



# Model of Health and Wellbeing Evaluation Framework Manual

Performance Management Committee

---

November 2019

### 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		Review and update – entire document

# Contents<sup>1</sup>

INTRODUCTION .....	1
Background .....	1
Purpose .....	2
The Framework .....	3
RESULTS-BASED LOGIC MODEL.....	4
EVALUATION QUESTIONS & INDICATORS.....	6
<i>Process evaluation/measures</i> .....	7
<i>Outcome (or Impact) evaluation/measures</i> .....	7
<i>Indicator Use</i> .....	7
<i>Principles of Good Indicators</i> .....	7
EVALUATION FRAMEWORK INDICATOR TECHNICAL SPECIFICATIONS.....	8
<i>Mandatory (M) versus Required (R) data</i> .....	9
<i>Optional (Op) Data</i> .....	9
<b>Registration Data</b> .....	<b>9</b>
General Identifying Client Information – M .....	9
Sociodemographic Data .....	10
• Gender Identity – R .....	10
• Sexual Orientation – R.....	11
• Racial or Ethnic Group – R.....	11
• Country of Origin and Year of Arrival – R .....	12
• Homeless status – R .....	12
• Inclusive Definition of Francophone – R .....	12
• Preferred Language of Service – R .....	13
• Income and Number of persons supported by income – R .....	13
• Household Composition – R .....	14
• Highest Education Level Attained – R .....	14
• Religion – Op .....	15
• Disabilities – R .....	15
• Chart Status – M.....	16
• Termination Reason – R .....	16
• Ongoing Primary Care Client (OPCC) Status – M.....	16
<b>Wellbeing Data</b> .....	<b>16</b>
• Sense of Community Belonging – R .....	16
• Self-rated Physical Health - R .....	17
• Self-rated Mental Health - R .....	17
<b>Individual Service Event Data</b> .....	<b>18</b>
Individual Service Events or Encounters .....	18
• Date of Contact - M.....	18

---

<sup>1</sup> Data elements with **M = Mandatory**, **R = Required** and **Op = Optional**, based on organizational need

• Location of Contact – R .....	19
• Language of Contact – R.....	19
• Type of Contact – R .....	19
• Mode of Contact – R .....	20
• Reason for Visit – Op.....	20
• Issues Addressed - M .....	20
• Procedures Performed - R.....	21
• Services Provided - R.....	22
• Referrals Made.....	23
• Provider Types – R.....	23
• Agencies – R .....	26
• Immunizations - R .....	27
<b>Personal Development Group Data .....</b>	<b>27</b>
• Nature of Group – M.....	27
• Nature of Group Membership – M .....	28
• Nature of Group Sessions – M .....	28
• Group Life Span – M.....	28
• PDG Source – M .....	28
• Group Location – M.....	29
• Specific Issues Addressed – M.....	29
• Staff Involved and Role – M .....	29
• Total Individuals Registered – M .....	30
• Total Number Completed – M .....	30
• PDG Activities – M.....	30
• PDG Objectives – R.....	31
• Intended Populations – R.....	31
• % of Intended Populations (IP) Registered – M .....	34
• % of Intended Population Completed – M.....	34
• (Group) Member Prior State – R .....	34
• (Group) Member Outcomes – R.....	34
<b>Community Initiatives.....</b>	<b>35</b>
Community Initiatives Reporting Tool .....	36
<b>GLOSSARY.....</b>	<b>37</b>
<b>ACRONYMS .....</b>	<b>39</b>
<b>REFERENCES.....</b>	<b>40</b>
<b>APPENDIX 1: CORE INDICATORS AND OPTIONAL INDICATORS .....</b>	<b>42</b>
<b>APPENDIX 2: MODEL OF HEALTH AND WELLBEING ATTRIBUTES.....</b>	<b>52</b>

