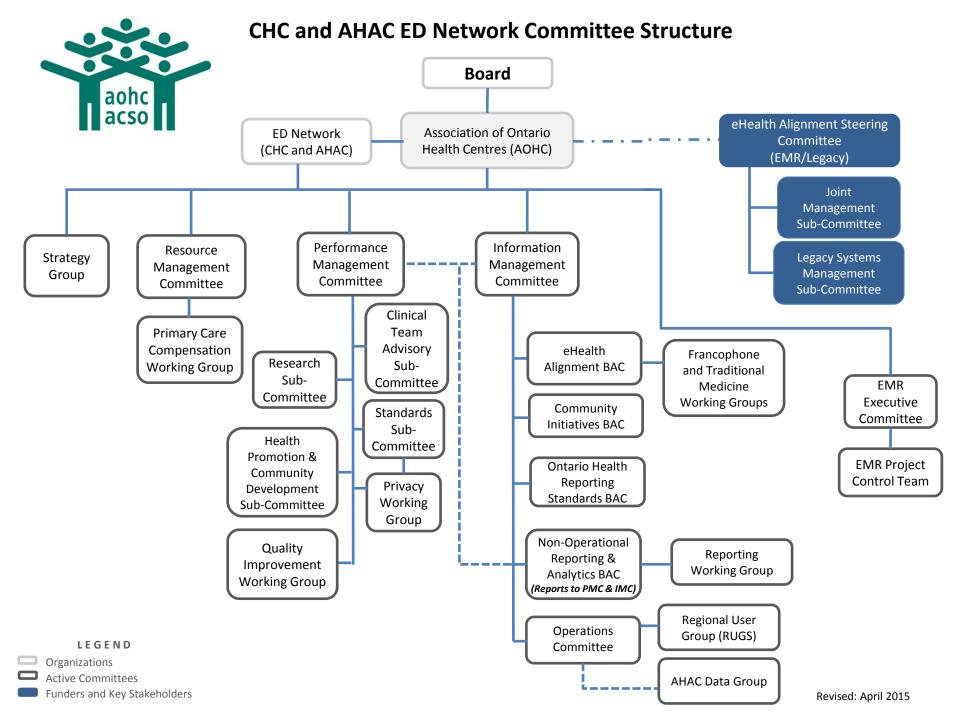
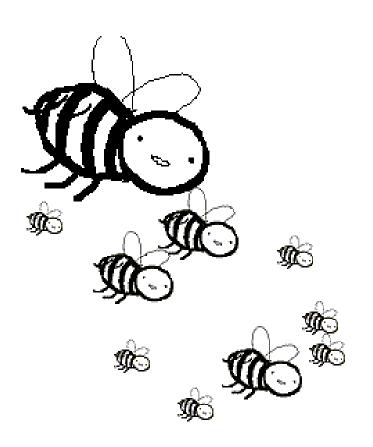
Developing Primary Care Measures that Matter: Creating a CHC Primary Care Dashboard

