Model of Health and Wellbeing
Evaluation Framework Manual

Equity - Performance - Improvement - Change (EPIC) Learning Health System Steering Committee (Formerly PMC)

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Version Control Information

Version	Author	Approved on	Approved by	Summary of Changes
1.0	RDSSs	August 2014	PMC	Initial Version
2.0	Arron Service	February 2015	PMC	PMC Feedback
3.0	Arron Service	Final Version	PMC	Final Edits
4.0	Nancy LaPlante	September 2018	EL Network	Complete refresh
4.2	Nancy LaPlante	November 2018	PMC	Updates to Vital 8 Wellbeing data fields
5.0	Christine Randle, Brian Sankarsingh, Wendy Banh, Rodney Burns, Catherine Macdonald	January-November 2019	PMC	Review and update – entire document
6.0	Nancy LaPlante	June 2021	EPIC	Added: Appendix 3. Services Provided and Procedures Performed Definitions
7.0	Christine Randle, Catherine Macdonald, Stéphanie Lamothe	December 2024	EPIC	Updates based on 3-year review and to align sociodemographic data fields with new Health Equity Questionnaire.

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Introduction

The Community Health Centre (CHC) Evaluation Framework (the Framework) has been designed in the context of the Model of Health and Wellbeing (MHWB) (Figure 1) which outlines the values and principles that unite Alliance members. The model consists of three values and eight attributes which characterize the programs and services provided by Alliance member centres. A detailed description of the model can be found in Appendix 2.

Figure 1: Model of Health and Wellbeing

A Results-Based Logic Model (RBLM) has been developed to show how member activities and their outcomes are linked to the attributes of the MHWB. The direct outcomes within the RBLM form the basis for indicator development and are used to consistently and accurately measure the indicator specifications for data collection. This model and its relationship to the MHWB is discussed at length in the next section of this document.

This document provides an overview of the Alliance's measurement framework as well as technical specifications of the individual indicators. The overview describes how the framework is organized around the MHWB.

Background

There is a growing demand for better evaluation and performance management in health care. In the past, healthcare reforms were not always based on evidence; progress was often driven by political arguments or the interests of specific professional groups rather than by the results of sound evaluations (Watson, Broemeling, Reid & Black, 2004). Health care organizations need a meaningful way to demonstrate the value of their programs and services to their stakeholders. This requires a common approach to describing the services a centre provides, in order to demonstrate their value. At the provincial level, the common conceptual framework used to do this is the Model of Health and Wellbeing (MHWB), pictured above (Figure 1).

The community-based primary healthcare sector developed this evidence-informed model to describe and guide the delivery of primary health care (Rayner et al., 2018). The model defines health in the same way as the World Health Organization (WHO), as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

The vision of the Alliance is the best possible health and wellbeing for everyone living in Ontario. The MHWB guides us towards this goal by identifying the kind of transformative change that can remove the barriers that keep people and communities from achieving optimal health. It provides a common conceptual framework against which all services can be evaluated. To achieve this, the MHWB incorporates eight attributes that member centres agree are critical components of the community-governed primary health care, health promotion and community development programming they provide. The attributes describe these services as:

1. Interprofessional, integrated and coordinated
2. Anti-oppressive and culturally safe
3. Accountable and efficient
4. Grounded in a community development approach
5. Community governed
6. Based on the determinants of health
7. Population needs-based
8. Accessible.

These attributes are discussed in detail in Appendix 2.

Although it is challenging to distill the services delivered by diverse CHCs across Ontario into a single conceptual framework, and then into a single measurement framework, this effort is critical in helping to understand the collective goal. It also serves as a measurement of progress along the way.

Indigenous Primary Health Care Organizations (IPHCOs) have produced a similar Model of Wholistic Health and Wellbeing with an emphasis on culturally appropriate design. The evaluation framework for this model is distinct and separate from the this evaluation framework (the Framework).

Purpose

The Framework is intended to support ongoing assessment and evaluation of programs and services, serves as the underpinning for more focused investigations, and should be the starting point for conducting evaluations of specific programs. It is recommended that researchers use the Framework as a first step in developing more focused and detailed program-based conceptual models and evaluation frameworks. The Framework is designed to be generic enough to apply broadly across all programs and services and does not provide direct support for detailed evaluation of any single program. Accordingly, it should not be viewed as a program-specific evaluation guide.

For centres looking to evaluate specific services, additional work will need to be completed at the program level. This can be done by first ensuring that programming is evaluable and anchored in a common conceptual framework, then identifying appropriate indicators that might inform program output and outcome measures. The Framework can support these more focused evaluation efforts by providing information on the collective outputs and outcomes that member teams are working towards.

The Framework

The Framework contains a series of discrete but associated components that can be used to evaluate programs and services according to the eight attributes of the MHWB. A separate data entry manual is available.

The Framework is divided into several sections:

1. Results-Based Logic Model (RBLM)
2. Evaluation questions and indicators (process and outcome measures*)*
3. Glossary
4. Acronyms
5. Appendix 1: Indicator data sources
6. Appendix 2: Attributes of the Model of Health and Wellbeing

Evaluation Framework Review Process

The technical specifications are subject to a three-year revision cycle to ensure that the data fields continue to reflect current practice. In June 2023, three working groups were assembled to review the registration data, the individual service event data, and the PDG data. The information provided by these committees was shared with all CHCs requesting feedback on any recommendations. The survey results were reviewed by the Director of Research (Jen Rayner), the Provincial Data Management Coordinator (Christine Randle) and the QIP-L (Stéphanie Lamothe).

Results-Based Logic Model

Results-based logic models (RBLM) represent, in a linear format, the links between resource inputs, activities performed, services delivered, and outcomes achieved. They identify the critical areas that require monitoring, evaluation, and reporting. Deriving evaluation and performance measures from a common conceptual model of service, in this case the Model of Health and Wellbeing, improves the relevance of the (proxy) indicators and ensures that they adequately reflect organizational values.

The RBLM, therefore, serves as the bridge between the conceptual and the operational – in other words, between the Model of Health and Wellbeing and the performance indicators and EMR data entry manual. The RBLM was developed through rigorous consultation with both subject matter experts and literature including:

- Decision-makers at Alliance member centres;
- Decision support specialists and staff at member centres who have expertise in evaluation and performance management;
- Previous logic models developed by Alliance members;
- The results-based logic model for primary care developed by the Centre for Health Services and Policy Research at the University of British Columbia (Watson, Broemeling, Reid & Black, 2004);

- Reviews of the Treasury Board of Canada results-based management accountability framework (2010); and
- The Ontario Ministry of Health and Long-Term Care primary care performance measurement framework (2013).

Figure 2 (below) illustrates the relationship between practice theory (the MHWB), measurement theory (the RBLM), key questions & indicators (Framework), and Data Collection (Laplante & Service, 2015). The full logic model (RBLM) is depicted in Figure 3 (next page).

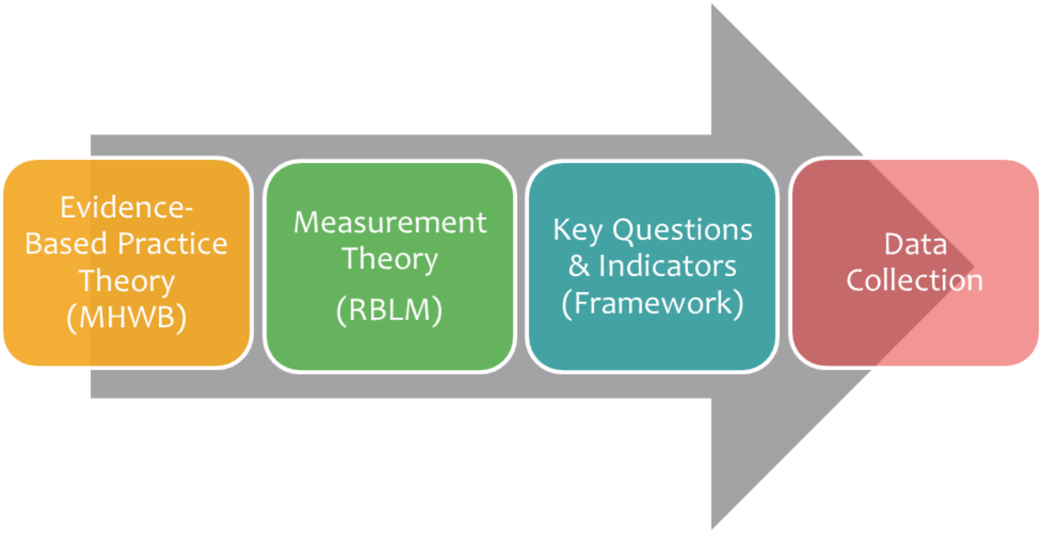

Figure 2: From practice theory to data collection.

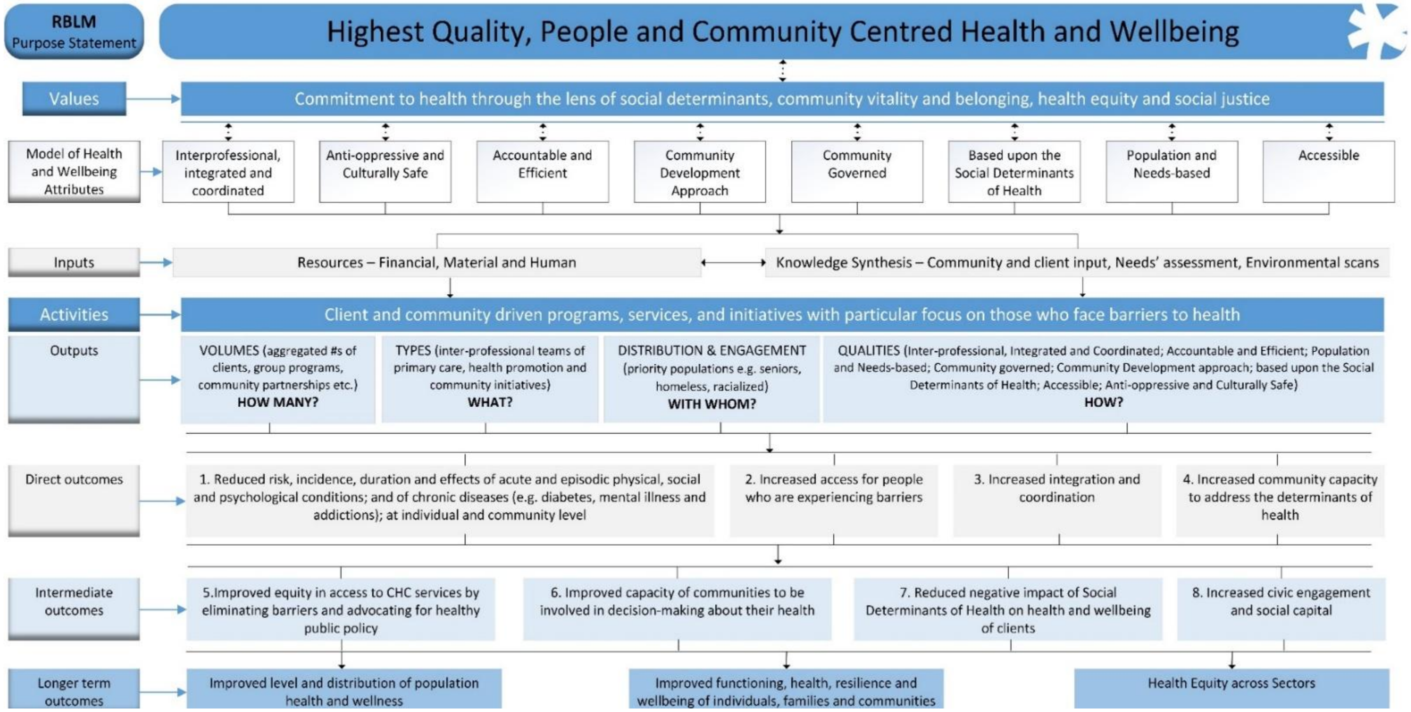

Figure 3: Results-Based Logic Model for evaluating CHC programs and services. Click here to see enlarged version.