## List of Tables

Table 1- Correspondences between the RBLM direct outcomes (rows) and the MHWB attributes (columns).....	7
Table 2: Registration Data: Overview .....	9
Table 3 - General Client Information - Mandatory/Required .....	10
Table 4 - Sociodemographic data - Gender (Identity) .....	11
Table 5 - Sociodemographic data - Sexual Orientation .....	11
Table 6 - Sociodemographic data - Racial or Ethnic Group .....	12
Table 7 - Sociodemographic data - Country of Origin and Year of Arrival .....	12
Table 8 - Sociodemographic data - Homeless status .....	12
Table 9 - Sociodemographic data - Inclusive Definition of Francophone .....	13
Table 10 - Sociodemographic data - Preferred Language of Service .....	13
Table 11 - Sociodemographic data - Income and Number of persons supported by income .....	14
Table 12 - Sociodemographic data - Household Composition.....	14
Table 13 - Sociodemographic data - Highest Education Level Attained .....	15
Table 14 - Sociodemographic data - Religion .....	15
Table 16 - Sociodemographic data - Disabilities.....	15
Table 16 - Sociodemographic data - Chart Status.....	16
Table 17 - Sociodemographic data - Termination Reason .....	16
Table 18 - Sociodemographic data - Ongoing Primary Care Status .....	16
Table 19 - Wellbeing data - Sense of Community Belonging.....	17
Table 20 - Wellbeing data - Self-rated Physical Health.....	17
Table 21 - Wellbeing data – Self-rated Mental Health .....	17
Table 22: Individual Service Event Data: Overview .....	18
Table 23 - Individual Service Event - Date of Contact.....	18
Table 24 - Individual Service Event - Location of Contact.....	19
Table 25 - Individual Service Event - Language of Contact .....	19
Table 26 - Individual Service Event - Type of Contact.....	20
Table 27 - Individual Service Event - Mode of Contact.....	20
Table 28 - Individual Service Event - Reason for visit .....	20
Table 29 - Individual Service Event - Issues Addressed .....	20
Table 30 - Individual Service Event - Procedures Performed.....	21
Table 31 - Individual Service Event - Services Provided.....	23
Table 32 - Individual Service Event - Provider Types .....	25
Table 33 - Individual Service Event – Agencies.....	26
Table 34 - Individual Service Event - Immunizations .....	27
Table 35: Personal Development Group Data: Overview .....	27
Table 36 - Personal Development Group - Name of Group.....	27
Table 37 - Personal Development Group - Nature of Group Membership .....	28
Table 38 - Personal Development Group - Nature of Group Sessions.....	28
Table 39 - Personal Development Group - Group Life Span .....	28
Table 40 - Personal Development Group - PDG Source.....	28
Table 41 - Personal Development Group - Group Location.....	29
Table 42 - Personal Development Group - Specific Issues Addressed.....	29
Table 43 - Personal Development Group - Staff Involved and Role .....	29
Table 44 - Personal Development Group - Total Individuals Registered .....	30

Table 45 - Personal Development Group - Total Number Completed.....	30
Table 46 - Personal Development Group - PDG Activities.....	30
Table 47 - Personal Development Group - PDG Objectives.....	31
Table 48 - Personal Development Group - Intended Populations.....	33
Table 49 - Personal Development Group - % of IP Registered .....	34
Table 50 - Personal Development Group - % of IP Completed.....	34
Table 51 - Personal Development Group - Member Prior State.....	34
Table 52 - Personal Development Group - Member Outcomes .....	34
Table 53: Community Initiatives: Overview.....	36

## 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](#).

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.



Figure 1: Model of Health and Wellbeing

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 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 distil 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.

The Aboriginal Health Access Centres (AHACs) 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 CHC evaluation framework (the Framework).

The MHWB was updated in 2014 and formed the impetus for a review of the Framework. This work was completed in 2015 and resulted in the inclusion of a comprehensive list of potential and existing indicators.

In 2016, the [Performance Management Committee](#) (PMC) requested that guidance be provided on the meaningfulness and utility of the indicators. Consequently, a working group was launched to validate the 100+ indicators listed in the Framework. These indicators required refinement to ensure relevance for the sector. This also led to the identification, testing and implementation of a core set of the “vital few” for CHCs to measure. After the identification of the “Vital 8” Core indicators, a revision to the 2015 Framework began.

In 2017, the Framework was significantly revised for two reasons:

1. To update, change and/or remove *Registration*, *Individual Service Event* and *PDG*, data fields
2. To align with earlier, more comprehensive versions that listed the rationale for all of the mandatory and required data capture

## **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

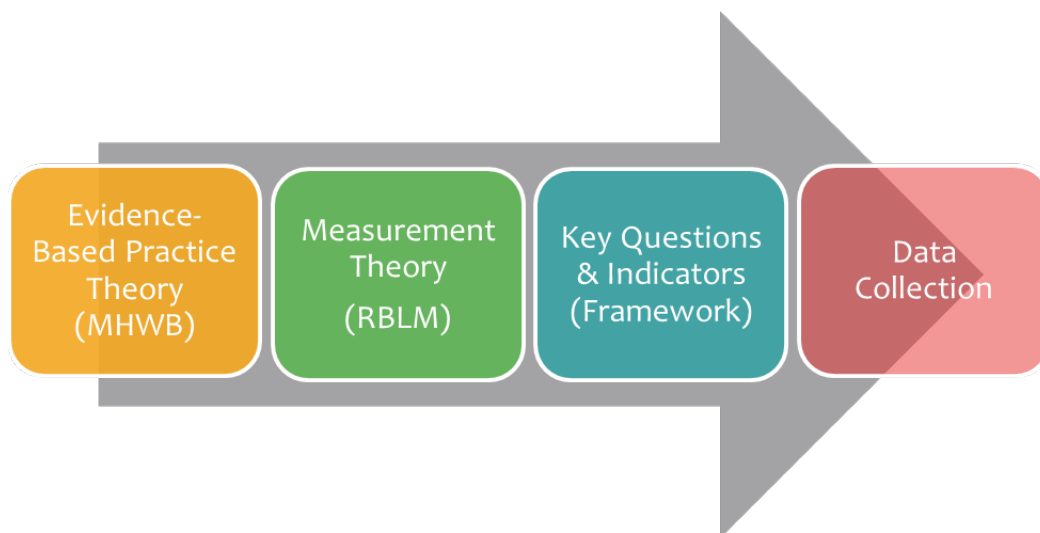
## Results-Based Logic Model

Results-based logic models 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).
- 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.*