Clinical Team Advisory Group



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 ©





- 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



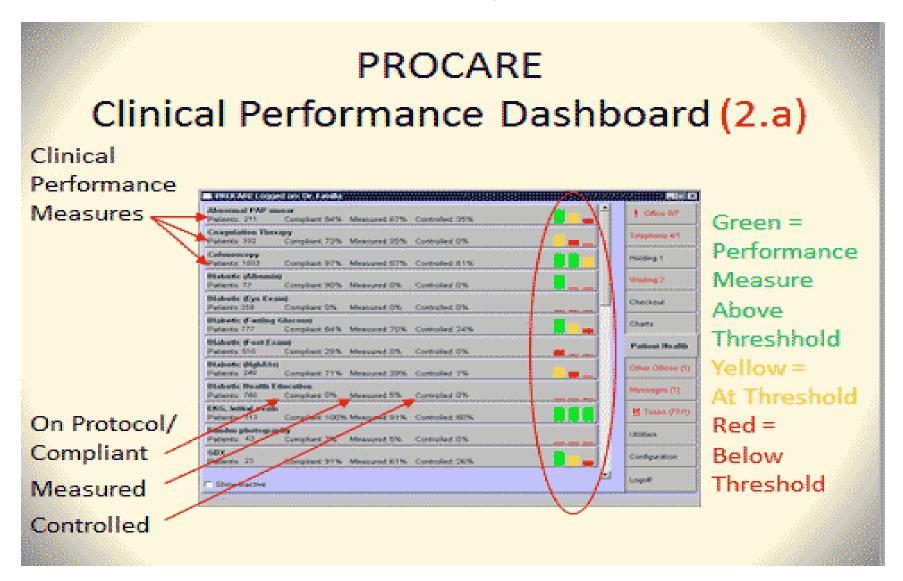
Primary Care Dashboard

- 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

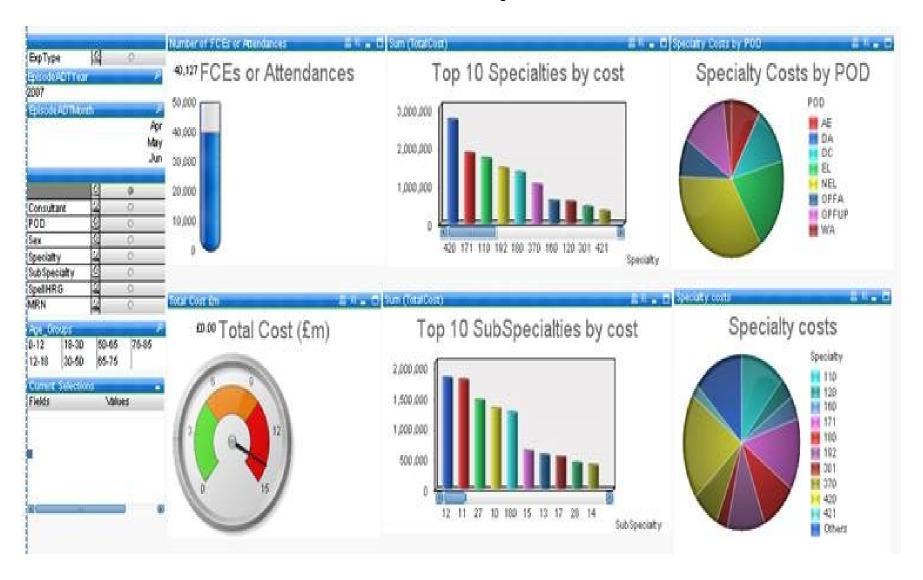
What is a dashboard?

- 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



Example





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

Sixteen

Ontario organizations come together for a groundbreaking project to measure primary health care performance.



http://www.hqontario.ca/publicreporting/primary-care

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

Primary Care Performance Measurement Framework

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

Access	Integration	Efficiency	Effectiveness	Focus on Population Health	Safety	Patient-Centredness	Appropriate Resources
Extent of (avoidable) emergency department, walk-in clinic, urgent care centre use "(Integration) - Access to a regular primary care provider - Access to an inter- professional primary care team - Timely access at regular place of care - Access to after hours care (telephone and in-person) - Access to non face-to-face care (e.g., telephone, email, etc.) - Access to home visits for target populations	Information sharing across the continuum of care including patients and family caregivers Care coordination with other health and community care providers and services "(Efficiency and Patient-Centredness) Time to referred appointment with medical/surgical specialist or other specialized services "(Access) Hospital admissions and readmissions "(Effectiveness) Effectiveness) Waiting time for community services	Per capita health care cost (primary care, specialist care, hospital care, diagnostics, pharmaceuticals, long-term care, community care) Support for family caregivers Unnecessary duplication of diagnostic tests/imaging Implementation and meaningful use of Electronic Medical Records/Electronic Health Records '(Integration) Self management support and collaboration with patients and families '(Patient-Centredness and Effectiveness)	Management of chronic conditions including people with mental health and addictions and multiple chronic conditions ** Advanced disease/palliative care ** Symptom management *(Patient-Centredness) ** Negotiated care plan for patients with chronic conditions *(Patient-Centredness) ** Shared clinical decision-making ** (Patient-Centredness)	Preventive care for infants and children (beyond immunization) Health and sociodemographic information about the population being served (including health status) Immunization through the life span D Screening and management of risk factors for cardiovascular disease and other chronic conditions, (e.g., obesity, smoking, physical inactivity, diet, alcohol and substance abostance abostance stock, sociodemographic characterisstics, sexual and other high risk behaviours)) "(Effectiveness) Chronic disease screening (e.g. cancer, diabetes, hypertension, asthma, depression, dementia)	Infection prevention and control Medication management, including medication reconciliation Recognition and management of adverse events including medical errors Injury prevention (Focus on Population Health)	Respect for patients' and families' values, culture, needs and goals Process to obtain patient/client and caregiver input regarding health care services Respectful and understandable communication with patients Coordination of care within the primary care setting Process for addressing suggestions/ complaints	Comprehensive scope of primary care practice Funds received by primary care practices (by category) Human resources availability, composition (skills mix) and optimized scope of practice Healthy work environment and safety Funding and use of electronic systems to link with other settings *(Integration) Practice improvement and planning Human resources training and professional development, including patient- and family- centred care *Provider remuneration methods Total cost of care *(Efficiency)
Patient access to their own health information *(Efficiency)	Primary care providers' access to specialist advice via telephone, email, etc. Time to referred diagnostic tests (e.g., CAT scan, MRI, etc.) Shared care arrangements for patients to see a specialist in their regular primary care setting	Extent of generic prescribing	Equ	*(Effectiveness) SD		ractice level priority	Availability of information technology systems Information technology investment and expenditure Provider satisfaction (employee engagement culture)

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 <u>all primary care</u> 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

last 9 months

% of clients with HTN with BP recorded in the

CTA Prioritization	РСРМ		
% 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

% of clients with coronary artery disease who

months (HbA1c, lipid profile, blood pressure,

% of clients with HTN with BP recorded in the

% of clients with chronic conditions who had a

% of clients with depression who have been

% of clients who report getting help from a

professional when they had emotional distress

(anxiety or depression, in the past two years)

asked if they had thoughts about suicide

received the following tests in the last 12

foot exam in the past 12 months

obesity screening, all of the above)

review in the last 12 months

last 9 months

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	% of patients aged 12 and over who report smoking daily or occasionally
their PCP regarding health behaviours/ risk factors (e.g alcohol use, exercise,	% of patients who are obese, overweight, underweight or normal weight
smoking, etc	% 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



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