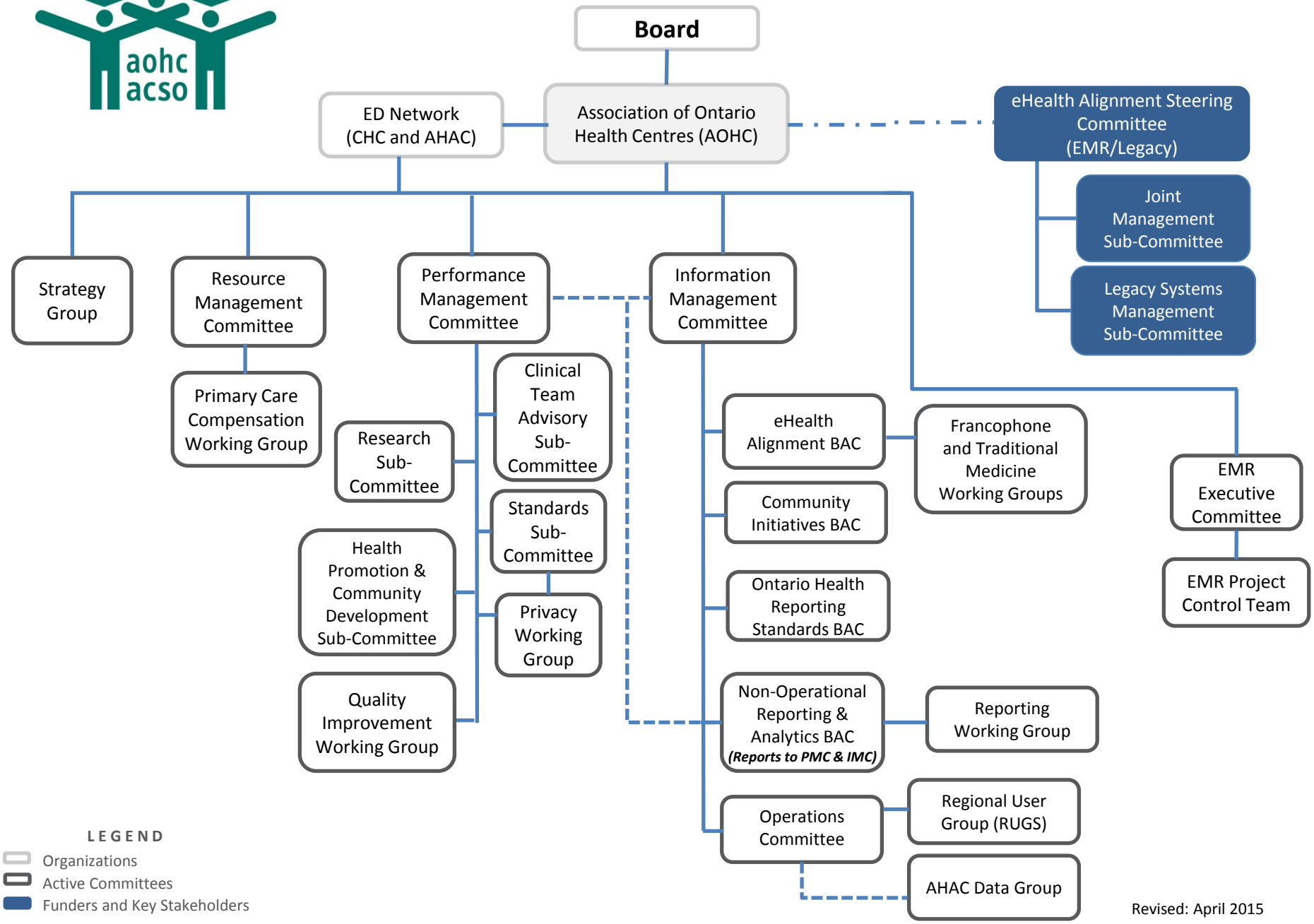
Developing Primary Care Measures that Matter: Creating a CHC Primary Care Dashboard