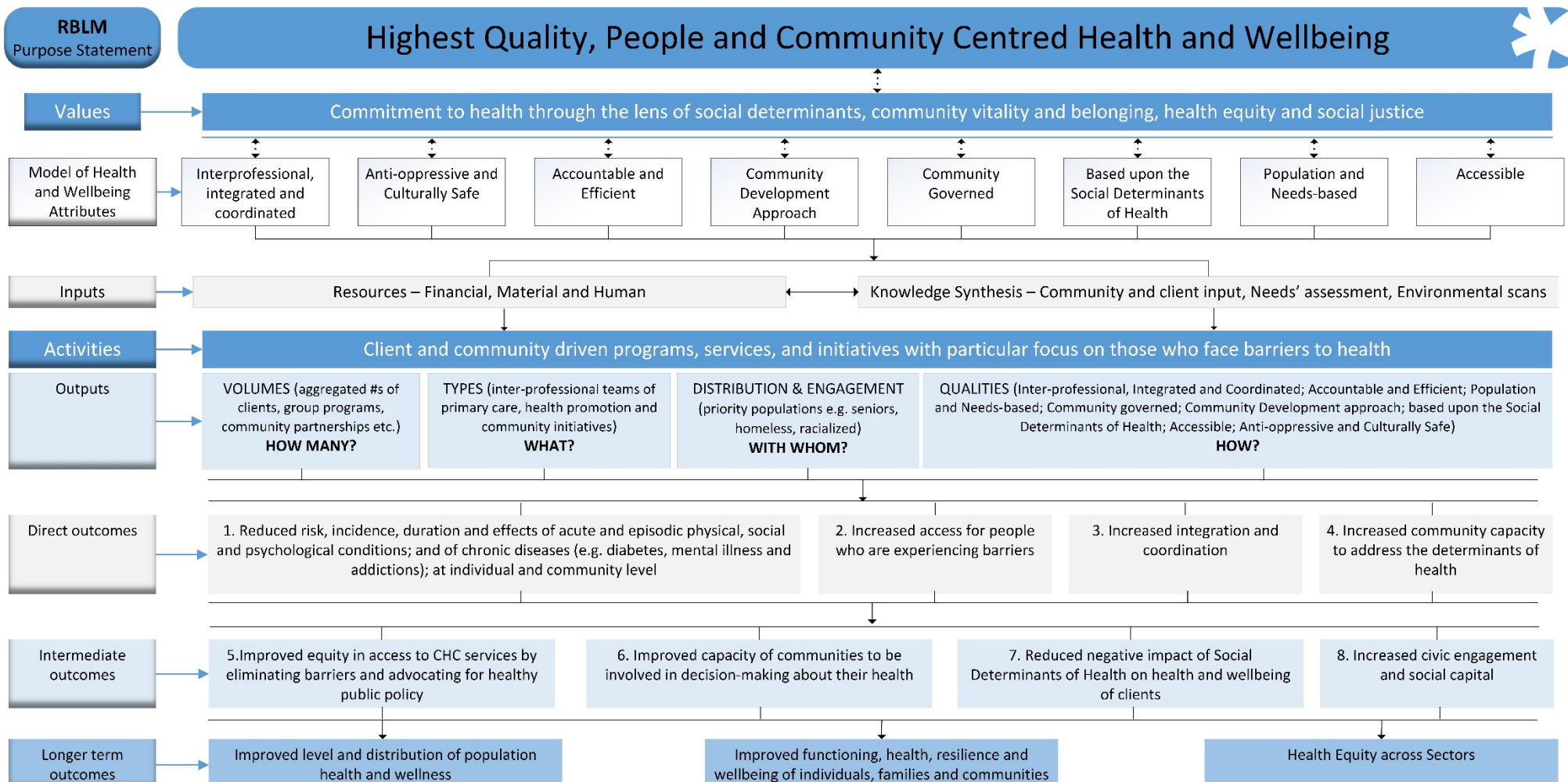


Figure 3: Results-Based Logic Model for evaluating CHC programs and services

## 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: % of encounters of clients whose Preferred Language is other than English and who receive service with same Language of Contact or Interpretation; % of community members reporting participation in organized activities; % of clients who always feel comfortable and welcome at [name of CHC]; % of clients who report that their family physician/nurse practitioner is sensitive to their cultural, ethnic and spiritual background and values; and % of clients reporting they never/rarely participate in community events and activities.