Evaluation Questions & Indicators

A critical component of the Framework is the identification of strategic and overarching questions that are intended to guide evaluation activities and approaches. These questions arise from the four direct outcomes of the RBLM. Each direct outcome has a set of performance indicators that enable teams to answer these questions, thereby evaluating their progress towards the direct outcomes of the RBLM.

For example, the second direct outcome in the RBLM is "increased access for people who are experiencing barriers." One of the questions arising from this outcome asks, "Does service integration, coordination in CHCs increase access for people who are experiencing barriers compared to standard care, other models?" Indicators that can help teams answer these questions include the following:

- Among clients whose Preferred Language is not English, the % of encounters for which either the recorded Language of Contact is the same as the Preferred Language, or Interpretation is provided;
- % of community members reporting participation in organized activities, and/or % of clients reporting they never/rarely participate in community events and activities;
- % of clients who always feel comfortable and welcome at [name of CHC]; and
- % of clients who report that their family physician/nurse practitioner is sensitive to their cultural, ethnic and spiritual background and values.

The tables in Appendix 1 list the key questions arising from each of the RBLM direct outcomes and the indicators that can help centres answer these questions. It is important to note there is **not** a one-to-one correspondence between the questions and the indicators; answering each question will require examining the results of several indicators.

Table 1 (below) illustrates the correspondences between each of the RBLM direct outcomes and the attributes of the MHWB. Keeping these correspondences in mind enables us to remember what is ultimately being measured is whether programs and services are delivering on the commitment to the MHWB.

		Attributes of the MHWB							
		Interprofessional, integrated and coordinated	Community development approach	Determinants of Health	Accessible	Accountable and Efficient	Community Governance	Population and Needs-based	Anti-oppressive and Culturally Safe
RBLM Direct Outcomes	Reduced risk, incidence, duration and effects of acute and episodic physical, social and psychological conditions; and of chronic diseases; at individual and community level	✓	✓	✓	✓	✓			
	Increased access for people who are experiencing barriers	✓	✓	✓	✓	✓		✓	
	Increased integration and coordination	✓	✓	✓		✓			
	Increased community capacity to address the determinants of health	✓	✓	✓			✓	✓	

Table 1- Correspondences between the RBLM direct outcomes (rows) and the MHWB attributes (columns*)*

Process evaluation/measures

Process evaluation examines the extent to which program implementation has taken place, the nature of the people being served and the degree to which the program operates as expected.

Outcome (or Impact) evaluation/measures

Measures of **outcome** can take on several levels of complexity. The most elementary level involves the assessment of the condition of those who have received the service – that is, are clients healthier? More challenging evaluations might attempt to demonstrate that receiving program services caused this positive change (Posavac & Carey, 2010).

Indicator Use

Appendix 1 lists the Framework indicators and the data sources for each of them, as well as the key questions these indicators are meant to help answer, organized according to the corresponding direct outcomes of the RBLM. It also spells out the correspondences between the direct outcomes, key questions, and MHWB attributes.

Principles of Good Indicators

To be meaningful, indicators should adhere to the following principles: They should be valid, reliable, sensitive, acceptable, feasible, universal, and inclusive. These seven principles are defined below; collectively, they state that good indicators measure the right things consistently and accurately, in a way that can be understood and accepted; that the process of collecting the data is does not create undue burden; and that the same indicators have consistent meaning in diverse settings. These principles were selected by the Alliance's Provincial evaluation framework indicator validation Working Group, based on work by the Canadian Institute for Health Information (CIHI) (2012), Health Quality Ontario (HQO) (n.d.) and the World Health Organization (WHO) (Campbell, Braspenning, Hutchinson, and Marshall 2008).

- **Valid**: The indicator measures what it is supposed to be measuring.
- **Reliable**: The indicator can produce consistent results each time.
- **Sensitive**: The indicator is sensitive and can measure changes over time or between groups.
- **Acceptable**: The indicator is understandable and credible.
- **Feasible**: The indicator can be collected and managed.
- **Universal**: The indicator can be used with different groups.
- **Inclusive**: An indicator that is developed with more than one group is more likely to be inclusive.

Evaluation Framework Indicator Technical Specifications

This section is a guide to identify the information that should be collected. It also serves to familiarize new staff who are involved in the data-collection process. It is recommended that existing staff review the background and purpose of the Framework. This will help re-orient them to the data gathering context and serve as a reminder to the underlying rationale behind the specific pieces of data being collected.

Individual client information is gathered whenever there is contact with CHC staff that meets the criteria below. Contact warranting documentation is defined as:

- An interaction between an individual client and the provider, for the purpose of receiving individualized service, which justifies a notation in the client's chart.
- An interaction between the centre and a third party which has a direct bearing on either the provision of, or access to, services for the individual client and which justifies notation in the client's chart.

Information is documented for both telephone or other technologies and face-to-face contact with clients and third parties. Each interaction with a provider fulfilling the above requirements requires documentation. Each individual provider should indicate the actions for which they are responsible.

Data collected from clients can be categorized as **mandatory**, **required**, or **optional**. These categorizations are explained in detail below. Each type of information is extremely valuable for the purposes of analysis, and it is important that it is recorded. Three broad categories of individual client information are to be gathered:

- General identifying information.
- Sociodemographic information.
- Information about interactions with the client.

Mandatory (M) versus Required (R) data

Data collected that relates to the Evaluation Framework is classified as either **mandatory** or **required**.

- **Mandatory** data must be collected; a field for mandatory data must not be left blank. The tables below identify the mandatory data that must be collected, coded "M." All Alliance member CHCs collect this data, so members can rely on a robust data set to benchmark against.
- **Required** data is also mandatory when applicable. It must be collected when it is appropriate to do so, but it can be left blank otherwise. For example, if a client was born in Canada, there is no need to enter a date of Arrival to Canada. However, if the client was born outside Canada, then the arrival date is required. Required data are identified as R.

Optional (Op) Data

There are some data fields that are solely dependent on organizational need. These are identified in this document as optional – coded "Op." Members collecting data for these indicators will only be able to benchmark against other members who are collecting data for the same indicators. In some cases, this may be a small subset of their peers.

The process for gathering data is described below, divided into three sections by type of data:

1. **Registration data** – This answers basic questions about **who member centres are serving.**
2. **Individual service event (or Encounter) data** – These are detailed information about the **service or program delivery with providers for individual clients.**
3. **Personal development group (PDG) data** – These are detailed information about **services and program delivery of groups**.

Community Initiative (CI) data is collected separately for CI programs. More information about this can be found in the Community Initiative Resources Tool Online Guide.

Registration Data

When	Usually during the first contact and then updated when a change occurs or at a minimum every two years
Who	Determined by each member centre
How	The Electronic Medical Record
Why	This information helps answer questions such as: • Are members serving their intended populations? • Are members addressing the demographic and other determinants of health?
What	Two types of individual client information should be collected for all registered clients: • General client information • Sociodemographic information for each client

Table 2: Registration Data – Overview

General Identifying Client Information – M

General identifying client information is gathered at the first face-to-face contact with the client if feasible. Members must have enough reliable information to identify individuals. The ability to count every client is vital, as it ensures that all services are properly recorded, and it supports the ability to demonstrate outcomes against the MHWB. Furthermore, when clients are not uniquely identified or are not registered, data quality is adversely affected. As a result, information sent to administrative databases such as the Ontario Healthcare Financial and Statistical (OHFS) database and the Ontario Case Costing Initiative (OCCI) is incomplete, affects how funding is allocated and impedes decision-makers' ability to understand system outcomes.

M	R	
x		Client Name: For individual CHC purposes only – not for province-wide use.
x		Client code (chart) number: A number that uniquely identifies this person; A code number should be assigned (likely automatically by the EMR) whether or not the name and other information is provided
x		Date of birth: yyyy/mm/dd
x		Address: Postal Code. If the client is homeless or no fixed address, organization's postal code can be used
x		Health Card / Insurance Status: OHIP Interim Federal Health (IFH) Aboriginal Non-Insured Health Benefits (NIHB) 3rd party private insurer Other Canadian provincial health insurance Not insured Eligible for OHIP, but do not have card 3 month waiting period Other Prefer not to answer Do not know

Table 3 - General Client Information - Mandatory/Required

Sociodemographic Data

Sociodemographic data helps to better understand the clients that members serve. This data is important when planning programs and services, evaluating the effectiveness of programs and services, and measuring health equity. This information is collected for each client. Typically, members collect this data during the first visit; however, there may be circumstances where this is not feasible.

Each member centre needs to determine the best time for gathering this information while maintaining clients' trust. Information should be updated at subsequent contacts if status on any of the demographics is believed to have changed. At a minimum, all demographic data should be updated every two years.

In 2024, changes to the sociodemographic data fields were largely guided by the *Measuring Health Equity*, launched by Ontario Health. This updated set of questions emerged from the existing *Measuring Health Equity* project and through extensive consultations with the Toronto Region Data Collection, Analysis & Use Community of Practice, the SPARK Study team, subject matter experts, and research literature. The collection of sociodemographic data is set to become mandatory in all healthcare organizations at the provincial level in the spring of 2024.

The following sociodemographic information is to be collected about all individual clients.

- ***Sex assigned at birth - M***

M	R	
x		Female Male Intersex Other Do not know Prefer not to answer

Table 4 - Sociodemographic Data - Sex assigned at birth

- ***Gender Identity – M***

Traditional research acknowledges significant health-related differences between men and women. With increasing recognition of **gender diversity**, there is an emerging consensus healthcare services lack adequate strategies to ensure access to quality health care. At the individual client level, gender identity data can provide information for things such as room assignment or types of tests to plan for. At the aggregate level, this data can be used to understand the health care experiences of vulnerable groups such as transgender clients.

Choose all that apply.

M	R	
x		Man Woman Gender fluid or Gender queer Questioning or unsure Non-binary Two-spirit Other (please specify) Do not know Prefer not to answer

Table 5 - Sociodemographic data - Gender (Identity)

- ***Identify as transgender – M***

Transgender is an umbrella term used to describe people whose gender identity or gender expression differs from the sex they were assigned at birth.

M	R	
x		Yes No Prefer not to answer

Table 6 - Sociodemographic data - Identify as Transgender

- ***Sexual Orientation – M***

2SLGB2Q+ (Two-Spirit, Lesbian, Gay, Bisexual, Queer, and other) populations experience multiple barriers to quality health care, such as social stigma and different health-seeking behaviours. These barriers affect their access to health services and the quality of care they receive. Collecting information about **sexual orientation** can help members address these inequities and assist with healthcare planning at both the individual and aggregate level.

