



**EFFECTIVE GOVERNANCE
FOR QUALITY AND PATIENT SAFETY**



STRATEGY AND MEANINGFUL MEASUREMENT

THE ROLE OF THE BOARD



Learning goal: Be able to ...

- help the Board know how well the organization is doing on its strategic priorities and guide action to further improve performance
- clarify how to target resources to affect performance on quality indicators (e.g. services, IT, education)
- lead to action using “*good enough*” data

Boards Continually Assess Value

- Are we getting closer to achieving our goals?
- What else do we need to do to achieve our goals?
- Are there some programs/services that are not getting us anywhere?
- Should we reallocate resources?
- How does our performance stack up against our peers?



Strategy and Measurement

- Strategy: Explicitly stated (i.e. strategic plan must exist)
 - **specific** goals
 - shared so everyone in the organization **knows the goals**
- Measurement:
 - clearly **related** to strategic goals (i.e. meaningful)
 - based on indicators for which you have **easy access to data** to assess performance (i.e. measurable)
 - Reflects the **work staff are doing** (i.e. meaningful)

Step 1: Plan to perform

- Three levels of planning
 - Strategic plan:
 - outlines the priorities
 - Operational plan:
 - outlines what **to do** to achieve the priorities
 - Quality Improvement plan:
 - outlines what **to do better**

Step 2: Quality Improvement Plan

- Why do a QIP
 - It's a good idea: It provides direction to the ED and organization to ensure you all achieve your strategic priorities
 - You have to: FHTs, AHACs, NPLCs, CHCs are **REQUIRED** to submit Ministry QIP annually
- What is a QIP
 - Specific measures, timelines and targets related to the strategic priorities
 - Action-oriented and outcome-driven plan to guide activities of organization and focus attention of the Board on improving quality

Support from AFHTO:

Data to Decisions: Advancing Primary Care

- Manageable meaningful measurement, consistent with Starfield principles of comprehensive, patient-centered team-based primary care
- Manageable
 - Minimize additional reporting effort
 - Encourage alignment in reporting requirements
- Meaningful:
 - Allow teams to compare themselves to peers
 - Enable teams to take local (individual) and collective (i.e. at the association-level) action
- See [link to video](#) on members only page