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 that 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 that 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***

In order 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) (Cambbell, 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 gathering 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 members 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**

<b>When</b>	Usually during the first contact and then updated when a change occurs or at a minimum every three years
<b>Who</b>	Determined by each member centre
<b>How</b>	The Electronic Medical Record
<b>Why</b>	This information helps answer questions such as: <ul style="list-style-type: none"><li>• Are members serving their intended populations?</li><li>• Are members addressing the demographic and other determinants of health?</li></ul>
<b>What</b>	Two types of individual client information should be collected for all registered clients: <ul style="list-style-type: none"><li>• General client information</li><li>• Sociodemographic information for each client</li></ul>

*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		Sex: Male; Female; other/unknown
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 three years.

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

- **Gender Identity – R**

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.

M	R
	x Male Female Intersex Trans - Female to Male Trans - Male to Female Two-spirit ( <i>a term used by Indigenous people</i> ) Other Do not know Prefer not to answer

Table 4 - Sociodemographic data - Gender (Identity)

- **Sexual Orientation – R**

LGB2Q\* (Lesbian, Gay, Bisexual, Two-Spirit, Queer, and other) populations experience multiple barriers to quality health care, such as social stigma and different health-seeking behaviours. These barriers, affects their access to health services access 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.

M	R
	x Bisexual Gay Heterosexual Lesbian Queer ( <i>a term used by people who do not follow common sexual orientations</i> ) Two-Spirit ( <i>a term used by Indigenous people</i> ) Other (Please specify): _____ Do not know Prefer not to answer

Table 5 - Sociodemographic data - Sexual Orientation

- **Racial or Ethnic Group – R**

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.

M	R
	x Asian – East Asian - South Asian - South East Black - African Black - Caribbean Black - North American First Nations Indian - Caribbean Indigenous/Aboriginal Inuit Latin American Metis Middle Eastern White - European White - North American Mixed Heritage Other Do not know Prefer not to answer

Table 6 - Sociodemographic data - Racial or Ethnic Group

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

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 7 - 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 8 - Sociodemographic data - Homeless status

- **Inclusive Definition of Francophone – R**

**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 9 - Sociodemographic data - Inclusive Definition of Francophone

- **Preferred Language of Service – R**

**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 10 - Sociodemographic data - Preferred Language of Service

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

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-\$14,999 \$15,000-\$19,999 \$20,000-\$24,999 \$25,000-\$29,999 \$30,000-\$34,999 \$35,000-\$39,999 \$40,000-\$59,999 \$60,000 to 89,999 \$90,000 to \$119,999 \$120,000 to \$149,999 \$150,000 or more Do not know Don't want to answer
	x	<b>Number of persons supported by income</b> 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  <b>(Note: this is Statistics Canada definition of the “Economic Family”).</b>

Table 11 - Sociodemographic data - Income and Number of persons supported by income

- **Household Composition – R**

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	Couple with children Couple without child Sole Member Grandparents with Grandchild(ren) Extended Family Unrelated housemates Siblings Single Parent Other Do not know Prefer not to answer

Table 12 - Sociodemographic data - Household Composition

- **Highest Education Level Attained – R**

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	Too young for primary completion Primary or equivalent ( <i>grades 1-8</i> ) Secondary or equivalent College University Bachelor's University Post-Graduate No formal education Other ( <i>specify</i> ) Do not know Prefer not to answer

Table 13 - Sociodemographic data - Highest Education Level Attained

• **Religion – Op**

Unlike other data fields, this one is optional depending upon the organizational need for the data.	Catholic Protestant Christian Orthodox Christian Muslim Jewish Buddhist Mennonite Hindu Sikh Eastern Religions Other Religions No religious affiliation
---	---

Table 14 - Sociodemographic data - Religion

• **Disabilities – R**

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	Chronic Illness Developmental Disability Drug or Alcohol Dependence Learning Disability Mental Illness Physical Disability Sensory Disability (i.e. hearing or vision loss) Other None Do not know Prefer not to answer

Table 15 - Sociodemographic data - Disabilities

- **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. The EMR does not automatically change this status, so centres will have to do it manually.

M	R	
x		Active Inactive

Table 16 - 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 17 - Sociodemographic data - Termination Reason

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

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 18 - 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 – R**

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 19 - Wellbeing data - Sense of Community Belonging

- **Self-rated Physical Health - R**

**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 20 - Wellbeing data - Self-rated Physical Health

- **Self-rated Mental Health - R**

**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 21 - Wellbeing data – Self-rated Mental Health

## Individual Service Event Data

### Individual Service Events or Encounters

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.

<b>When</b>	There is contact/interaction between CHC staff and a client and services are received by the client
<b>Who</b>	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.
<b>How</b>	<p>Information is completed about each contact with individual clients. Contact warranting documentation is defined as:</p> <ul style="list-style-type: none"> <li>• An interaction between an individual client and the provider for the purpose of receiving individualized service, that justifies a notation in the client chart.</li> <li>• 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.</li> </ul> <p>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).</p>
<b>Why</b>	This information helps answer questions about the work that happens on a one-on-one basis.
<b>What</b>	All information regarding one-on-one encounters.