Choose all that apply.

M	R	
x		Straight/Heterosexual Asexual Pansexual Bisexual Queer Demisexual Questioning or unsure Gay Lesbian Same-gender loving Two-spirit Other (please specify) Do not know Prefer not to answer

Table 7 - Sociodemographic data - Sexual Orientation

- ***Ethnic or cultural background – M***

Ethnicity is a concept that attempts to capture socio-cultural identity; it can include place of origin and aspects of culture. Ethnic groups share common identity, heritage, ancestry, or history, often with identifiable cultural, linguistic, and/or religious characteristics. Ethnicity is distinct from racialized group.

M	R	
x		Please specify I don’t know Prefer not to answer

Table 8 - Sociodemographic data - Ethnic or cultural background

- ***Racial group – M***

A social construct used to categorize and classify groups of people based on observable physical traits. These categories often carry cultural, historical, and societal significance, influencing perceptions, opportunities, and interactions.

Significant differences have been noted between racialized groups and white Canadians, even when controlling for gender, age, immigrant status, income and education. Capturing data about **racial or ethnic group** helps members and decision-makers in their population healthcare planning efforts and enables them to address health equity gaps.

Choose all that apply.

M	R	
x		White (e.g., European descent) Black (e.g., African, Afro-Canadian, Afro-Caribbean, Afro-Egyptian etc.) Latin American (Hispanic or Latin American descent) East Asian (e.g., Chinese, Korean, Japanese, Taiwanese, etc.) South Asian (e.g., Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan, etc.) Southeast Asian (e.g., Filipino, Vietnamese, Cambodian, Thai, Indonesian, etc.) Middle Eastern, Arab or West Asian (e.g., Afghan, Egyptian, Iranian, Lebanese, Persian, Turkish, Kurdish, etc.) Not Applicable (Identify as First Nations, Metis or Inuk/Inuit) Other Do not know Prefer not to answer

Table 9 - Sociodemographic data - Racial group

- ***Identify as First Nations, Métis and/or Inuk/Inuit – M***

M	R	
x		Yes, First Nations (status or non-status) Yes, Métis Yes, Inuit No I don't know Prefer not to answer

Table 10 - Sociodemographic data - Identify as First Nations, Métis, or Inuit

- ***Country of Origin and Year of Arrival – M***

Newcomers to Canada have different health outcomes and healthcare needs than other Canadians and, for the first few years after arrival, have lower mortality rates, a phenomenon known as the *Healthy Immigrant Effect.* However, this effect declines significantly within two to five years of arrival in Canada. Moreover, the diversity of the newcomer population means individual health needs vary, so it is important to track each client's country of origin and time since arrival in Canada (Ng, 2011).

M	R	
x		*List of >100 countries provided in EMR software.* *If response is not "Canada", enter the year of arrival to Canada.*

Table 11 - Sociodemographic data - Country of Origin and Year of Arrival

- ***Homeless status – R***

Many organizations receive specific funding for homeless or under-housed clients. This data field supports the capture of this data.

M	R	
	x	Homeless / no address Shelter Other temporary

Table 12 - Sociodemographic data - Homeless status

- ***Inclusive Definition of Francophone – M***

Preferred Language of Service is not the same as **Mother Tongue**. Significant barriers to access exist for this linguistic group, and not all member centres have the capacity to provide service in French to their clients. Providing professional interpreters can minimize this impact and lead to better communication, increased client satisfaction and better health outcomes. Improving the questions used to assess francophone linguistic identity is critically important for Alliance members and particularly for those centres that serve Francophone communities.

M	R	
X		1. What is your mother tongue? a. French b. English c. Other 2. If your mother tongue is neither French nor English, in which of Canada's official languages are you more comfortable? a. French b. English

Table 13 - Sociodemographic data - Inclusive Definition of Francophone

- ***Preferred Language of Service – M***

Preferred Language of Service identifies the language in which the client feels most comfortable receiving services. With barriers to primary care, diagnostic imaging, client follow-up, pain management, medication prescriptions and chronic disease management, this data can facilitate the use of professional interpreters which leads to optimal communication, client satisfaction and better health care outcomes.

M	R	
x		*List of >100 languages provided in EMR software*

Table 14 - Sociodemographic data - Preferred Language of Service

- ***Require language interpretation – Op***

Unlike other fields, this one is optional according to your organization's need for the data.	Yes No

Table 15 – Sociodemographic Data - Require language interpretation

- ***Preferred Written Language – Op***

Preferred Written Language identifies the language in which the client feels most comfortable receiving written information. This data can facilitate the use of professional translators which leads to optimal communication, client satisfaction and better health care outcomes.

Unlike other fields, this one is optional according to your organization’s need for the data.	*List of >100 languages provided in EMR software*

Table 11 - Sociodemographic data - Preferred Written Language

- ***Income and Number of persons supported by income – M***

The objective of this data is to identify whether clients are living above or below the poverty line. There is consensus that income is a powerful predictor of poor health status and treatment outcomes. Identify gross income from all sources within the following ranges:

M	**R**	
x		$0 - $19,999 $20,000 – $39,999 $40,000 - $59,999 $60,000 - $79,999 $80,000 - $119,999 $120,000 - $149,999 $150,000 or more Do not know Don't want to answer
x		**Number of persons supported by income** Identify the number of people this combined income supports; not to exceed 19 persons. The number of people that the household income supports in combination with the total household income determines if the client is living above or below the poverty line. The number should include all people living in the same dwelling who are related by blood, marriage, or common-law. **(Note: this is Statistics Canada definition of the “Economic Family”).**

Table 16 - Sociodemographic data - Income and Number of persons supported by income

- ***Currently have difficulty paying for basic needs – M***

M	**R**	
x		Yes No Do not know N/A Prefer not to answer

Table 17 – Sociodemographic data - Currently have difficulty paying for basic needs

- ***Current housing situation – M***

This refers to the living arrangements for the client. It is intended to help identify the degree of isolation, which is a risk factor for poor health outcomes.

M	**R**	
x		A place you or your family owns Staying in someone else’s place because you have no alternative A place you or your family rents Experiencing homelessness (e.g., shelter, living in a public place or vehicle) Correctional facility Social housing, Subsidized housing or Rent -geared -to –income Long -term care facility

M	R	
		Supportive housing or Group Home
		Other
		Do not know
		Prefer not to answer

Table 18 - Sociodemographic data – Housing Situation

- ***Who they live with – M***

This refers to the living arrangements for the client. It is intended to help identify the degree of isolation, which is a risk factor for poor health outcomes.

M	R	
x		Parent(s) or Guardian(s)
		Sibling(s)
		Spouse or Partner
		Other family
		Child(ren)
		Friends or Roommates
		Grandparent(s)
		Paid caregiver or attendant
		Alone
		Other
		Do not know
		Prefer not to answer

Table 19 – Sociodemographic data - Who they live with

- ***Current education level – M***

Education is linked with health benefits such as the ability to effectively navigate the healthcare system; higher skills, which can lead to better employment; and better personal health behaviours.

M	R	
x		No formal schooling
		Grade school (grade 1-8)
		Some high school, but did not yet graduate
		High school or high school equivalency certificate (grade 9-12)
		Completed Registered Apprenticeship or other trades certificate or diploma (or ongoing)
		College, CEGEP or other non-university certificate or diploma (or ongoing)
		Undergraduate degree or some university
		Postgraduate degree or professional designation (e.g., Master's, PhD, MD)
		Other
		Do not know
		Prefer not to answer

Table 20 - Sociodemographic data - Current Education Level

- ***Religious or spiritual affiliation – Op***

Choose all that apply.

Unlike other data fields, this one is optional depending upon your organization's need for the data.	Agnosticism Confucianism Pagan Unitarianism Animism or Shamanism Hinduism Protestant Zoroastrianism Atheism Islam Rastafarianism Baha' I Faith Jainism Roman Catholic Buddhism Judaism Sikhism Christian Orthodox Native Spirituality Spiritual Christian, not included elsewhere on this list Not Applicable, I do not have a religious or spiritual affiliation Other Do Not Know Do Not Want to Answer

Table 21 - Sociodemographic data – Religious or Spiritual Affiliation

- ***Identify as a person with a disability – M***

With self-identified diverse types of disabilities, there are different patterns of health care utilization. Access and satisfaction with health care services could be lower among clients with disabilities due to a lack of appropriate access to care, accessible health information, or procedural accommodation.

M	**R**	
M		Yes No If you wish, please specify Do not know Prefer not to answer

Table 22 - Sociodemographic data - Identify as a person with a disability

- ***Benefit from support related to disability – M***

With self-identified diverse types of disabilities, there are different patterns of health care utilization. Access and satisfaction with health care services could be lower among clients with disabilities due to a lack of appropriate access to care, accessible health information, or procedural accommodation.

M	R	
x		Alzheimer's Disease/Dementia Developmental Disability Sensory Disability (e.g., low vision, blindness, deafness, hard of hearing etc.) Autism Spectrum Disorder Drug or Alcohol Dependence Chronic Illness (e.g. sickle cell, diabetes etc.) Learning Disability Physical Disability Cognitive Disability Mental Illness Other None Do not know Prefer not to answer

Table 23 – Sociodemographic Data - Benefit from support related to disability

- ***Chart Status – M***

Active clients are those who have had an encounter or participated in a registered personal development group (PDG) within the last three years. **Inactive clients** have not had an encounter or participated in a registered PDG for at least three years. ***NOTE***: The EMR does not automatically change this status, so centres will have to do it manually.

M	R		
x			Active Inactive

Table 24 - Sociodemographic data - Chart Status

- ***Termination Reason – R***

M	R	
	x	Moved Transient No appt. in 3 years Transferred Care Deceased No longer eligible Other

Table 25 - Sociodemographic data - Termination Reason

- ***Ongoing Primary Care Client (OPCC) Status – R***

Clients who receive their ongoing primary care from the centre are considered to be **Ongoing Primary Care Clients**. These clients are included in denominators used for various indicators in the multi-sector service accountability agreement (M-SAA), a contract each CHC has with its funding body.

M	R	
	x	Ongoing primary care client

Table 26 - Sociodemographic data - Ongoing Primary Care Status

Wellbeing Data

The wellbeing indicators are taken from the Canadian Index of Wellbeing (CIW) developed by the University of Waterloo.

- ***Sense of Community Belonging – M***

This indicator reflects the CIW domain *Community Vitality*. A strong sense of belonging is shown to have a positive impact on an individual's wellbeing. The 2014 Be Well Survey conducted by the Alliance in partnership with the CIW found that a positive sense of belonging leads to positive health benefits. A sense of community belonging has been identified as a priority for demonstrating the effectiveness of comprehensive primary healthcare within the Model of Health and Wellbeing.

M	R	
x		Very strong Somewhat strong Somewhat weak Very weak Do not know Prefer not to answer

Table 27 - Wellbeing data - Sense of Community Belonging

- ***Self-rated Physical Health - M***

Perceived physical health corresponds several measures in the CIW *Healthy Populations* domain, and it is used for broader benchmarking. It is a subjective measure of overall health status. Individuals' self-assessment of their health may include aspects that are difficult to capture clinically, such as incipient disease, disease severity, physiological and psychological reserves, and social function. Studies have demonstrated that this is a reliable and valid measure, associated with functional decline, morbidity and mortality. Perceived health is often more effective than clinical measures for predicting help-seeking behaviours and health service use. Perceived health is a relative measure—evidence suggests that people assess their health in relation to their circumstances and expectations, and their peers.