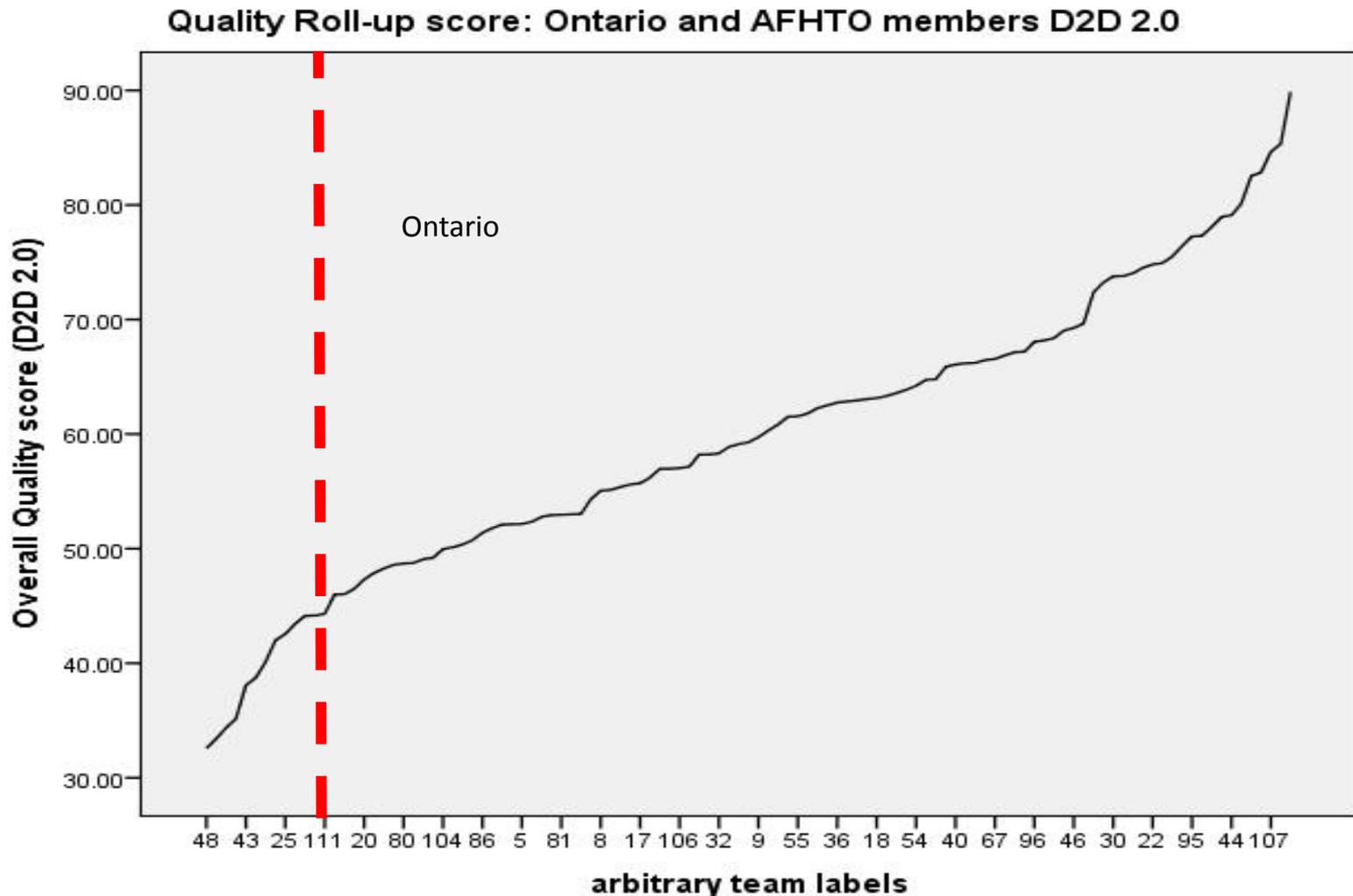
D2D

- Data on a small number of [indicators](#)
 - D2D 3.0 included data from nearly two-thirds of AFHTO members (116 teams) caring for nearly 2M Ontarians
 - Voluntarily contributed
 - Possible to measure (ie data currently available)
 - “Meaningful” – indicators selected by members
- Team -level benefits of **membership-wide** reporting
 - Enables teams to see where they stack up against peers
 - Helps focus/prioritize local improvements in care and data quality
 - Gives teams a voice in the future of measurement in primary care
- Produced with help of 35+ [QIDSS](#), available to ALL members

What are we learning from D2D?

- AFHTO members are measuring!
 - Quality roll-up indicator reflects quality according to what matters to patients
 - Quality measured in this way is also associated with lower per capita costs
- AFHTO members are leading
 - With use of EMR data to reflect what the WHOLE team is doing (eg. diabetes care)
 - With actual measurement of EMR data quality!
- Physician leadership is making a difference
 - Made it possible to explore data about human resources capacity
- AFHTO members are well equipped to move from measuring to improving quality

AFHTO: higher quality, lower cost



Using data: What is changing since D2D 1.0?

- Team Characteristics:
 - Better scores on team climate and changes in QI goal orientation
- EMR use
 - Increased data standardization *despite no change* in EMR functionality
- QI activity
 - More conversations with physicians and board re: QI and performance
 - Physician ambassadors: associated with better team characteristics
- Performance on processes/outcomes of care
 - No change on the core d2d indicators (old data, 8 month interval)
- Outstanding questions:
 - impact of EMR maturity, physician ambassadors, team structure and characteristics on performance

Boards and D2D

- Many resources on AFHTO members-only web-site
- Increasing tools and support for teams to generate data for D2D
 - HQO portal to access team-level performance data – check with physicians first
 - Standardized EMR queries (multiple EMRs, multiple indicators)
 - “success stories” from high performers (coming soon to web site)
- Next iteration coming Fall 2016
 - Sign up for your team-level performance report (HQO Portal)
 - See step by step guide on members only website for more information about what to do when
 - Read your D2D ebulletin every 2 weeks -- Board chair, ED, Medical Lead
 - Approximately 44% of recipients open the ebulletin – relatively stable over more than 30 issues
 - Contact your QIDSS!



CAPABILITY ASSESSMENT

- Think about your strategic priorities. Reflect on one that will help your organization to “do some thing better” (i.e. involve improving quality in some way)
- Think of some indicators that would demonstrate the organization is making progress

Step 3:

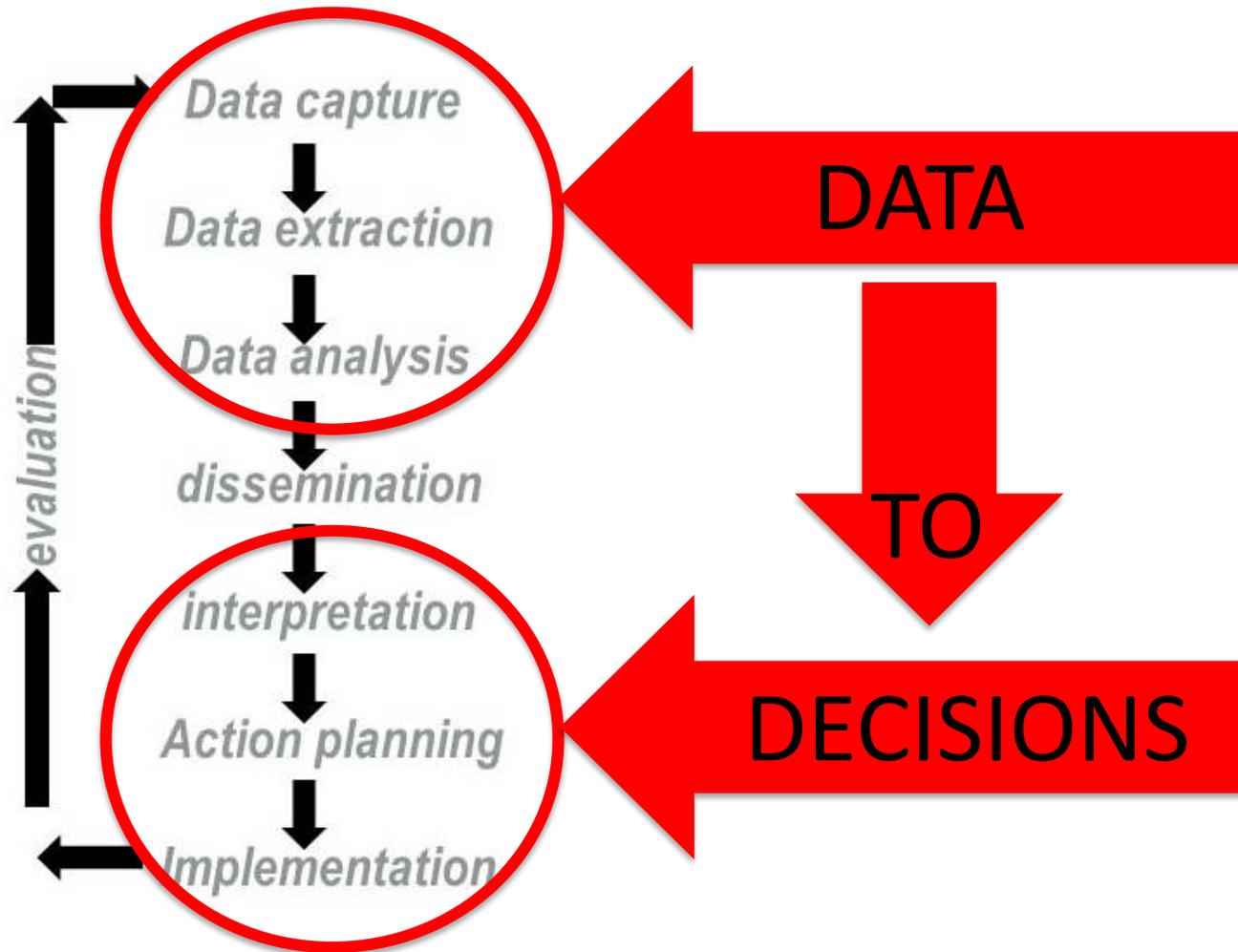
Track progress on your priorities

- Choose *JUST A FEW* indicators -- less is *WAY* more
- Make sure you can *EASILY* get the data: *measuring* progress should not distract from *making* progress
 - For help with choosing indicators and capturing data, refer to D2D, QIDSS, EMR Community of Practice and your peers
- Pay attention to stories as well as numbers (qualitative and quantitative data)
- Report often to see progress or lack thereof in time to make changes to improve (at least monthly, if possible)

An option: Use D2D to help track progress

- Choose a priority based on D2D
 - Identify peers from D2D with better performance in an area of interest to your team – they might have useful ideas or suggestions
- Set up a local process to capture data on D2D indicators in near-real-time
 - D2D is produced at most twice a year, often with “old” data
- Set up a process for staff and board to review reports on these local data on an ongoing basis. **SHARE STORIES!**
 - Frequent small reports are more useful than big annual reports
- Compare to peers at next iteration of D2D

Step 4: Take action!





Quality Improvement Plans



Example: Real QIPs

Samples from AFHTO member organizations

Alignment: QIP, PCPMF and manageable, meaningful measurement

| D2D | PCPMF | QIP |
|---|---------|---------|
| Health care system cost | yes | no |
| Same/next day appointments | yes | yes |
| Reasonable wait for appointment | no | no |
| Patient involved in care | yes | yes |
| Patient satisfaction with office staff | yes | no |
| Childhood immunization (rostered and all children) | yes | no |
| Colorectal cancer screening | yes | yes |
| Cervical cancer screening | yes | yes |
| Readmissions to hospital | yes | yes |
| Regular primary care provider (individual and team) | yes | no |
| Diabetes care | Sort of | Sort of |
| Time spent delivering care (exploratory indicator in D2D 3.0) | Sort of | no |
| 7-day follow-up (Exploratory indicator in D2D 2.0) | Sort of | Sort of |



CAPABILITY ASSESSMENT

- What is ONE thing you can do to improve quality by Tuesday? (Don Berwick)
- Ideas
 - patient experience
 - patient transitions
 - small trials or best



LEADERSHIP – IT’S THE BOARD’S JOB

- Priorities
- Strategy
- Plan
- Improve