Table 22 - 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 23 - 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, a satellite location or another contact point?

A satellite is defined as a location where health services are delivered outside of the main CHC, and which is characterized by:

- Regular operations, defined as a minimum of 21 hours per week.
- A fixed, accessible location, secured through ownership, a lease or a written agreement.
- Funding administered through the CHC.

A satellite should not be confused with a point of service or an access point, which do not meet the requirements listed above.

M	R	
	x	Centre – main location Satellite Community Agency School Public Space Client home Hospital Other

Table 24 - 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 25 - 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, 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 26 - 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 27 - 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	<i>The list provided by Electronic Nomenclature and Classification Of Disorders and Encounters for Family Medicine (ENCODE-FM)</i>
--	--

Table 28 - 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		<i>The list provided by Electronic Nomenclature and Classification Of Disorders and Encounters for Family Medicine (ENCODE-FM)</i>

Table 29 - Individual Service Event - Issues Addressed

- **Procedures Performed - R**

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

M	R
	x Biopsy Blood pressure monitoring Broncho-spirometry Clipping toenails Cryotherapy Debridement Diaphragm fitting EKG Eye exam (Snellen's technique) Eye irrigation Fecal disimpaction FOBT kit supplied Footwear adjustments/orthotics Foreign body exeresis Immobilization Injection of drugs IUD insertion IUD removal Middle ear cleaning Minor surgery Nail dremmel Onychectomy Oxymetry 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 Venipuncture Wound exploration (without repair) Wound Care

Table 30 - Individual Service Event - Procedures Performed

• **Services Provided - R**

List of actions undertaken –choose all that apply.

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 complementary interventions counselling regarding breastfeeding cultural ceremony cultural teaching interpretation 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 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

M	R
	periodic health examination permanent health card application physical therapy postnatal care prenatal care preventive care psychological assessment recommendation/assistance repeated assessment speech/language therapy 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 31 - Individual Service Event - Services Provided

- **Referrals Made**

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

M	R
	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 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

M	R
	Psychologist Radiologist Recreation Worker/Therapist Registered Practical Nurse ( <i>RPN</i> ) Respiratory Therapist Respirologist Rheumatologist Service access coordinator Social worker Speech/Language Pathologist Student/trainee Surgeon - general Surgeon - oral Surgeon - speciality ( <i>eye, heart, brain, etc.</i> ) System Navigator Traditional Healer Trained (paid) peer worker Urologist Volunteer Volunteer Coordinator Welfare worker Physician Assistant Youth Worker

*Table 32 - Individual Service Event – Referrals - Provider Types*

- **Agencies – R**

M	R			
	x	<b>Health Services</b> Addiction centre for alcohol and drugs Alternative health care clinic Ambulatory care facility ( <i>lab, x-ray, radiology, ultrasound, etc.</i> ) 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 ( <i>Psych</i> ) Clinic Physio/occupational therapy clinic Practitioner office - solo/group Preventive care clinic ( <i>mammogram, travel/tropical/infectious medicine, etc.</i> ) Primary care organization ( <i>outside of CHCs</i> ) Public health department Rehabilitation centre Research/Planning Focused Organization Sports medicine centre Urgent care centre Women's Health Centre/Clinic Other Health Agency/Organization	<b>Social and Community Service</b> 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 bank/soup kitchen Home Care Agency Housing agency ( <i>not-for-profit</i> ) 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 Welfare office Women's organization Other Social and Community Service	<b>Community Group</b> 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

Table 33 - Individual Service Event – Agencies

- **Immunizations - R**

M	R	
	x	<i>This field comes from the list of immunizations housed in the Electronic Medical Record.</i>

Table 34 - 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.

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

Table 35: 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 36 - 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 / recurring Open

*Table 37 - 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 38 - 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 39 - 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 40 - 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 Other

Table 41 - 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 42 - 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	<b>Staff Involved</b> Internal staff name selected from a drop-down External Staff added via text
x	<b>Staff Role</b> Facilitator Partner Leader Volunteer Facilitator Student Facilitator Resource Support / Advisor Trainer / Educator Client Enabler Other

Table 43 - Personal Development Group - Staff Involved and Role

- **Total Individuals Registered – M**

M	R	
x		# participants who are registered in the group

Table 44 - Personal Development Group - Total Individuals Registered

- **Total Number Completed – M**

M	R	
x		# participants who completed group

Table 45 - Personal Development Group - Total Number Completed

- **PDG Activities – M**

Description of the activities occurring with the group.