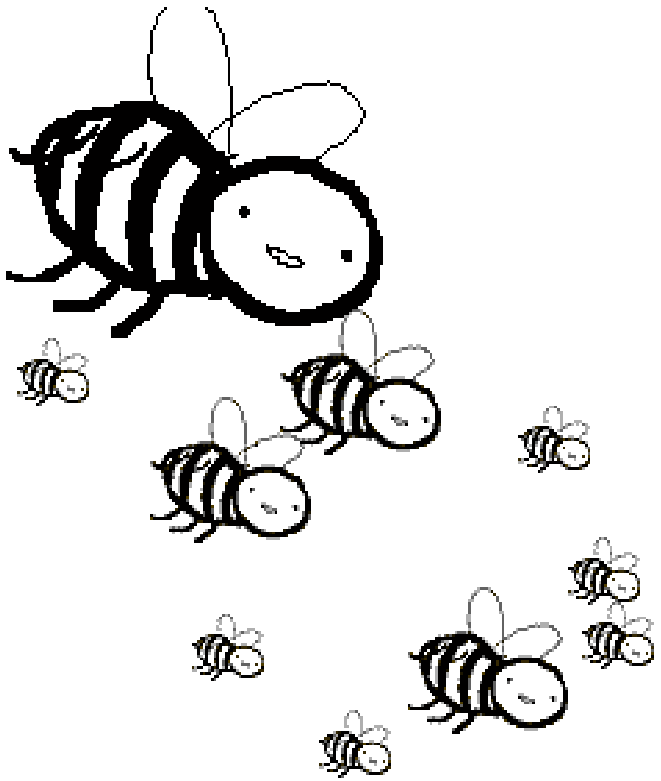
Clinical Team Advisory Group

CHC and AHAC ED Network Committee Structure



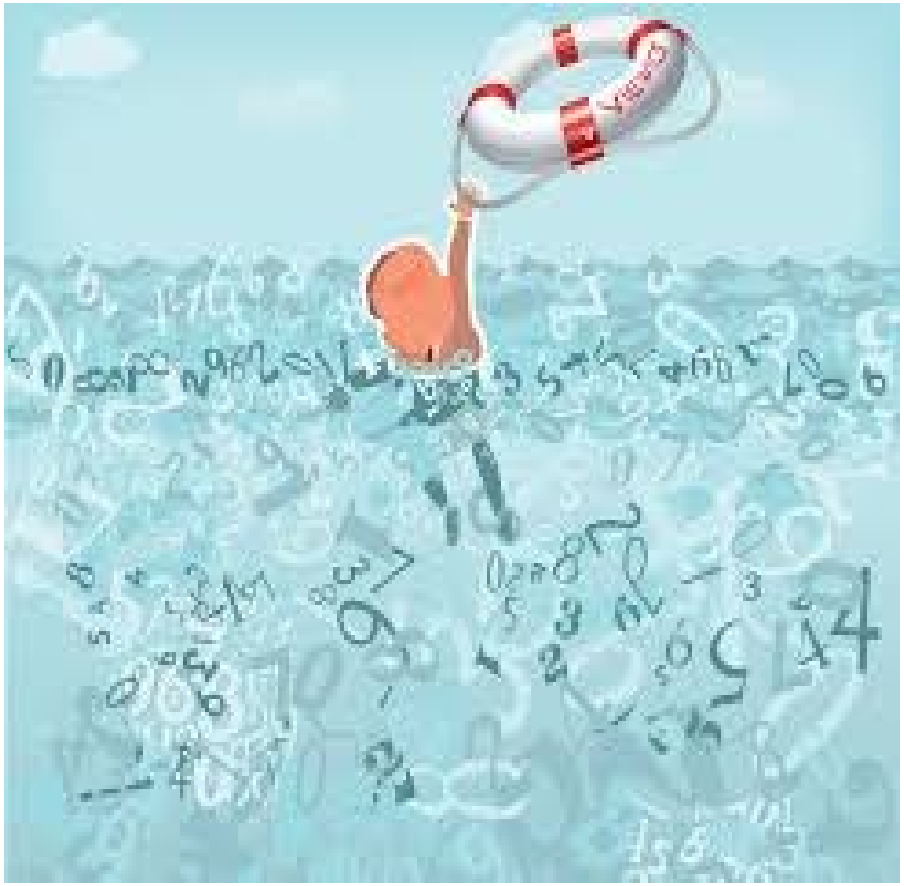
Revised: April 2015

Clinical Team Advisory (CTA)



