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 😊
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
PROCARE
Clinical Performance Dashboard (2.a)

Clinical Performance Measures

On Protocol/Compliant Measured Controlled

Green = Performance Measure Above Threshold
Yellow = At Threshold
Red = Below Threshold
Example
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/](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)

**Access**
- Extent of (available) emergency department, walk-in clinic, urgent care centre use *(Integration)*
- Access to a regular primary care provider *(Integration)*
- Access to an interprofessional primary care team *(Integration)*
- Timely access at regular place of care *(Integration)*
- Access to after-hours care (telephone and in-person) *(Integration)*
- Access to non-face-to-face care (eg, telephone, email, etc.) *(Integration)*
- Access to home visits for target populations *(Integration)*
- Patient access to their own health information *(Integration)*

**Integration**

**Efficiency**
- Information sharing across the continuum of care including patients and family caregivers *(Integration)*
- Care coordination with other health and community care providers and services *(Integration)*
- Time to referred appointment with medical/surgical specialist or other specialized services *(Integration)*
- Hospital admissions and readmissions *(Integration)*
- Follow-up with regular primary care provider post hospital discharge *(Integration)*
- Waiting time for community services *(Integration)*
- Primary care provider access to specialist advice via telephone, email, etc. *(Integration)*
- Shared care arrangements for patients to see a specialist in their regular primary care setting (eg, CAT scan, MRI, etc.) *(Integration)*

**Effectiveness**
- Per capita health care cost (primary care, specialist care, hospital care, diagnostics, pharmaceuticals, long-term care, community care) *(Integration)*
- Support for family caregivers *(Integration)*
- Unnecessary duplication of diagnostic tests/imaging *(Integration)*
- Implementation and meaningful use of Electronic Medical Records/Electronic Health Records *(Integration)*
- Self-management support and collaboration with patients and families *(Integration)*
- Patient wait times in office *(Integration)*
- Extent of generic prescribing *(Integration)*

**Focus on Population Health**
- Management of chronic conditions including people with mental health and addictions and multiple chronic conditions *(Integration)*
- Advanced disease/palliative care *(Integration)*
- Symptom management *(Integration)*
- Negotiated care plan for patients with chronic conditions *(Integration)*
- Shared clinical decision-making *(Integration)*
- Chronic disease screening (eg, cancer, diabetes, hypertension, asthma, depression, dementia) *(Integration)*
- Prenatal care *(Integration)*

**Safety**
- Infection prevention and control *(Integration)*
- Medication management, including medication reconciliation *(Integration)*
- Recognition and management of adverse events including medical errors *(Integration)*
- Immunization through the life span *(Integration)*
- Screening and management of risk factors for cardiovascular disease and other chronic conditions, eg, obesity, smoking, physical inactivity, diet, alcohol and substance abuse, socioeconomic characteristics, sexual and other high risk behaviours) *(Integration)*
- Injury prevention *(Integration)*

**Patient-Centredness**
- Respect for patients' and families' values, needs and goals *(Integration)*
- Process to obtain patient/client and caregiver input regarding health care services *(Integration)*
- Recognizable and understandable communication with patients *(Integration)*
- Coordination of care within the primary care setting *(Integration)*
- Process for addressing suggestions/complaints *(Integration)*

**Appropriate Resources**
- Comprehensive scope of primary care practice *(Integration)*
- Funds received by primary care practitioners *(Integration)*
- Human resources availability, composition (full-time, part-time) and optimized scope of practice *(Integration)*
- Healthy work environment and safety *(Integration)*
- Funding and use of electronic systems to link with other settings *(Integration)*
- Practice improvement and planning *(Integration)*
- Human resources training and professional development, including patient and family-centred care *(Integration)*

**Equity**

Legend
- * = Also relevant to mentioned domain
- = Measurement area for future consideration
- = System level priority
- = System & Practice level priority
- = Practice level priority

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

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

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

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

<table>
<thead>
<tr>
<th>CTA Prioritization</th>
<th>PCPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of clients who report working out a care plan about their chronic conditions</td>
<td>Percentage of patients with diabetes with 2 or more glycated hemoglobin (HbA1c) tests within the past 12 months</td>
</tr>
<tr>
<td>% of clients with diabetes who report having a foot exam in the past 12 months</td>
<td></td>
</tr>
<tr>
<td>% 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)</td>
<td></td>
</tr>
<tr>
<td>% of clients with HTN with BP recorded in the last 9 months</td>
<td>% of clients with HTN with BP recorded in the last 9 months</td>
</tr>
<tr>
<td>% of clients with chronic conditions who had a review in the last 12 months</td>
<td></td>
</tr>
<tr>
<td>% of clients with depression who have been asked if they had thoughts about suicide</td>
<td></td>
</tr>
<tr>
<td>% of clients who report getting help from a professional when they had emotional distress (anxiety or depression, in the past two years)</td>
<td></td>
</tr>
</tbody>
</table>
## Focus on population health

<table>
<thead>
<tr>
<th>CTA Prioritization</th>
<th>PCPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of eligible patients who had colorectal screening</td>
<td>% of eligible patients who had colorectal screening</td>
</tr>
<tr>
<td>% of eligible patients who had cervical screening</td>
<td>% of eligible patients who had cervical screening</td>
</tr>
<tr>
<td>% of patients aged 12 and over who report smoking daily or occasionally</td>
<td>Population descriptive characteristics (age, sex, income, etc collected for all patients)</td>
</tr>
<tr>
<td>% 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)</td>
<td>% of patients aged 12 and over who report smoking daily or occasionally</td>
</tr>
<tr>
<td></td>
<td>% of patients who are obese, overweight, underweight or normal weight</td>
</tr>
<tr>
<td></td>
<td>% of patients aged 65+ years who received pneumococcal vaccine</td>
</tr>
</tbody>
</table>
## Patient Centredness

<table>
<thead>
<tr>
<th>CTA Prioritization</th>
<th>PCPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of clients who report that their PCP is able to communicate with them in a language they can understand</td>
<td>% 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</td>
</tr>
<tr>
<td>% of clients who can talk about personal problems related to their health condition</td>
<td>% of patients who report that their MD/NP or someone else spends enough time with them</td>
</tr>
<tr>
<td>% of clients who report being treated with respect by the PCP</td>
<td></td>
</tr>
</tbody>
</table>
## Safety

<table>
<thead>
<tr>
<th><strong>CTA Prioritization</strong></th>
<th><strong>PCPM</strong></th>
</tr>
</thead>
</table>
| % 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

<table>
<thead>
<tr>
<th>CTA Prioritization</th>
<th>PCPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy work environment and safety</td>
<td>No priorities at the practice level</td>
</tr>
<tr>
<td>Practice improvement and planning</td>
<td></td>
</tr>
<tr>
<td>Practice undertakes annual patient satisfaction survey</td>
<td></td>
</tr>
</tbody>
</table>
## Administrative

<table>
<thead>
<tr>
<th>CTA Prioritization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average # of encounters/day</td>
</tr>
<tr>
<td>Average # of encounters/provider/day</td>
</tr>
<tr>
<td>Average # of client visits per year</td>
</tr>
<tr>
<td># of clients with &gt;50 visits per year</td>
</tr>
<tr>
<td>Client re-visit rate</td>
</tr>
<tr>
<td>No Show Rate</td>
</tr>
<tr>
<td># of clients with 4+ conditions</td>
</tr>
<tr>
<td>Costing data – cost per clinical client, cost per provider</td>
</tr>
</tbody>
</table>
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