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

Table 46 - 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 47 - 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 <b>Age Groups</b> 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 <b>Gender</b> Male Female Intersex Trans - Female to Male Trans - Male to Female Two-spirit
	x <b>Sexual Orientation</b> Gay Lesbian Heterosexual Bisexual Queer (a term used by people who do not follow common sexual orientations) Two-spirit (a term used by Aboriginal people) Other

M	R	
	x	<b><i>Racial or Ethnic Group</i></b> Asian - East Asian - South Asian - South East Black - African Black - Caribbean Black - North American First Nations Indian - Caribbean Indigenous/Aboriginal Inuit Latin American Metis Middle Eastern White - European White - North American Mixed Heritage Other
	x	<b><i>Physical / Mental Condition</i></b> AIDS/HIV Alcohol dependence Heart Disease/hypertension Arthritis Asthma / COPD Chronic pain 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

<b>M</b>	<b>R</b>	
	x	<b><i>Social / Economic Condition</i></b> 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	<b><i>Role / Identity / Status</i></b> 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	<b><i>Languages Spoken</i></b> List of 100+ languages

*Table 48 - 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 49 - 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 50 - 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 51 - 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 52 - 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.

CIs should be captured in the online [Community Initiative Resource Tool](#) (CIRT).

<b>When</b>	At the end of each month
<b>Who</b>	<p>One person should have overall responsibility for monitoring the updating of the CI information each month into the CIRT. However, one person is not expected to have all the information. Staff and volunteers involved in the initiative can decide together on the best way to collect the data for that month.</p> <p>Everyone involved in CIs is encouraged to get in the habit of keeping notes throughout the month to help with the monthly updates using routine meetings and communications as opportunities to gather information about activities and milestones achieved by canvassing colleagues, volunteers, participants and other stakeholders for information</p>
<b>How</b>	Information is completed about a CI in the Community Initiatives Resource Tool
<b>Why</b>	This information helps answer questions about the work that happens from the community development work
<b>What</b>	A monthly snapshot describing goals, objectives, activities and outcomes

*Table 53: Community Initiatives: Overview*

### **Community Initiatives Reporting Tool**

The [Community Initiatives Resource Tool](#) can be accessed through the Alliance website. Contact [birt@allianceon.org](mailto:birt@allianceon.org) to obtain a username and password.

Version 3 of CIRT has been re-designed with the following tabs:

1. General
2. Target Population
3. Influences
4. Goals
5. Objectives
6. Activities
7. Partners
8. Resources
9. Assessment

## Glossary

TERM	DEFINITION
<b>Access Point</b>	<p>An Access Point is a location affiliated with the centre. It will have all of the following characteristics:</p> <ul style="list-style-type: none"> <li>• Health services are delivered less than 21 hours per week, perhaps in conjunction with a partner;</li> <li>• The site delivers a specific health service or bundle of services;</li> <li>• The site staff originates from the main centre or a satellite;</li> <li>• No reception or administrative support staff</li> <li>• Administration and infrastructure support provided by the main centre.</li> </ul> <p>See also <b>satellite</b>.</p>
<b>Active Client</b>	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.
<b>Baseline information</b>	Information collected at the beginning of a project that serves as the basis for comparison with information collected later.
<b>Community Initiative</b>	A community initiative is a set of activities aimed at strengthening the capacity of the community to address factors affecting its collective health.
<b>External Referral</b>	A referral made to a provider/service outside the centre.
<b>Indicators</b>	Indicators are specific measures indicating the degree to which goals and/or objectives have been achieved.
<b>Internal Referral</b>	A referral of made to a provider/service within the centre.
<b>Interpretation Services</b>	<p>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.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• The language of contact is always the language the provider spoke while delivering the service.</li> </ul>

TERM	DEFINITION
<b>Logic Model</b>	<p>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.</p> <ul style="list-style-type: none"> <li>• <b>Target populations</b> 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.</li> <li>• <b>Inputs</b> include resources dedicated to or consumed by the program. Examples are money, staff, and staff time, volunteers and volunteer time, facilities, equipment, and supplies.</li> <li>• <b>Outputs</b> 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).</li> <li>• <b>Outcomes</b> 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.</li> </ul>
<b>Mandatory Data</b>	Data which is necessary for a record to be valid. The field cannot be blank. See also <b>Required Data</b> and <b>Optional Data</b> .
<b>Multi-Sectoral Accountability Agreement (M-SAA)</b>	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.
<b>Ongoing Primary Care Client (OPCC)</b>	A registered client who receives <u>ongoing</u> primary care from a centre. This group forms the denominator for mandatory M-SAA reporting.
<b>Personal Development Group (PDG)</b>	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.
<b>Process evaluation</b>	An assessment of what activities were implemented, the quality of implementation, and the strengths and weaknesses of the implementation.
<b>Required Data</b>	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.