- Mandate: PMC has identified measurement related to clinical quality of care & QI as one of its focus areas. Provide guidance & advice on all projects related to primary care measurement, and QI
- Clinical Providers
  - Dietitians, Nurses, Nurse Practitioners, Physicians
- Clinical Directors/Managers
- Clinical measurement, indicators, EMR functionality, best practices, QI, research projects, innovative ideas/ brainstorming
- Looking for new members ☺

Our Reality…



- Lots of indicators & reported data
- Indicators prioritized by systems outside of the sector
- Perceived as not useful for decision making or improvement in clinical care
- Solution…prioritize a set of measurements that are useful to us as clinicians & clinical decision makers
- Create a dashboard

Importance of measuring & benchmarking

Primary Care Dashboard

- Quality information is a driver of performance
- Clinical dashboard → relevant & timely information to inform decisions & improve quality of client care
- PC administrative dashboard → data for decision making, benchmarking & QI
- Provide an active performance monitoring tool for clinical engagement, operational effectiveness, clinical outcomes & patient experience

What is a dashboard?

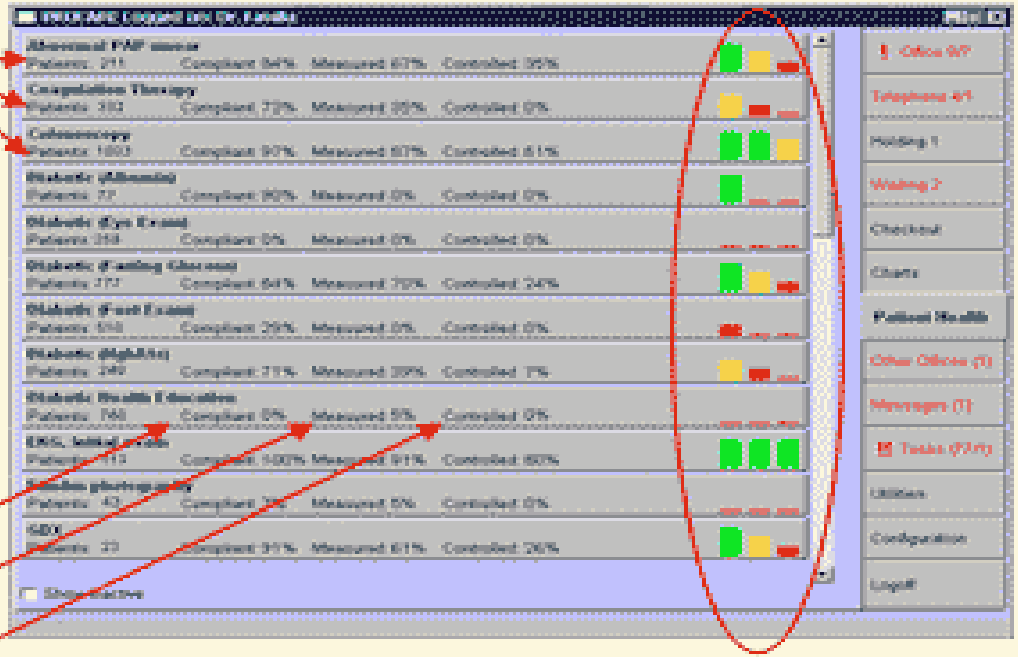
- Set of priority measures and metrics
  - Dashboards are a useful tool for presenting data in a meaningful way
- Visual tool to provide non-technical users the answers they need to be more productive, efficient and effective
- Patterns and trends can be seen at a glance
- Breaks down data barriers – anyone can access and use information