M	R	
x		Excellent Very good Good Fair Poor Do not know Prefer not to answer

Table 28 - Wellbeing data - Self-rated Physical Health

- ***Self-rated Mental Health - M***

Perceived mental health corresponds to the *Mental Health* measure in the CIW *Healthy Populations* domain, and it is used for broader benchmarking. It is a subjective measure of overall health status. When people rate their health, they think not only of their current situation but also of trajectories, declines and improvements (Statistics Canada).

M	R	
x		Excellent Very good Good Fair Poor Do not know Prefer not to answer

Table 29 - Wellbeing data – Self-rated Mental Health

Additional Optional Questions

- *In the past 12 months, not able to pay the mortgage or rent on time*
- *Within the past 12 months, worried whether food would run out before could buy or get more*
- *Within the past 12 months, the food bought just didn't last and could not buy or get more*
- *In the past 12 months, unable to get medicine or medical supplies, or do anything to make them last longer because of the cost*
- *In the past 12 months, has lack of transportation impacted medical appointments, meetings, work, or from getting things needed for daily living*
- *Currently have consistent access to a phone or the internet*
- *In the past 1*
- *2 months, missed making a payment on any utility bills (e.g., electric, gas/oil, water) because of cost*
- *Have people who you can open up to or confide in*
- *Have people to rely on if you needed help*
- *Currently employed (this includes self-employed, full-time, part-time or other)*
- *Currently looking for work*
- *Main job is temporary or part-time (e.g., casual, contract, freelance, short-term, seasonal)*
- *Current employment could be negatively affected if you raised concerns about your work (e.g., health, safety, rights)*
- *In the past 12 months, did income change a lot from month to month*

Individual Service Event Data

Individual Service Events or Encounters are used to record the clinical notes for client interactions. Providers create an encounter each time there is a service provided to or for a client.

When	There is contact/interaction between CHC staff and a client and services are received by the client
Who	The staff involved - only one staff member per encounter – if there is more than one provider involved, each individual should complete their own encounter. Staff members should complete individual encounters every time they have a one-on-one interaction with a client.
How	Information is completed about each contact with individual clients. Contact warranting documentation is defined as: • An interaction between an individual client and the provider for the purpose of receiving individualized service, that justifies a notation in the client chart. An interaction between the centre and a third party, which has a direct bearing on either the provision of or access to services for the individual client and which justifies notation in the client's chart. Information is documented for both telephone or other technologies and face-to-face contact with clients and third parties. Each interaction with a provider fulfilling the above requirements requires documentation. Each encounter should be associated with only one provider. If a provider is working in coordination with other providers, each one should record their own encounter. Information about the nature and content of the contact is documented during or immediately following the contact regardless of the location and type of encounter (that is, whether it happens face-to-face, by telephone or via a third party).
Why	This information helps answer questions about the work that happens on a one-on-one basis.
What	All information regarding one-one-one encounters.

Table 30 - Individual Service Event Data: Overview

- ***Date of Contact - M***

This is a record of the day, month, and year on which the service event takes place.

M	R		
x		Day Evening Night	Weekday Weekend Stat Holiday

Table 31 - Individual Service Event - Date of Contact

- ***Location of Contact – R***

Location of contact answers the question, *where did the contact/encounter take place?* That is, was it at the main CHC site, an alternate location or another contact point?

M	R	
	x	Centre – main location Centre – alternate location Community Agency

M	R	
		Partner Agency School Public Space Client home Hospital Other

Table 32 - Individual Service Event - Location of Contact

- ***Language of Contact – R***

This is the language that the provider speaks during the service event. If a cultural interpreter is involved this should be recorded as *interpretation* under *services provided*.

M	R	
	x	*List of >100 languages provided in EMR software*

Table 33 - Individual Service Event - Language of Contact

- ***Type of Contact – R***

This is a record of the type of interaction between the client and either the provider of the service or a **third** party involved in the delivery of care.

In 2018, the EPIC Committee (formerly PMC) clarified that an encounter with a "significant other" (that is, a parent or spouse) is not considered "with third Party on behalf of the client;" rather, it should be documented as an encounter with the client.

M	R	
	x	in person - individual in person - family in person - couple by phone with third party on behalf of the patient by email by text by video

Table 34 - Individual Service Event - Type of Contact

- ***Mode of Contact – R***

The nature of an individual contact between a client and a provider.

M	R	
	x	Scheduled Appointment Walk-in contact On-call contact Crisis emergency contact Urgent / same day Other

Table 35 - Individual Service Event - Mode of Contact

- ***Reason for Visit – Op***

For each contact, indicate the specific reason for the visit as identified by the client.

Unlike other data fields, this one is optional depending upon the organizational data collection	*The list provided by Electronic Nomenclature and Classification of Disorders and Encounters for Family Medicine (ENCODE-FM)*

Table 36 - Individual Service Event - Reason for visit

- ***Issues Addressed - M***

For each contact, indicate all of the issues addressed by the provider during the contact. This list comes from the Electronic Nomenclature and Classification of Disorders and Encounters for Family Medicine (ENCODE-FM), a bilingual (English and French) clinical terminology of symptoms, complaints, diagnoses, disorders, and reasons for encounter, designed for use in primary care EMRs.

M	**R**	
x		*The list provided by Electronic Nomenclature and Classification Of Disorders and Encounters for Family Medicine (ENCODE-FM)*

Table 37 - Individual Service Event - Issues Addressed

- ***Procedures Performed - R***

This field provides a list of clinical procedures commonly performed in person at centres. Choose all that apply.

See Appendix 3 for definitions

M	**R**	
	x	Biopsy Birth control implant Birth control removal Blood pressure monitoring Broncho-spirometry Cautery Clipping toenails Collection of specimen Cryotherapy Debridement Diaphragm fitting EKG Excision of dermal lesions Eye exam (Snellen’s technique) Eye irrigation Fecal disimpaction FIT test ordered Footwear adjustments/orthotics Foreign body exeresis Glucometer reading Immobilization Immunization given Injection of drugs IUD insertion

M	R	
		IUD removal
		Local anaesthetic
		Mammogram ordered
		Middle ear cleaning
		Minor surgery
		Nail Dremel
		Onychectomy
		Oximetry and oxygen saturation
		Pap test
		Physical therapy
		Plaster cast
		Psychotherapy
		Removal of stitches or staples
		Respiratory physical therapy
		Stretching
		TB test
		TB test reading
		Trimming
		Urine drug test
		Urine test
		Venipuncture
		Wound exploration (without repair)
		Wound Care

Table 38 - Table Individual Service Event - Procedures Performed

- ***Services Provided - R***

List of actions undertaken by the encountering provider in relation to the service event. Choose all that apply. See Appendix 3 for definitions

M	R	
	x	accompaniment
		advocacy
		anonymous HIV service
		application for limited eligibility
		basic support
		care plan documentation
		case conference
		case management/coordination
		chart Review
		chronic illness monitoring
		client care written correspondence
		client intake/interview
		cognitive assessment
		complementary interventions
		counselling regarding breastfeeding
		cultural ceremony
		cultural teaching
		interpretation

M	R	
		interpreter dispatching dental care diagnostic tests request discussion regarding the diagnostic findings discussion regarding the treatment plan dispensing medication external referral family planning/birth control family/couple counselling foot care forms completion gender affirming care general assessment health advice/instructions health card registration services individual counselling information provision about community resources intermediate assessment internal consultation internal referral medication prescription medication reconciliation medication renewal mental health care minor assessment occupational therapy other identification services palliative care periodic health examination permanent health card application physical therapy postnatal care prenatal care preventive care psychological assessment recommendation/assistance repeated assessment speech/language therapy social prescribing supportive counselling traditional healing transportation assistance triage well baby health examination well baby support well child health examination written translation of care provided to the patient

Table 39 - Individual Service Event - Services Provided

- ***Referrals Made - R***

Referrals for clients are documented to specific provider types and/or to certain agencies. Referrals may be internal or external.

- ***Provider Types – R***

M	R	
	x	Acupuncturist Allergist Alternative/Complementary therapist - other Audiologist Cardiologist Case Worker Childcare/preschool teacher Child welfare worker Chiropodist Chiropractor Community Developer Community Health Worker Counselor Cultural Interpreter Dental Assistant Dental Hygienist Dental Technician Dentist Denturist Dermatologist Diabetes Educator Dietitian/Nutritionist Early Childhood Educator E.N.T. specialist Emergency Physician Endocrinologist Gastroenterologist Gerontologist Gynecologist Haematologist Harm Reduction Worker Health Promoter/Educator Home care worker Hypnotist Infectious disease specialist Intake Worker Internist Kinesiologist Lab Technician Lactation Consultant

M	R	
		Lawyer Legal aid Massage Therapist Medical Office Assistant Medical technician/technologies Midwife Naturopath Neurologist Nurse Nurse Practitioner (RN-EC) Obstetrician Occupational Therapist Oncologist Ophthalmologist Optometrist Osteopath Other Outreach Worker Pediatrician Peer Support Worker Personal Support Worker Pharmacist Physician Psychometrist Physiotherapist Physiatrist Podiatrist Psychiatrist Psychologist Radiologist Recreation Worker/Therapist Registered Practical Nurse (RPN) Respiratory Therapist Respirologist Rheumatologist Service access coordinator Social worker Speech/Language Pathologist Student/trainee – non-clinical Student/trainee - clinical Surgeon - general Surgeon - oral Surgeon - speciality (eye, heart, brain, etc.) System Navigator Traditional Healer Trained (paid) peer worker Urologist

M	R	
		Urogynecologist Volunteer Volunteer Coordinator Welfare worker Physician Assistant Youth Worker

Table 40 - Individual Service Event – Referrals - Provider Types

- ***Agencies – R***

M	R			
	x	**Health Services**	**Social and Community Service**	**Community Group**
		Addiction centre for alcohol and drugs Alternative health care clinic Ambulatory care facility (*lab, x-ray, radiology, ultrasound, etc.*) Another CHC Our centre Dental Clinic Early childhood development centre Emergency department Hospital - acute for adults Hospital - acute for children Hospital - chronic Hospital - long term Hospital - psychiatric Mental Health (*Psych*) Clinic Physio/occupational therapy clinic Practitioner office - solo/group Preventive care clinic (*mammogram, travel/tropical/infectious medicine, etc.*) Primary care organization (*outside of CHCs*) Public health department Rehabilitation centre Research/Planning Focused Organization Sports medicine centre Tele-Health Urgent care centre Walk-in Clinic Women's Health Centre/Clinic	Children's Aid Society Children/youth agency Clothing exchange/distribution centre Colleges/Universities Community care access agency Community mental health agency Community resource centre Cultural Interpretation Centre Employment centre Ethno-specific organization Family support agency Fitness club Food insecurity agency Home Care Agency Housing agency (*not-for-profit*) Legal/Legal Aid agency Parent resource centre Police department Recreational agency Research/Planning Focused organization School board Services for the physically challenged Seniors' agency Settlement agency for immigrants Shelter for victim of family violence Shelter for the homeless Support network - self-help groups	Broad Focus Interest Group/Coalition Business Association Farmer's Association Labour Organization Parent/School Association Religious/Ecumenical/Faith group Residents Association Service Club Single Issue Interest Group/Coalition United Way Informal Community Group Other Community Group

M	R			
		Other Health Agency/Organization	Welfare office Women's organization Other Social and Community Service	

Table 41 - Individual Service Event – Agencies

- ***Immunizations - R***

M	R	
	x	*This field comes from the list of immunizations housed in the Electronic Medical Record.*

Table 42 - Individual Service Event - Immunizations

Personal Development Group Data

A personal development group (PDG) is defined as a series of time-limited or on-going sessions conducted, facilitated or supported by internal or external staff, whose purpose is to effect changes in participating individuals' behaviour, knowledge or attitudes. They may also be characterized by changing themes and fluctuating memberships. A PDG has a specific purpose that is designed to address one or more issues; it might also be targeted at certain populations.