TERM	DEFINITION
<b>Satellite</b>	A permanent location where health services are delivered outside of the main centre. Satellite centres are characterized by: <ul style="list-style-type: none"> <li>• Regular operations (minimum of 21hr/week);</li> <li>• Fixed, accessible location, secured through ownership, a lease or a written agreement.</li> <li>• Ongoing, dedicated staff</li> <li>• Its own administrative and infrastructure support</li> </ul>
<b>Service Event</b>	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.
<b>Services Provided</b>	Services undertaken by the provider.
<b>Target Populations</b>	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

## Acronyms

TERM	MEANING
AHAC	Aboriginal Health Access Centre
BIRT	Business Intelligence Reporting Tool
CHC	Community Health Centre
CI	Community Initiatives
CIRT	<a href="#">Community Initiatives Reporting Tool</a>
CIW	Canadian Index of Wellbeing
DOH	Determinants of Health
ENCODE-FM	Electronic Nomenclature and Classification Of Disorders and Encounters for Family Medicine
HQO / QIP	Health Quality Ontario / Quality Improvement Plans
ICES	Institute for Clinical Evaluative Sciences
IP	Intended Population
LGB2Q*	Lesbian, Gay, Bisexual, 2-Spirited, Queer, or other
LHIN	Local Health Integration Network
MHWB	<a href="#">Model of Health and Wellbeing</a>
M-SAA	Multi-Sectoral Accountability Agreements (see <a href="#">Glossary</a> )
OPCC	Ongoing Primary Care Client (see <a href="#">Glossary</a> )
PDG	<a href="#">Personal Development Group</a>
PMC	Performance Management Committee ( <i>see the Glossary for more information</i> )
RBLM	<a href="#">Results-based Logic Model</a>

## References

- Alberta Health (2013). Primary Health Care Evaluation Framework. Accessed May 6, 2019 from <https://open.alberta.ca/publications/6862113>.
- Campbell, S. M.; Braspenning, J.; Hutchinson, A; and Marshall, M. (2002). Research methods used in developing and applying quality indicators in primary care. *Quality & Safety in Health Care* 11:358-364. Accessed May 6, 2019 from <https://www.who.int/management/district/ResearchMethodsQualityIndicatorsPHC.pdf>.
- Canadian Institute for Health Information (2012). *Pan-Canadian Primary Health Care Indicator Development Project*. Accessed May 6, 2019 from [https://secure.cihi.ca/free\\_products/Pan-Canadian\\_PHC\\_Indicator\\_Update\\_Report\\_en\\_web.pdf](https://secure.cihi.ca/free_products/Pan-Canadian_PHC_Indicator_Update_Report_en_web.pdf).
- Canadian Institute for Health Information and Health Quality Ontario (2013). *Ontario Primary Care Performance Measurement Summit Proceedings Report*. Accessed May 6, 2019 from <http://www.hqontario.ca/Portals/0/Documents/pr/pc-summit-proceedings-report-en.pdf>.
- Canadian Institute for Health Information and Statistics Canada (n.d.). *Health Indicators Consensus Conference report: Report from the Third Consensus Conference on Health Indicators*. Accessed May 6, 2019 from <https://www150.statcan.gc.ca/n1/pub/82-230-x/82-230-x2009001-eng.htm>.
- Government of Canada (2010). *Treasury Board of Canada results-based management accountability framework*. Accessed May 6, 2019 from <http://www.tbs-sct.gc.ca/cee/tools-outils/polrmaf-polcgr-eng.asp>.
- Health Quality Ontario (n.d). *How Indicators are Selected to Measure Ontario's Health System Performance*. Accessed May 6, 2019 from <https://www.hqontario.ca/System-Performance/Measuring-System-Performance/How-Indicators-are-Selected>.
- Health Quality Council of Alberta (2005). *Alberta Quality Matrix for Health: User Guide*. Accessed May 6, 2019 from [https://hqca.ca/wp-content/uploads/2018/05/HQCA\\_User\\_Guide\\_Web.pdf](https://hqca.ca/wp-content/uploads/2018/05/HQCA_User_Guide_Web.pdf).
- Hoffman, K. (2009). A Decision Support System for Community Initiatives: Background and Recommendations for Action: Final Report. Submitted to the Alliance.
- Laplante, Nancy and Service, Aaron (2015). Wellbeing Evaluation Framework & Data Entry Manual Presented at Community Connections 2015. Richmond Hill, Ontario: June 2, 2015.
- Ng, Edward (2011). The healthy immigrant effect and mortality rates. *Statistics Canada Health Reports*. Accessed 01 May 2019 from: <https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2011004/article/11588-eng.pdf?st=vTrP62Si>.
- Posavac, E.J., and Carey, R. G. (2010). *Program Evaluation Methods and Case Studies* (8<sup>th</sup> ed). Prentice Hall, Upper Saddle River, New Jersey.

R. A. Malatest & Associates Ltd. (n.d.). Primary Care Initiative Evaluation. Accessed May 6, 2019 from Available from: <http://pcnevolution.pcnpmo.ca/SiteCollectionDocuments/PCNe%20Overview/malatest-PHC-PrimaryCareInitiative-Evaluation2011.pdf>

Pyra Management Consulting Services Inc. and Research Power (2006). *A Primary Health Care Evaluation System for Nova Scotia*. Prepared for IncorporatedNova Scotia Department of Health. Accessed May 6, 2019 from <https://novascotia.ca/dhw/publications/Primary-Health-Care-Evaluation-Report-2006.pdf>.