Example

PROCARE

Clinical Performance Dashboard (2.a)

Clinical Performance Measures



On Protocol/ Compliant

Measured

Controlled

Green = Performance Measure Above Threshhold

Yellow = At Threshold

Red = Below Threshold

Example


ExpType
2007
Apr
May
Jun
Consultant
POD
Sex
Specialty
SubSpecialty
SpellHRG
MRN
Age_Groups
0-12
12-18
18-30
30-50
50-65
65-75
75-85
Current Selections
Fields
Values
40,127 FCEs or Attendances
50,000
40,000
30,000
20,000
10,000
0
Top 10 Specialties by cost
3,000,000
2,000,000
1,000,000
0
420 171 110 192 180 370 160 120 301 421
Specialty
Specialty Costs by POD
POD
AE
DA
DC
EL
NEL
OPFA
OPFUP
WA
£0.00 Total Cost (£m)
0
3
6
9
12
15
Top 10 SubSpecialties by cost
2,000,000
1,500,000
1,000,000
500,000
0
12 11 27 10 180 15 13 17 28 14
SubSpecialty
Specialty costs
Specialty
110
120
160
171
180
192
301
370
420
421
Others


Principles
•Data availability
•No additional data entry
•Meaningful & actionable
•QI/Iterative approach
•Validated indictors

Existing Data Sources
Quality Book of Tools

- Developed by Cheryl Levitt & Linda Hilts
  - McMaster University
- Book of practice management and clinical care indicators
- Aligned with the Attributes of a High Performing Health System
- Patient Centred, Equitable, Timely and Accessible, Safe, Effective Clinical Practice, Efficient, Integrated and Continuous, Appropriate Practice Resources
- http://qualitybookoftools.ca/

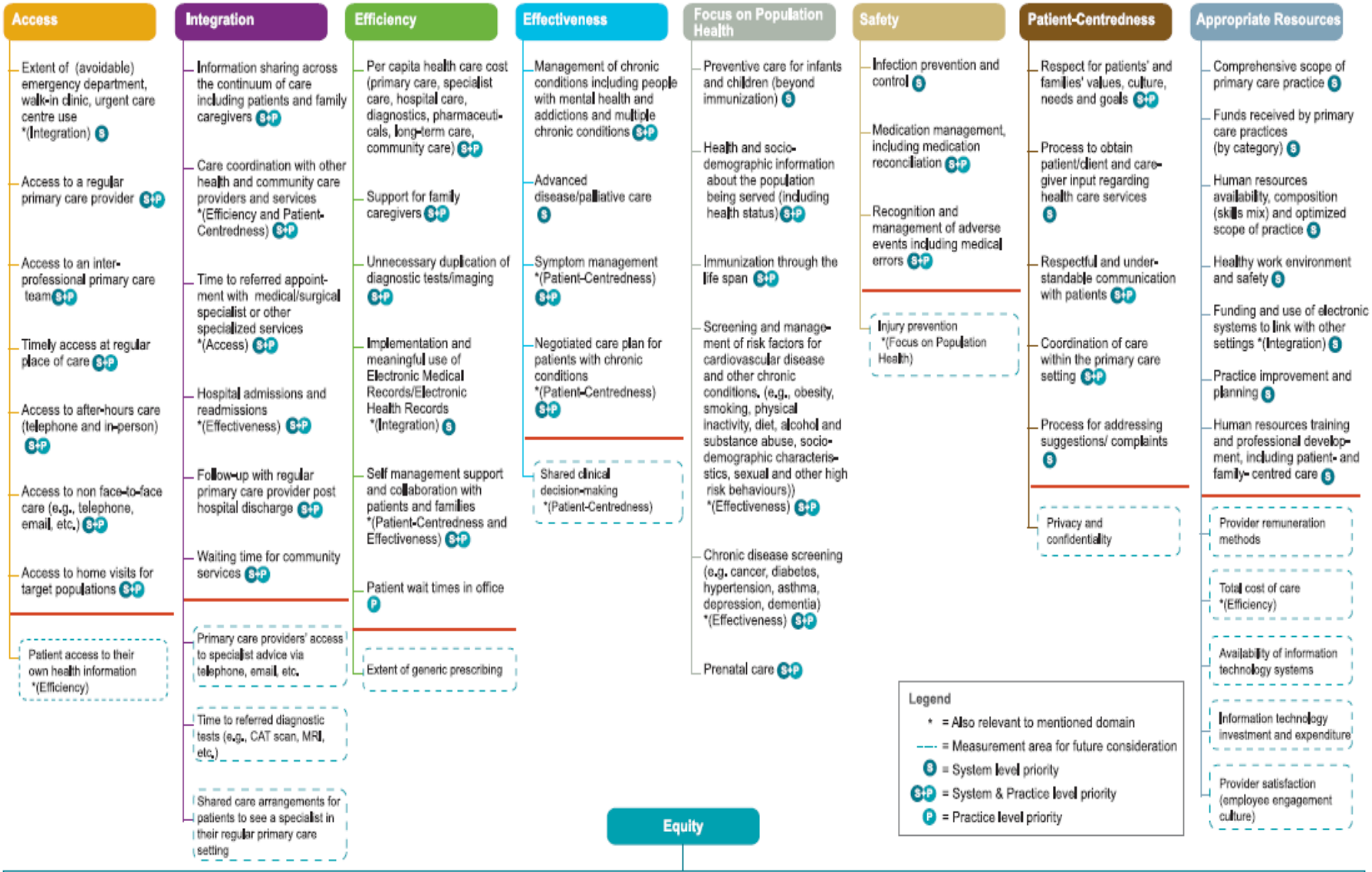
Existing Data Sources: Primary Care Performance Measurement Framework