PDGs are conducted, facilitated or supported by centre staff, and their objectives and outcomes are recorded in the EMR. PDGs are distinct from Community Initiatives (CIs) in that they are focused on individual change as opposed to broader-based community development or change.

When	Every time a group meets.
Who	The staff involved (*this may be a volunteer*)- one staff member will record all staff/volunteers involved in the group.
How	Electronic Medical Record.
Why	This information helps answer questions about the work that happens on a group basis.
What	Attendance and Group Information.

Table 43 - Personal Development Group Data: Overview

- ***Nature of Group – M***

The classification **Registered Group** is used to record the provision of a group service or activity and the identity of the participants. The majority of participants must be registered into the centre's EMR and linked to the group as a member, and their attendance at each group session must be recorded. Registered groups are often closed, recurring groups with a clear beginning and end.

The classification **Non-Registered Group** is used to record the provision of a group service or activity in which the identity of participants is infeasible or impractical to record. Non-registered group activities are open to everyone. Participants do not need to register, and attendance are not documented. Although members can be linked, this record for this group would indicate only the number of participants, not their identities.

M	R	
x		Registered Non-registered

Table 44 - Personal Development Group - Name of Group

- ***Nature of Group Membership – M***

Indicates whether the group session has been planned with the intent of having a closed/recurring membership only allowing for new members to join up until a specific time or session or open where new members are invited to join at any time.

M	R	
x		Closed – Time limited membership Open – Membership at any time

Table 45 - Personal Development Group - Nature of Group Membership

- ***Nature of Group Sessions – M***

Indicates the type of leadership the group has. Note: this field was re-purposed in 2017 after a data field review

M	R	
x		Centre staff-led Volunteer-led Partner-led Peer-led

Table 46 - Personal Development Group - Nature of Group Sessions

- ***Group Life Span – M***

Indicate whether the group sessions are intended to have a "time-limited" number of sessions or whether it is to have a more "open-ended", continuing lifespan.

M	R	
x		Time-limited Open-ended

Table 47 - Personal Development Group - Group Life Span

- ***PDG Source – M***

The source records linkages that keep track of the evolution of the work that centres do within groups. This information describes how the need for the group originated within the CHC.

M	R	
x		Other Personal Development Group Community Initiative Centre Objective Based on Individual Encounter(*s*) Other

Table 48 - Personal Development Group - PDG Source

- ***Group Location – M***

The location of where the group session was held.

M	R	
x		Centre Satellite Location Community Agency School Public Space Residence Building Hospital Virtual Other

Table 49 - Personal Development Group - Group Location

- ***Specific Issues Addressed – M***

M	R	
x		*Select the issues addressed during the group contact* - Electronic Nomenclature and Classification Of Disorders and Encounters for Family Medicine *(ENCODE-FM®)*

Table 50 - Personal Development Group - Specific Issues Addressed

- ***Staff Involved and Role – M***

This documents all the staff involved in the group and their role.

M	R	
x		**Staff Involved** Internal staff name selected from a drop-down External Staff added via free-type text field
x		**Staff Role** Facilitator Partner Leader Volunteer Facilitator Student Facilitator Resource Support / Advisor Trainer / Educator Client Enabler Other

Table 51 - Personal Development Group - Staff Involved and Role

- ***Total Individuals Registered – M***

M	R	
x		*# participants who are registered in the group*

Table 52 - Personal Development Group - Total Individuals Registered

- ***Total Number Completed – M***

M	R	
x		*# participants who completed group*

Table 53 - Personal Development Group - Total Number Completed

- ***PDG Activities – M***

Description of the activities occurring with the group.

M	R	
x		Created forums to introduce or bring people together Created opportunities for hands-on training and experience (*e.g. peer-helping, crisis intervention, conflict resolution, babysitting, First Aid, etc.*) Discussed common issues of concern Encouraged the development of natural networks (*e.g. fitness or health workshops, drop-ins, clothing exchange, parent support, babysitting co-ops*) Encouraged group members to learn more about issues or topic outside of the group Encouraged healthy problem-solving in the group (*e.g. through mediation, conflict resolution*) Group planned, implemented and evaluated group activities Increased awareness of group members strengths and capacities Individual group members shared knowledge or experience with group Practiced individual skills to support self-management of health issues Promoted development of interpersonal and social skills Promoted development of mutual support Promoted group awareness of source of problems and problem-solving strategies Provided educational information to the group on issue or topic Provided group members opportunity to identify and discuss individual concerns and to receive feedback from the group Provided opportunities for group members to use or share what they have learned (*e.g. through role play or peer support*) Raised individual awareness of facilities, services, resources Recognized or celebrated individual successes Taught individual skills to support self-management of health issues Used common activities or interests to bring people together (*e.g. crafts, cooking, homework clubs*) Used opportunities to build group strength (*e.g. crisis situation*)

Table 54 - Personal Development Group - PDG Activities

- ***PDG Objectives – R***

Identifies original objective(*s*) of Personal Development Group

M	R	
	x	Change in Behaviour Developing Strengths or Talents Enhancing lifestyle or the quality of life Identifying or improving potential Improving health Improving self-awareness Improving self-knowledge Improving social abilities Increase access to basic needs

Table 55 - Personal Development Group - PDG Objectives

- ***Intended Populations – R***

Indicates the population that the group was initially intended to benefit and may not reflect the actual attendees. This should be documented once – at or before the group's start-up – and can be combined with documented information about the target population's participation rates.

M	R	
	x	***Age Groups*** General population Babies (*0-18 months*) Young children (*19 months-4 years*) Children (*5-9 years*) Younger youth (*10-14 years*) Older youth (*15-19 years*) Young adults (*20-34 years*) Adults (*35-49 years*) Older adults (*50-64 years*) Seniors (*65 years and over*)
	x	***Gender*** Man Woman Gender fluid or Gender queer Questioning or unsure Non-binary Two-spirit Transgender Other
	x	***Sexual Orientation*** Straight/Heterosexual Asexual Pansexual Bisexual Queer Demisexual Questioning or unsure Gay Lesbian Same-gender loving Two-spirit Other

M	R	
	x	***Racial or Ethnic Group*** Indigenous (First Nations, Métis and/or Inuk/Inuit) White (e.g., European descent) Black (e.g., African, Afro-Canadian, Afro-Caribbean, Afro-Egyptian etc.) Latin American (Hispanic or Latin American descent) East Asian (e.g., Chinese, Korean, Japanese, Taiwanese, etc.) South Asian (e.g., Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan, etc.) Southeast Asian (e.g., Filipino, Vietnamese, Cambodian, Thai, Indonesian, etc.) Middle Eastern, Arab or West Asian (e.g., Afghan, Egyptian, Iranian, Lebanese, Persian, Turkish, Kurdish, etc.) Indigenous (First Nations, Metis or Inuk/Inuit) Other
	x	***Physical / Mental Condition*** AIDS/HIV Alcohol dependence Heart Disease/hypertension Arthritis Asthma / COPD Chronic pain Dementia Depression Diabetes Eating disorder Nutritional Health Mental / Behavioural Issue Nicotine dependence Obesity Physical Disability / Frailty Physical Health Sexual Health Oral Health Mental Health Sexual Health Substance use/addictions Hepatitis C Other

M	R	
	x	***Social / Economic Condition*** Food Security Homelessness Inadequate housing Language/cultural barrier Low income/poverty Low literacy Occupational/workplace risks Perpetrators of violence/abuse Racism Discrimination Social isolation Underemployment Unemployment Survivors of violence/abuse Violence/abuse Witness of violence/abuse Other
	x	***Role / Identity / Status*** Caregivers Volunteers Persons in conflict with the law Family members/support person(s) Health providers Newcomers Parents Expectant parents New parents Single parent Refugees Students Other
	x	***Languages Spoken*** List of 100+ languages

Table 56 - Personal Development Group - Intended Populations

- ***% of Intended Populations (IP) Registered – M***

The % of the intended population that the group was initially intended to benefit.

M	R	
x		*Enter % numeric value of IP registered*

Table 57 - Personal Development Group - % of IP Registered

- ***% of Intended Population Completed – M***

The % of the intended population that completed a certain, locally-determined, proportion of the sessions. Centres choose their own definition of completion for each PDG.

M	R	
x		*Enter % numeric value of IP completed*

Table 58 - Personal Development Group - % of IP Completed

- ***(Group) Member Prior State – R***

This field is a way to identify the group members' "before" status. This is a unique score for each group member. It can be used in conjunction with the Member Outcomes field as a measure of how a client's health outcomes changed over the course of their participation.

M	R	
	x	Doesn't meet group objectives Meets some of the group objectives Meets group objectives Exceeds group objectives

Table 59 - Personal Development Group - Member Prior State

- ***(Group) Member Outcomes – R***

This field is a way to identify the outcome/evaluation of the group members "after" status. This is a unique score for each group member. It can be used in conjunction with the Member Prior State field as a measure of how a client's health outcomes changed over the course of their participation.

M	R	
	x	Doesn't meet group objectives Meets some of the group objectives Meets group objectives Exceeds group objectives Did not complete group

Table 60 - Personal Development Group - Member Outcomes

Community Initiatives

A community initiative is a set of activities aimed at strengthening the capacity of the community to address factors affecting its collective health. Community initiatives seek to involve communities and groups in identifying and changing conditions that shape their lives and health prospects as a group. This may change be brought about through environmental improvements in the broadest sense; that is, it may improve the physical, economic, or social environment; introduce new services; or affect policy change. It may also be accomplished by increasing participants' collective ability to achieve such change themselves or to adapt to conditions they cannot affect, such as technological change. Through community initiatives, groups of people are supported to gain greater control over key determinants of their health and thereby improve their health.

The rationale for community initiatives is derived from the Ottawa Charter for Health Promotion (1986), which states, "Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies."

There are challenges facing the documentation of community initiatives. For example:

- Community initiatives often have no clear beginning or end but evolve out of ongoing community discussions and existing activities.
- Partners and participants may come and go and issues may change over time.
- Goals and objectives may shift as work with the community progresses, and outcomes may thus be different from those originally conceived.
- Personal Development Groups may be included as part of a community initiative.

