Indicator #4 Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system. (Oxford County Community Health Centre)	**5.90** Performance (2023/24)	**3** Target (2023/24)	**NA** Performance (2024/25)	**--** Percentage Improvement (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increasing provider awareness of data collection.

Process measure

- Number of primary care providers aware of the specifics of this QIP indicator

Target for process measure

- 100% (i.e. 5/5)

Lessons Learned

This was discussed at the first several primary care meetings of this fiscal year.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Engaging team-based discussions on methods for decreasing new opioid prescription.

Process measure

- # of primary care team meeting where new opioid prescription is an agenda item

Target for process measure

- 50% (i.e. 6/12)

Lessons Learned

N/A

Comment

Unfortunately, we were unable to gain traction with this indicator because we were not reliably able to measure it. The writer (Director) attempted several times to consult the Alliance for Healthier Communities, and Telus supports for methods to mine this data using the EMR, but were ultimately unsuccessful.