Raphael, D. (ed.) (2009). *Social Determinants of Health: Canadian Perspectives*. 2nd edition. Toronto: Canadian Scholars' Press Incorporated.

Rayner, Jennifer; Muldoon, Laura; Bayoumi, Imaan; McMurchy, Dale; Mulligan, Kate; and Tharao, Wangari (2018). "Delivering primary health care as envisioned: A model of health and well-being guiding community-governed primary care organizations", *Journal of Integrated Care*, Vol. 26 Issue: 3, pp.231-241, <https://doi.org/10.1108/JICA-02-2018-0014>. Accessed April 30, 2019.

Watson, D.E., Broemeling, A.-M. , Reid, R. and Black, C. (2004). "A Results-Based Logic Model for Primary Health Care: Laying an Evidence-Based foundation to Guide Performance Measurement, Monitoring and Evaluation." Vancouver: Centre for Health Services and Policy Research.

Watson, D.E. 2009. "for Discussion: A Roadmap for Population-Based Information systems to Enhance Primary Healthcare in Canada." *Healthcare Policy* 5(Sp): 105–20.

Weinstein, S. (2014). *Bramalea Community Health Centre / Four Corners Health Centre Community Initiative Evaluation Guide*.

World Health Organization. (2008). *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Geneva: World Health Organization.

World Health Organization (n.d.). *Primary Care Evaluation Tool*. Accessed May 6, 2019 from [http://www.euro.who.int/\\_data/assets/pdf\\_file/0004/107851/PrimaryCareEvalTool.pdf](http://www.euro.who.int/_data/assets/pdf_file/0004/107851/PrimaryCareEvalTool.pdf).

## Appendix 1: Core indicators and Optional Indicators

In 2016, at the request of the 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	
<b>DIRECT OUTCOME #1:</b> 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	
Key Questions	MHWB Attribute	
How does interprofessional 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 effects of selected conditions and diseases compared to similar people who do not?	A. Interprofessional, integrated and coordinated	

Key Questions	MHWP Attribute
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
How can 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
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

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): <ul style="list-style-type: none"> <li>• Tobacco use;</li> <li>• Unhealthy eating habits;</li> <li>• Problem alcohol drinking;</li> <li>• Obesity</li> <li>• Physical inactivity</li> <li>• Social isolation</li> <li>• Poverty/ Food insecurity</li> </ul>	EMR / CIRT
*% of clients reporting involvement in care decisions	Client experience
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) <ul style="list-style-type: none"> <li>• Acute episodic care</li> <li>• Non-urgent care (e.g. well-baby care, prenatal care, chronic disease management)</li> <li>• Prevention and health promotion services</li> <li>• Primary mental health care</li> <li>• Psychosocial services (e.g. counselling advice for physical/emotional/ financial concerns)</li> <li>• Case management for vulnerable populations</li> <li>• Referral to and follow-up care from specialized services</li> <li>• Nutrition counselling</li> <li>• Dental services</li> <li>• End-of-life care</li> </ul>	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
% of adults with diagnosed diabetes with an HbA1c value less than 7 percent	EMR / BIRT

Optional Indicators	Data Source(s)
% 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

RBLM Direct Outcome	MHWB Attributes	
<b>DIRECT OUTCOME #2:</b> 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	
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? <sup>2</sup>	C. Determinants of Health	
What are the key DoH for the particular CHC (e.g. First Nation, poverty, income, housing, security, carding, etc.)? <sup>3</sup>	C. Determinants of Health	
Are CHCs identifying people with barriers and addressing barriers to DOH and wellbeing compared with other models? <sup>4</sup>	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	

<sup>2,3,4</sup> Identified by Community Health and Wellbeing (CHW) strategy working group as priority areas

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

Optional Indicators	Data Source
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)
% 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

RBLM Direct Outcome	Model of Health and Wellbeing Attributes	
<b>DIRECT OUTCOME #3:</b> 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	
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	
How do the CHCs work together to serve the Non-insured clients, CIs or PDGs?	E. Accessible	

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

RBLM Direct Outcome	MHWB Attributes	
<b>DIRECT OUTCOME # 4:</b> Increased community capacity to address the determinants of health.	<b>A.</b> Interprofessional, integrated and coordinated	✓
	<b>B.</b> Community Development Approach	✓
	<b>C.</b> Determinants of Health	✓
	<b>D.</b> Accountable and Efficient	
	<b>E.</b> Accessible	
	<b>F.</b> Community Governance	✓
	<b>G.</b> Population and needs-based	✓
	<b>H.</b> Anti-oppressive and culturally safe	
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	
Does CHC community governance increase community capacity to address the determinants of health?	F. Community Governance	
Core (Vital 8) Indicators		Data Source(s)
<b>*% of community members with a strong or very strong sense of belonging to the community (O)</b>		Client survey
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

## 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.

### 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



Figure 4: Model of Health and Wellbeing

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.