Whereas PDGs and service encounters are aimed at improving the health outcomes of individuals, CIs are programs aimed at strengthening communities by addressing factors that affect their collective health. CIs seek to involve communities and community groups in identifying and changing conditions that shape their lives and health prospects as a group. To accommodate these characteristics, the evaluation approach calls for a monthly snapshot of any activities that have occurred during the month under review, as well as a record of key "milestones" or "outcomes" achieved. Changes in issues, partners and their roles can all be tracked month by month or as required.

Glossary

TERM	DEFINITION
Access Point	An Access Point is a location affiliated with the centre. It will have all of the following characteristics: • Health services are delivered less than 21 hours per week, perhaps in conjunction with a partner; • The site delivers a specific health service or bundle of services; • The site staff originates from the main centre or a satellite; • No reception or administrative support staff • Administration and infrastructure support provided by the main centre. See also **satellite.**
Active Client	A registered client who has had either an individual service encounter or was involved in a personal development group (PDG) session within the last three years.
Baseline information	Information collected at the beginning of a project that serves as the basis for comparison with information collected later.
Community Initiative	A community initiative is a set of activities aimed at strengthening the capacity of the community to address factors affecting its collective health.

TERM	DEFINITION
External Referral	A referral made to a provider/service outside the centre.
Indicators	Indicators are specific measures indicating the degree to which goals and/or objectives have been achieved.
Internal Referral	A referral of made to a provider/service within the centre.
Interpretation Services	A service provided by a centre in which an interpreter (whether a member of staff, a centre volunteer, or a contractor paid by the centre) is used to provide language interpretation during a contact between a provider and a client. • This is a service and should be collected as such. The interpreter is not captured as a staff involved. Interpretation services alone do not warrant an encounter. • The language of contact is always the language the provider spoke while delivering the service.
Logic Model	A diagram that shows what a program is supposed to do, with whom and why. Logic models typically include information on a program's target population, intended activities, intended inputs and intended outputs, and intended outcomes. • **Target populations** include the individuals, groups, organizations or communities for and with whom a program's services are designed. They are a program's priority population or its intended reach. • **Inputs** include resources dedicated to or consumed by the program. Examples are money, staff, and staff time, volunteers and volunteer time, facilities, equipment, and supplies. • **Outputs** are the direct products of program activities and are usually measured in terms of the volume of work accomplished (for example, the number of counselling sessions conducted, number of people served). • **Outcomes** are a change that occurs as a result of a project or program and shows the benefits or changes in people or groups participating in a program. Outcomes are often associated with impact evaluations. There are different levels of outcomes: short term, intermediate and long term.
Mandatory Data	Data which is necessary for a record to be valid. The field cannot be blank. See also **Required Data** and **Optional Data**.

TERM	DEFINITION
Multi-Sectoral Accountability Agreement (M-SAA)	The Local Health System Integration Act (2006) requires that LHINs have a service accountability agreement in place with each health service provider it funds. These agreements form the basis for a multi-year planning and funding framework for each LHIN-funded provider.
Ongoing Primary Care Client (OPCC)	A registered client who receives ongoing primary care from a centre. This group forms the denominator for mandatory M-SAA reporting.
Personal Development Group (PDG)	A series of time-limited or on-going sessions conducted, facilitated or supported by internal or external staff, whose purpose is to effect changes in participating individuals' behaviour, knowledge or attitudes.
Process evaluation	An assessment of what activities were implemented, the quality of implementation, and the strengths and weaknesses of the implementation.
Required Data	These data fields must be completed for reporting, where possible. Missing data in the required fields will result in incomplete/inaccurate funder reports. There will be no error message on the screen if the field is left blank.
Satellite	A permanent location where health services are delivered outside of the main centre. Satellite centres are characterized by: • Regular operations (minimum of 21hr/week); • Fixed, accessible location, secured through ownership, a lease or a written agreement. • Ongoing, dedicated staff • Its own administrative and infrastructure support
Service Event	An encounter with an individual client or a session for a personal development group. The term "encounter" is often also used to signify a service event.
Services Provided	Services undertaken by the provider.
Target Populations	Target populations are the priority populations as identified by broad organizational, CI and group objectives. They are often related to sociodemographic characteristics of the target population

Table 61 - Glossary

Acronyms

TERM	MEANING
AHAC	Aboriginal Health Access Centre
BIRT	Business Intelligence Reporting Tool
CHC	Community Health Centre
CI	Community Initiatives
CIRT	Community Initiatives Reporting Tool
CIW	Canadian Index of Wellbeing
DOH	Determinants of Health
ENCODE-FM	Electronic Nomenclature and Classification of Disorders and Encounters for Family Medicine
EPIC	Equity - Performance - Improvement - Change (EPIC) Committee (Formerly PMC)
HQO / QIP	Health Quality Ontario / Quality Improvement Plans
ICES	Institute for Clinical Evaluative Sciences
IP	Intended Population
2SLGBQ+	2-Spirited, Lesbian, Gay, Bisexual, Queer, or other
LHIN	Local Health Integration Network
MHWB	Model of Health and Wellbeing
M-SAA	Multi-Sectoral Accountability Agreements (see Glossary)
OPCC	Ongoing Primary Care Client (see Glossary)
PDG	Personal Development Group
RBLM	Results-based Logic Model

Table 62 - Acronyms

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Appendix 1 | Core indicators and Optional Indicators

In 2016, at the request of the EPIC Committee (formerly Performance Management Committee), the Evaluation Framework Indicator Working Group reviewed existing indicators and identified a list of optional indicators with a "vital few" (collectively known as "The Vital 8" to be collected and measured across the sector). These are intended as a first step to better measure the CHC Model of Health and Wellbeing.

The tables below illustrate the following:

- The associations between the four direct outcomes in the Results-Based Logic Model (RBLM) and the eight attributes of the Model of Health and Wellbeing (MHWB) (yellow headers).
- The key questions associated with each direct outcome, and the MHWB attributes they correspond to (green headers).
- Core (Vital 8) indicators and their data sources for each direct outcome (blue headers).
- Optional indicators and their data sources for each direct outcome (blue headers).

RBLM Direct Outcome	MHWB Attributes	
DIRECT OUTCOME #1: Reduced risk, incidence, duration, and effects of acute and episodic physical, social, and psychological conditions and of chronic diseases (e.g., diabetes, mental illness and addictions) at individual and community level.	**A.** Interprofessional, integrated and coordinated	✓
	B. Community Development Approach	✓
	C. Determinants of Health	✓
	D. Accountable and Efficient	✓
	E. Accessible	✓
	F. Community Governance	
	G. Population and needs-based	
	H. Anti-oppressive and culturally safe	

Table 63 - Links between RBLM Direct Outcome 1 and MHWB Attributes

Key Questions	MHWB Attribute
How does interprofessional, comprehensive, and integrated care impact risk, incidence, duration and effects of acute and episodic physical, social and psychological conditions; and of chronic diseases (e.g. diabetes, mental illness and addictions); at individual and community level?	A. Interprofessional, integrated and coordinated
Are people who receive interprofessional care more likely to have reduced risk, incidence, duration and	A. Interprofessional, integrated and coordinated

Key Questions	MHWB Attribute
effects of selected conditions and diseases compared to similar people who do not?	
Can baseline measures be collected to capture the impacts of IP care on reduced incidence, duration and effects of acute and episodic physical, social and psychological conditions and of chronic diseases (e.g. diabetes, mental illness and addictions); at individual and community level?	A. Interprofessional, integrated and coordinated
Do communities who access CHC community development show reduced risk, incidence, duration or effects compared to similar communities who do not?	B. Community Development Approach
Do communities who engage with CHCs in community development have reduced risk, incidence, duration and effectiveness of acute and episodic physical, social and psychological conditions compared to before?	B. Community Development Approach
What are the ways CHCs address determinants of health that make a difference in reducing risk, incidence or duration, at individual or community level, compared to doing nothing or standard care?	C. Determinants of Health
How do accountability and efficiency impact the risk, incidence or duration, at individual or community level, compared to doing nothing or standard care?	D. Accountable and Efficient
Does accessibility to CHC services impact risk, incidence or duration, at individual or community level, compared to doing nothing or standard care in CHC clients?	E. Accessible
Are CHCs providing effective quality of care? (Efficiency is about effectiveness with least cost possible.)	N/A

Table 64 - Key Questions associated with RBLM Direct Outcome 1

Core (Vital 8) Indicators	Data Source(s)
*% of primary care clients receiving interprofessional care	BIRT
*% of PHC organizations who currently have specific programs and/or initiatives (including self-help and self-management groups) to reduce the following health risks in their practice population (CIHI): • Tobacco use; • Unhealthy eating habits; • Problem alcohol drinking; • Obesity • Physical inactivity • Social isolation • Poverty/ Food insecurity	EMR / CIRT
*% of clients reporting involvement in care decisions	Client experience

Table 65 - Core (Vital 8) Indicators and data sources for RBLM Direct Outcome 1

Optional Indicators	Data Source(s)
% of clients HbA1C receiving IP care vs not receiving interprofessional care	EMR
% of clients with serious mental illness receiving interprofessional care vs those not receiving IP care	EMR / BIRT
% of clients living with 1 serious mental illness who are offered TWO of the following: psychological services/referral; pharmacological therapy; psychiatry referral; or a psychosocial support group	EMR / BIRT
% of clients in the last 12 months who have had their medications reviewed and discussed, including those from other physicians (P)	BIRT
% of clients who access 3 or more of the following: (P) · Acute episodic care · Non-urgent care (e.g. well-baby care, prenatal care, chronic disease management) · Prevention and health promotion services · Primary mental health care · Psychosocial services (e.g. counselling advice for physical/emotional/ financial concerns) · Case management for vulnerable populations · Referral to and follow-up care from specialized services · Nutrition counselling · Dental services · End-of-life care	BIRT / EMR
% of clients who report that their family physician/nurse practitioner was informed and up-to-date about the care they received from specialists	Client survey
% of clients who access 3 or more provider types ever	BIRT
Collective impact indicators	CIRT
% of clients with a medical encounter that addresses ENCODE issues from the social chapter	EMR / BIRT
% of informal caregivers who received support for their caregiving role from their PHC organization over the past 12 months	EMR / Survey

Optional Indicators	Data Source(s)
% of adults with diagnosed diabetes with an HbA1c value less than 7 percent	EMR / BIRT
% of clients screened for · Diabetes · Asthma · congestive heart failure · coronary artery disease · mental illness · addictions	EMR / BIRT
% of clients who are pregnant or postpartum who have been screened for depression	EMR / BIRT
% of clients with the following: • Tobacco use; • Unhealthy eating habits; • Problem alcohol drinking; • Obesity; and • Physical inactivity • Social isolation • Poverty/ Food insecurity • SD variables (income, housing, education, gender identity, sexual orientation, racial/ethnic group)	BIRT
% of clients participating in a self-management program	EMR (PDG)
% of clients aged 12 and over who report smoking daily or occasionally	Client experience
% of clients who report they received relevant advice at their PC visits on staying healthy and avoiding illness	Client experience
% of clients who have a care plan about their chronic conditions	BIRT
% of clients with diabetes who report having a foot exam in the past 12 months	BIRT
% of clients with CAD who received/ordered the following tests (HbA1c, lipid profile, blood pressure, obesity screening, all of the above)	BIRT
% of clients with HTN with BP recorded in the last 12 months	BIRT
% of clients with chronic conditions who had a review in the last 12 months	BIRT
% of clients who report they received relevant advice at their PC visits on staying healthy and avoiding illness	Client experience
Polypharmacy - % of clients with 10+ prescriptions / medication reconciliation	BIRT
% of patients who report having a discussion within the past two years regarding healthy living behaviours	Client experience
% of clients who report being treated with respect by PCP	Client experience
% of clients who report they were given enough information about new medications	Client experience