- Measures primary care performance at the practice and system level.
- 8 domains + Equity
  - Access, Integration Efficiency, Effectiveness, Population Health, Safety, Patient- Centredness, Appropriately resources

http://www.hqontario.ca/public-reporting/primary-care

Primary Care Performance Measurement Framework

(Ontario Primary Care Performance Measurement Steering Committee, May 2014)



Equity is a cross-cutting domain and will be assessed in relation to a variety of economic and social variables such as income, education, gender, disability, social support, mental health status, urban/rural location, age, sexual orientation/identity, language, immigration, ethno-cultural identity and Aboriginal status.

Dashboard Prioritization - Methods

- Modified Delphi process (survey + summary + discussion + consensus)
- Survey created that included ~ 200 measures on a 7-point scale
  - PCPM – Focused on practice level measures
  - Quality Book of Tools – quality indicators included (yes/no questions excluded)
  - Common Administrative indicators
- CTA + additional staff responded (n = 42)

Dashboard Prioritization - Analyses

- For each indicator average score, standard deviation (and range) was calculated
- Rank ordered and presented back to group to ensure consensus (no indicator lost)
- High correlation between rankers
- Indicators that were ranked highly for the most part had little variation

PCPM Prioritization

- PCPM prioritization – somewhat parallel with CTA
- Of the 299 measures – 112 were considered practice level measures (others were system level)
- Many practice level measures are also system level measures
- 2 HQO working groups established – system and practice level prioritization groups (CHC reps on both + CHC co-chaired practice-level group)

PCPM Prioritization

- CTA results + similar survey sent to 400 providers (20% responded)
- Results analyzed & top indicators reviewed by smaller working group (clinicians from various PC models
- Identified an initial list of 10-15 high value practice level measures for all primary care providers in Ontario (CHCs ahead of the curve)
- Many of the PCPM measures are already reported in the CHC sector

Access

CTA Prioritization	PCPM
% of clients who report that when they call with a medical question they get an answer on the same day	% of total PC visits that are made to the MD with whom the patient is rostered or virtually rostered
% of clients who report that they have a family physician or NP	% of patients who report that they were able to see their MD/NP on the same or next day
	% of patients who report that getting care on evenings or weekends was hard