Table 66 - Optional indicators and data sources for RBLM Direct Outcome 1

RBLM Direct Outcome	MHWB Attributes	
DIRECT OUTCOME #2: Increased access for people who are facing barriers.	**A.** Interprofessional, integrated and coordinated	✓
	B. Community Development Approach	✓
	C. Determinants of Health	✓
	D. Accountable and Efficient	
	E. Accessible	✓
	F. Community Governance	
	G. Population and needs-based	✓
	H. Anti-oppressive and culturally safe	

Table 67 - Links between RBLM Direct Outcome 2 and MHWB Attributes

Key Questions	MHWB Attribute
Does service integration, coordination in CHCs increase access for people who are experiencing barriers compared to standard care, other models?	A. Interprofessional, integrated and coordinated
Are clients who experience barriers more likely to access interprofessional care in CHCs than other models, or before they accessed CHCs?	A. Interprofessional, integrated and coordinated
What intervention plans (e.g. CCP referral, case-conferencing, OPI language services) do the CHCs have in place to address the explicit and systemic barriers?	A. Interprofessional, integrated and coordinated
Do people experiencing barriers access CHCs addressing determinants of health compared to others (clinics, CHCs, other PC orgs) who do not? [1]	C. Determinants of Health
What are the key DoH for the particular CHC (e.g. First Nation, poverty, income, housing, security, carding, etc.)? [2]	C. Determinants of Health
Are CHCs identifying people with barriers and addressing barriers to DOH and wellbeing compared with other models?[3]	C. Determinants of Health
Do people experiencing barriers find CHCs more accessible than standard/other models?	E. Accessible
Do people experience barriers access CHC services more than other models?	E. Accessible
Do CHCs use population-needs based processes to service clients who face barriers?	G. Population and needs-based
How are the clients engaged in the discussion of addressing the DoH during program planning?	N/A

Table 68- Key Questions associated with RBLM Direct Outcome 2

[2,3,4] Identified by Community Health and Wellbeing (CHW) strategy working group as priority areas

Core (Vital 8) Indicators	Data Source
*% of eligible clients who received colorectal cancer screening by DOH (P)	EMR / BIRT
*% of eligible clients who received cervical cancer screening by DOH (P)	EMR / BIRT
*% of clients who always feel comfortable and welcome at [name of CHC]?	Client survey
*% of clients who rate their physical health Excellent/Very Good (O)	EMR / BIRT, Client survey
*% of clients who rate their mental health as Excellent/ Very Good	EMR / BIRT, Client survey

Table 69 - Core (Vital 8) Indicators and data sources for RBLM Direct Outcome 2

Optional Indicators	Data Source
% of eligible clients who received influenza vaccinations by DOH (P)	EMR / BIRT
% of eligible clients who received breast cancer screening by DOH (P)	EMR / BIRT
% of clients that report their appointments start on time or clinic wait times	Client survey
% clients who receive internal referral who actually attend said referral	EMR / BIRT
% of clients who report that they have emailed their family physician/nurse practitioner with a medical question in the last 12 months	Client survey
% of encounters of clients whose Preferred Language is other than English and who receive service with same Language of Contact or Interpretation	EMR / BIRT
% of community members reporting participation in organized activities (O)	Client survey / Canadian Index of Wellbeing (CIW) – Statistics Canada (StatsCan)
% of clients who report that their family physician/nurse practitioner is sensitive to their cultural, ethnic and spiritual background and values	Client survey
% of clients reporting they never/rarely participate in community events and activities	Client survey, EMR
Barriers to transportation % who always or often face barriers to accessing reliable transportation	Client experience
% who do not get involved in addressing issues or problems in their community	Client experience
Food insecurity % of clients reporting they ate less or skipped meals because there isn’t enough food at least once a week or at least once a month	Client experience
Experience of discrimination % reporting experiences of discrimination (religion, culture, ethnicity, language, sexual orientation, etc.)	Client experience
Lack of social support % of clients reporting fewer than 5 close friends	Client experience
Weak sense of community belonging/ community vitality *% of clients reporting weak/very weak sense of belonging to their community	EMR / BIRT
% of clients receiving ODSP out of total clients on income supports	ICES
% of clients reporting high satisfaction with CHCs stratified by income	Client experience
% of clients who report that their PCP helped them feel confident about their ability to take care of their health	Client survey(s)

Optional Indicators	Data Source
% of complex clients who have seen more than two providers	BIRT
**% who report that when they call with a medical question they get an answer on the same day	Client survey

Table 70 - Optional indicators and data sources for RBLM Direct Outcome 2

RBLM Direct Outcome	Model of Health and Wellbeing Attributes	
DIRECT OUTCOME #3: Increased integration and coordination.	**A.** Interprofessional, integrated and coordinated	✓
	B. Community Development Approach	✓
	C. Determinants of Health	✓
	D. Accountable and Efficient	✓
	E. Accessible	✓
	F. Community Governance	
	G. Population and needs-based	
	H. Anti-oppressive and culturally safe	

Table 71 - Links between RBLM Direct Outcome 3 and MHWB Attributes

Key Questions	Model of Health and Wellbeing Attribute
Do CHCs provide services that are more integrated and coordinated than standard care or other models, or than before clients accessed CHCs?	A. Interprofessional, integrated and coordinated
How do the CHCs plan and organize CCPs engaging multiple teams?	A. Interprofessional, integrated and coordinated
How many CHCs use coordinated care plans for addressing mental illnesses?	A. Interprofessional, integrated and coordinated
Do CHCs provide services that address more of the determinants of health, than before the client accessed or compared to other models?	C. Determinants of Health
Does increased integration and coordination in CHCs lead to better outcomes and less cost overall for clients and communities compared to standard care/other models/before client accessed CHC?	D. Accountable and Efficient
Do accountability and efficiency improve integration and coordination of services for clients and communities?	D. Accountable and Efficient
How do CHCs integrate (e.g. WEQI, Back Office integration, etc.) to work on the accessibility indicators and to share resources?	D. Accountable and Efficient
Is care at CHCs more integrated and coordinated for CHC clients regardless of gender, income, education, language, sexual orientation, race... than standard/other models/before accessing CHC?	E. Accessible

Key Questions	Model of Health and Wellbeing Attribute
How do the CHCs work together to serve the Non-insured clients, CIs or PDGs?	E. Accessible

Table 72- Key Questions associated with RBLM Direct Outcome 3

Optional Indicators	Data Source(s)
% of complex clients with coordinated care plans (P)	EMR / BIRT
% of primary care clients receiving non-primary care (MD/NP/RN/RPN/PA) services	EMR / BIRT
Readmissions rates	Practice Profile
% of all clients attending PDGs in one year	EMR / BIRT
% clients who receive primary care follow-up within 7-days post-hospital discharge (P/O)	Practice Profile
% clients with Preferred language other than English; low income; minimum education; non-binary gender; non-hetero sexual orientation; OR non-Caucasian; who receive referrals (external or internal) same rate as the general population?	EMR / BIRT

Table 73 - Optional indicators and data sources for RBLM Direct Outcome 3

RBLM Direct Outcome	MHWB Attributes	
DIRECT OUTCOME # 4: Increased community capacity to address the determinants of health.	**A.** Interprofessional, integrated and coordinated	✓
	B. Community Development Approach	✓
	C. Determinants of Health	✓
	D. Accountable and Efficient	
	E. Accessible	
	F. Community Governance	✓
	G. Population and needs-based	✓
	H. Anti-oppressive and culturally safe	

Table 74 - Links between RBLM Direct Outcome 4 and MHWB Attributes

Key Questions	MHWB Attribute
Does interprofessional, integrated coordinated CHC work increase community capacity to address determinants of health compared to doing nothing, other models, before engaging with the CHC team?	A. Interprofessional, integrated and coordinated
Does CHC involvement in addressing determinants of health increase community capacity to address determinants of health, compared to doing nothing, other models, before?	C. Determinants of Health

Key Questions	MHWB Attribute
Does CHC community governance increase community capacity to address the determinants of health?	F. Community Governance

Table 75 - Key Questions associated with RBLM Direct Outcome 4

Core (Vital 8) Indicators	Data Source(s)
*% of community members with a strong or very strong sense of belonging to the community (O)	Client survey

Table 76 - Core (Vital 8) Indicators and data sources for RBLM Direct Outcome 4

Optional Indicators	Data Source(s)
Which DOH does centre CIs address? (P)	Org survey, CIRT
% of community members, reporting 5 or more close friends (O)	Client survey
% centres with Board reflecting population centre is intended to serve	Org survey
% centres that have board members represented on their QIP committee	Org survey
% of community members reporting participation in organized activities (O)	Client survey

Table 77 - Optional indicators and data sources for RBLM Direct Outcome 3

Appendix 2 | Model of Health and Wellbeing Attributes

Interprofessional, Integrated, and Coordinated

The provision of comprehensive primary healthcare services to clients by multiple healthcare professionals who work collaboratively to deliver care. The “team” is a collection of individuals who are interdependent in their tasks and share responsibility for outcomes. Team-based care will be integrated and coordinated by ensuring that information flows easily both within the team but also as care is transitioned outside of the team to other community-based agencies, secondary (*specialists*), tertiary (*hospitals*) and long term care services.

Figure 4: Model of Health and Wellbeing

Population Needs-based

Clients and caregivers participate fully in their own care by goal setting and providing direction to services and programming. Communities are involved in directing, planning and governing centre services. Centres plan services and programs based on population and community needs.

Community Governed

A method of community engagement that ensures effective involvement and empowerment of local community representatives in the planning, direction-setting and monitoring of health organizations to address the health and wellbeing needs and priorities of populations within local neighbourhood communities. Alliance members are not-for-profit organizations, governed by community boards made of up members of the local community. Community boards and committees provide a mechanism for centres to represent and be responsive to the needs of their local communities, and for communities to develop democratic ownership over “their” centres. Community governance contributes to the health of local communities through engaged participation contributing to social capital and community leadership.

Accountable and Efficient

Alliance members are high-performing efficient organizations that are accountable to their funders and the local communities served. They strive to provide fair, equitable compensation and benefits for their staff. Capturing and measuring their work are essential parts of delivering comprehensive primary health care. Developing and implementing meaningful indicators based on the Model of Health and Wellbeing allows for reporting to all funders about services and programs delivered as well as the outcomes that follow.

Community Development Approach

Services and programs are driven by community initiatives and community needs; the community development approach builds on community leadership, knowledge, and the lived life experiences of community members and partners to contribute to the health and wellbeing of their communities. Centres increase the capacity of local communities to address their community-wide needs and improve their community and individual health and wellbeing outcomes.

Anti-oppressive and Culturally Safe

The notion that healthcare services will be provided in an anti-oppressive and culturally safe environment is an idea that moves beyond the traditional concept of tolerance or cultural sensitivity (acceptable to differences) to an activist orientation that seeks to eliminate the root causes of social inequity such as historic power imbalances and systematic discrimination. It is particularly important for those involved in systems that deliver healthcare services to understand the role that western medicine has and can play in the oppression of various ethnic, gender, sexual orientation, economic, religious and political groups to ensure organizations do not perpetuate such discrimination (e.g., eugenics).

Based on the Determinants of Health

The living conditions we experience through our lifetime that are shaped by the distribution of wealth, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities which can be seen in the unfair and avoidable differences in health status seen between people. Examples of social determinants of health include income, education, employment, working conditions, early childhood development, food insecurity, housing, social exclusion, social safety network, health services, gender, race, culture and disability. In most cases, these living conditions are imposed upon us by the quality of the communities, housing situations, work settings, health and social service agencies and educational institutions with which we interact.

Accessible

Clients should be able to get timely and appropriate healthcare services to achieve the best possible health outcomes. Access is multi-dimensional: affordability, availability (i.e., getting care when a person needs it), geographic and/or virtual accessibility (i.e., location of the care provider relative to where the client lives; accessibility via telehealth), accommodation (e.g., expanded hours of operation; ability to obtain an appointment in a reasonable time frame) and acceptability (e.g., physical access to the clinic, culturally appropriate services, receiving care from the appropriate health professional). Access is only achieved if all its components are ensured.

Appendix 3 | Definitions: Services Provided and Procedures Performed

Services Provided

Name	Definition
accompaniment	The intentional practice of presence
Advocacy	The act of directly representing or defending others.
anonymous HIV service	Testing of a person with certain infections, in particular HIV, and providing the results to public health departments without identifying the testee by name, only by a number.
application for limited eligibility	Application for limited eligibility
basic support	Basic support or supportive care (i.e. act of giving food, clothing or shower)
care plan documentation	A clinical skill, a sets of written instructions for specific activities to be undertaken to assist the client achieve their desired outcome.
case conference	Attending a scheduled meeting with other providers and/or family members and/or the client to discuss and develop a plan of care to benefit the client.
case management/coordination	Case management / coordination
chart review	Act of reviewing a chart
chronic illness monitoring	Monitoring client's chronic illness
client care written correspondence	Client/patient written communication
client intake/interview	Client intake/interview
complementary interventions	Complementary interventions
counselling regarding breast feeding	Counselling services are defined as services provided within the context of a professional relationship with the goal of assisting clients in addressing *breastfeeding* issues in their lives by such activities as helping clients to find solutions and make choices through exploration of options, identification of strengths and needs, locating information and providing resources, and promoting a variety of coping strategies, but do not include psychotherapy services.
cultural ceremony	Cultural ceremony
cultural teaching	Cultural teaching
dental care	Care for the teeth
diagnostic tests request	A generic term for any test used to determine the nature of severity of a particular condition e.g., imaging, laboratory tests, etc.
discussion regarding the diagnostic findings	Discussion regarding the diagnostic findings
discussion regarding the treatment plan	A documented plan that describes the patient's condition and procedure(s) that will be needed, detailing the treatment to be provided and expected outcome, and expected duration of the treatment prescribed by physician.

Name	Definition
dispensing medication	Includes preparing and giving medication for a client to take later, taking steps to ensure the pharmaceutical and therapeutic suitability of the medication for its intended use, and taking steps to ensure its proper use.
external consultation	To request or provide an opinion of/for an external provider. (The original provider maintains care of the issue.)
external referral	A referral made to a provider/service outside the centre. (The original provider transfers care of the issue.)
family planning/birth control	The act of making a conscious plan about the number and timing of children's births. It can include abortion, a discussion of the various means of contraception, fertility testing and even treatment.
family/couple counselling	Counselling services are defined as services provided within the context of a professional relationship with the goal of assisting clients in addressing *relationship* issues in their lives by such activities as helping clients to find solutions and make choices through exploration of options, identification of strengths and needs, locating information and providing resources, and promoting a variety of coping strategies, but do not include psychotherapy services.
foot care	Involves all aspects of preventative and corrective care of the foot and ankle.
forms completion	Forms completion
general assessment	A service that requires a full history (the elements of which must include a history of the presenting complaint, family medical history, past medical history, social history, and a functional inquiry into all body parts and systems), and, except for breast, genital or rectal examination where not medically indicated or refused, an examination of all body parts and systems, and may include a detailed examination of one or more parts or systems.
health advice / instructions	Health advice / instructions
health card registration services	Assisting a client in applying for OHIP and get a health card.
individual counselling	Counselling services are defined as services provided within the context of a professional relationship with the goal of assisting clients in addressing issues in their lives by such activities as helping clients to find solutions and make choices through exploration of options, identification of strengths and needs, locating information and providing resources, and promoting a variety of coping strategies, but do not include psychotherapy services.
information provision about community resources	Providing information to a client about resources that are available in their community to help meet their needs
intermediate assessment	A primary care service that requires a more extensive examination than a minor assessment. It also requires a history of the presenting complaint(s), inquiry concerning and examination of the affected part(s), region(s), system(s) or mental and emotional disorder as needed to make a diagnosis, exclude a disease and or assess function.
internal consultation	Consultation – internal: This means to request or provide an opinion of/for an internal provider. (The original provider maintains care of the issue.)

Name	**Definition**
internal referral	A referral made to a provider/service within the centre. (The original provider transfers care of the issue.)
interpretation	A service provided by a CHC – an interpreter (volunteer or paid by the CHC), is used to provide interpretation during a contact between a provider and a client.
interpreter dispatching	Interpreter dispatching
medication prescription	Medication prescription
medication reconciliation	Medication reconciliation
medication renewal	Medication renewal
mental health care	care for mental illness, behavioural maladaptations, and/or other problems that are assumed to be of an emotional nature, where there is consideration of the patient's biological and psychosocial functioning.
minor assessment	A minor assessment includes one or both of the following: *a.)* a brief history and examination of the affected part or region or related to a mental or emotional disorder; or *b.)* brief advice or information regarding health maintenance, diagnosis, treatment and/or prognosis.
occupational therapy	Occupational therapy
other identification services	Other identification services
palliative care	Care provided to a terminally ill patient in the final year of life where the decision has been made that there will be no aggressive treatment of the underlying disease and care is to be directed to maintaining the comfort of the patient until death occurs.
periodic health examination	Periodic health examination
permanent health card application	Permanent health card application
physical therapy	Physical therapy
postnatal care	Postnatal care
prenatal care	A prenatal major assessment includes a full history, and an examination of all parts or systems (and may include a detailed examination of one or more parts or systems), an appropriate record and advice to the patient. All other prenatal visits include the necessary history, examination, appropriate record and advice to the patient. All prenatal visits (major and minor and high risk) include pregnancy-related counselling as a form of providing advice to the patient or the patient's representative
preventive care	Preventive care
psychological assessment	Includes such psychiatric history, inquiry, and examination of the patient, as is appropriate, to enable the physician to complete, and includes completing, the relevant forms and to notify the patient, family, patient representative and relevant authorities under the Mental Health Act, where appropriate.
recommendation /assistance	Recommendation / assistance
repeated assessment	Ongoing monitoring of the patient's condition and intervening as appropriate.
speech/language therapy	Speech/language therapy

Name	Definition
traditional healing	Traditional healing
transportation assistance	Arranging or assisting with transportation when required.
transporting	Transporting
triage	Triage, sorting and allocating aid on the basis of need for or likely benefit from medical treatment.
well baby health examination	A periodic assessment of a well newborn/infant during the first two years of life including complete examination with weight and measurements, and instructions to the parent(s) or patient's representative regarding health care.
well baby support	Pediatric assessment also includes well baby care, which is a periodic assessment of a well newborn/infant during the first two years of life including complete examination with weight and measurements, and instructions to the parent(s) or patient's representative regarding health care.
well child health examination child	Determines whether the child's needs at different ages and stages are being met.
written translation of care provided to the patient	Written translation of care provided to the patient

Table 78 - Definitions of Services Provided

Procedures Performed

Name	Definition
Biopsy	*Removal of tissue to discover the presence, cause, or extent of a disease.* A biopsy is the removal of tissue from any part of the body to examine it for disease. Some may remove a small tissue sample with a needle while others may surgically remove a suspicious nodule or lump.
Blood pressure monitoring	Monitoring blood pressure. Blood pressure monitoring using a device that automatically measures blood pressure.
Bronchospirometry	Measuring ventilatory function of each lung separately.
Clipping toe nails	Clipping toe nails
Cryotherapy	Destruction of tissue of both benign and malignant lesions by the freezing and rethawing process.
Debridement	Removal of unhealthy tissue from a wound to promote healing.
Diaphragm fitting	Prevention of pregnancy by creating a barrier between uterus and sperm. A diaphragm is a reusable dome-shaped cup. It fits over the opening of the cervix.
EKG	Measures the electrical activity of your heart. It records this electrical activity as short, wavy lines that dip up and down on graph paper. The size and shape of these dips can reveal a number of things about your heart.
Eye exam (Snellen's technique)	Testing distance vision using a snellen chart.
Eye irrigation	Irrigating the eye
Fecal disimpaction	Decrease amounts of stool in the rectum and colon
FIT test ordered	Providing a FIT test to measure the possibility of colon cancer
Fobt kit supplied	Providing an FOBT kit to measure the possibility of colon cancer

Name	**Definition**
Footwear adjustments/orthotics	Adjusting/creating or prescribing foot orthotics source
Foreign body exeresis	Removing a foreign body
Immobilization	Holding a joint or bone in place with a splint, cast or brace.
Injection of drugs	Injecting a drug. Also called Subcutaneous Injection
IUD insertion	Inserting an IUD which is a small, T-shaped device that is inserted into a uterus as a method of birth control
IUD removal	Removing an IUD
Middle ear cleaning	Removal of any excessive earwax or debris safely. These instruments may include: a suction device; a spoon-like tool; forceps
Minor surgery	Any surgical procedure that does not involve anesthesia or respiratory assistance during the surgical procedure
Nail dremel	Filing or sanding the nail using a specialized tool
Onychectomy	Surgically moving a part or the whole toenail or fingernail.
Oxymetry and oxygen saturation	Measuring the concentration of oxygen in the blood in order to evaluate various medical conditions that affect the function of the heart and lungs.
Pap test	Testing of the cells of the cervix. The cervix is the opening between the vagina and the uterus. The Pap test looks for cells that are not normal and can cause cervical cancer.
Physical therapy	Provide services that develop, maintain and restore people's maximum movement and functional ability.
Plaster cast	Plaster cast is a protective shell of plaster or plastic, fiberglass and bandage that is molded to protect broken or fractured limb(s) as it heals.
Psychotherapy	Treatment of mental health problems by talking with a psychiatrist, psychologist or other mental health provider.
Removal of stitches or staples	Removal of stitches or staples
Respiratory physical therapy	Improving breathing by the indirect removal of mucus from the breathing passages of a patient.
Stretching	Stretching muscles to improve range of motion and muscle mobility.
TB test	Injecting one-tenth of a milliliter (ml) of PPD tuberculin.
TB test reading	"Reading" the skin test means detecting a raised, thickened local area of skin reaction, referred to as induration. Induration is the key item to detect, not redness or bruising.
Trimming	Trimming callus or nails
Venipuncture	Taking blood
Wound care	Providing wound care (including cleaning, dressing etc.)
Wound exploration (without repair)	Exploring wound (without repair)

Table 79 - Definitions of Procedures Performed