Integration

CTA Prioritization	PCPM
% of clients with chronic conditions who rate their PCP as VG/E in helping coordinate their care & treatment	% of people who were readmitted to a hospital (30 days and 1 year)
% of clients who report that their PCP was informed about the care they received from specialists	% of patients who see MD/NP within 7 days after discharge from hospital

Efficiency

CTA Prioritization	PCPM
% of clients who report that their PCP helped them feel confident about their ability to take care of their health	Per-capita health care expenditures by Category (broken out by LTC, ED Visits, hospitalizations, etc)
% of clients who report they received relevant advice at their PC visits on staying healthy & avoiding illnesses	Patient reported wait times from when their consultation was scheduled to start to when they met with a health care provider.
% of clients who report that their main PCP gave them a sense of control over their health	
% of clients with chronic conditions who report they were provided information about community programs	

Effectiveness

CTA Prioritization	PCPM
% of clients who report working out a care plan about their chronic conditions	Percentage of patients with diabetes with 2 or more glycated hemoglobin (HbA1c) tests within the past 12 months
% of clients with diabetes who report having a foot exam in the past 12 months	
% of clients with coronary artery disease who received the following tests in the last 12 months (HbA1c, lipid profile, blood pressure, obesity screening, all of the above)	
% of clients with HTN with BP recorded in the last 9 months	% of clients with HTN with BP recorded in the last 9 months
% of clients with chronic conditions who had a review in the last 12 months	
% of clients with depression who have been asked if they had thoughts about suicide	
% of clients who report getting help from a professional when they had emotional distress (anxiety or depression, in the past two years)	

Focus on population health

CTA Prioritization	PCPM
% of eligible patients who had colorectal screening	% of eligible patients who had colorectal screening
% of eligible patients who had cervical screening	% of eligible patients who had cervical screening
% of patients aged 12 and over who report smoking daily or occasionally	Population descriptive characteristics (age, sex, income, etc collected for all patients)
% of patients who report having a discussion within the past two years with their PCP regarding health behaviours/ risk factors (e.g alcohol use, exercise, smoking, etc	% of patients aged 12 and over who report smoking daily or occasionally
	% of patients who are obese, overweight, underweight or normal weight
	% of patients aged 65+ years who received pneumococcal vaccine

Patient Centredness

CTA Prioritization	PCPM
% of clients who report that their PCP is able to communicate with them in a language they can understand	% of patients who report that their MD/NP or someone else in the office involves them as much as they want in decisions about their care
% of clients who can talk about personal problems related to their health condition	% of patients who report that their MD/NP or someone else spends enough time with them
% of clients who report being treated with respect by the PCP	

Safety

CTA Prioritization	PCPM
% of clients who report they were given enough information about new medications	NONE ACCEPTED Working Group recommended developing measures not included on initial list: • polypharmacy among the elderly • up-to-date allergy status recorded

Appropriately Resourced

CTA Prioritization	PCPM
Healthy work environment and safety	No priorities at the practice level
Practice improvement and planning	
Practice undertakes annual patient satisfaction survey	

Administrative

CTA Prioritization
Average # of encounters/day
Average # of encounters/provider/day
Average # of client visits per year
# of clients with >50 visits per year
Client re-visit rate
No Show Rate
# of clients with 4+ conditions
Costing data – cost per clinical client, cost per provider


Have your say

Table Discussions

- Each table will take at least 1 domain + admin measures
- Discuss each one & select the top 2-3 measures that you feel are most actionable & meaningful
- Review your list of prioritized indicators & discuss what is missing
- CTA facilitators will be at each table taking notes
- Report back if time permits

Next Steps

- CTA will review and incorporate all feedback
- Specifications will be drafted defining indicator and data sources
- Dashboard developed, data populated, tested
- Data released and updated regularly
- Indicators reviewed yearly and dashboard will be refined over time