D2D 1.0 Launch

AFHTO

Oct 1, 2014

Agenda

- Alignment with AFHTO strategy
- Role of Quality Improvement Decision Support (QIDS) Program
- Rationale for D2D 1.0
- Description and orientation to D2D 1.0
- Example: review of an indicator
- Cost per patient: detailed discussion
- Additional resources
- Questions and comments from participants

AFHTO Strategic priorities

- 1. Work with the Ministry of Health, other partners and AFHTO members to ensure our members are supported to succeed in:
  - 1.1. Governing and leading high-quality, comprehensive, well-integrated interprofessional primary care organizations.
  - ***1.2. Measuring and improving the quality of care they deliver.***
  - 1.3. Achieving more seamless integration of health care and other supports required by their patient populations.
  - 1.4. Recruiting and retaining the staff needed to deliver high-quality, comprehensive, well-integrated interprofessional primary care.
- 2. ***Promote value*** delivered by interprofessional primary care teams and the role they could play in expanding patient access to high-quality, comprehensive, well-integrated interprofessional primary care.
- 3. Engage with AFHTO members to ensure AFHTO continues to reflect their aspirations, respond to their priority needs, and ***leverage their collective knowledge and capacity for the benefit of all members***.

http://www.afhto.ca/wp-content/uploads/AFHTO-Strategic-Direction-2013-03-06.pdf

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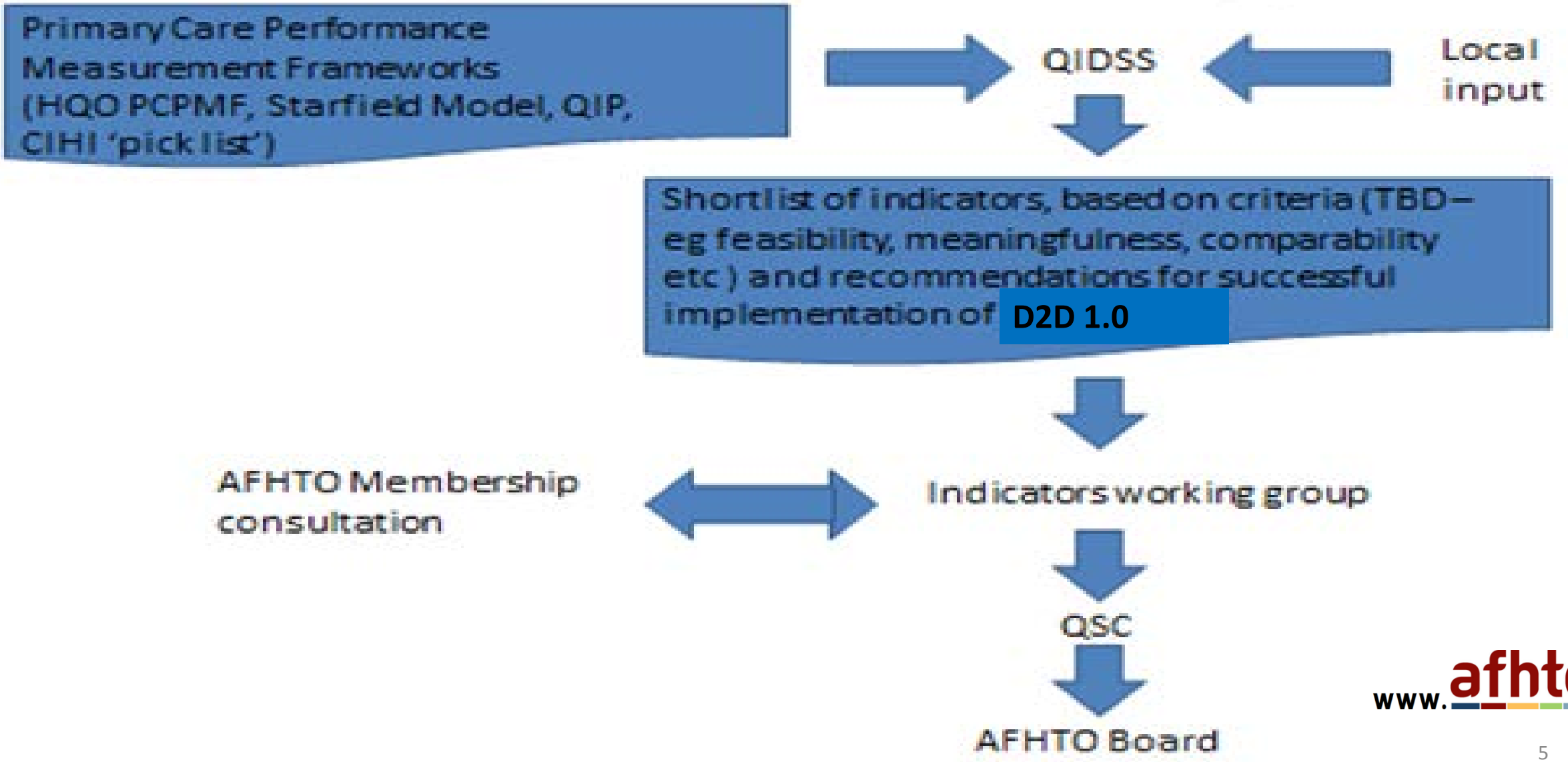
Quality Improvement Decision Support Program

- Oversight
  - Quality Improvement Decision Support Steering Committee
  - Subcommittees:
    - Indicators Working Group
    - EMR Data Management sub-committee
- QIDS program
  - 30+ QIDSS, employed by AFHTO members
  - 4 QIDS program staff, employed by AFHTO

D2D 1.0: Decision-making process



Why membership-wide measurement?

- We measure to demonstrate the value of patient-centered, relationship-based comprehensive primary care
- We measure to fulfill our commitment to our patients
  - Measurement helps us find the gaps locally AND provincially and direct the MOHLTC's attention to work *with* us (ie primary care providers) to improve the system
- We measure to fulfill our commitment to each other as Ontarians
  - Measurement helps us use our resources (especially QIDSS) to develop processes and tools that can help ALL primary care providers use manageable and meaningful measurement to improve quality

What is D2D 1.0?

- Summary of data from 50 teams on 11 indicators that were
  - Voluntarily contributed
  - Possible to measure (ie data currently available)
  - Meaningful
- An attempt to “get started” at ***membership-wide*** (vs local) reporting to
  - Help fuel local improvements in care and data quality
  - support efforts of teams to prioritize areas for immediate attention
  - shape the future of manageable, meaningful measurement in primary care
- produced by QIDS program and 30+ QIDSS but available to ALL members

D2D 1.0 indicator selection

- Stage 1: baseline (in PCPMF).
- Stage 2: in one existing multi-team reporting process.
- Stage 3: sort based on QIDSS & IWG -- 43 indicators.
- Stage 4: QIDSS vote (no elimination)
- Stage 5: prioritization based on Garden City FHT's survey of FHT physicians (Innovation project)
- Stage 6: shorter list based on IWG recommendation -- 26 indicators
- Stage 7: Membership-wide vote on 26 indicators.
- Stage 8: final short list based on vote, alignment with Starfield principles and balance between patient-derived data (ie via surveys) and other sources – 11 indicators

Excerpts from final indicators list recommendations made by Indicators working group, approved by QSC Jun 2014

Poll

- Did your team contribute data to D2D 1.0?
  - Data for all indicators
  - Data for some indicators
  - No data
  - Don’t know

Orientation to D2D 1.0

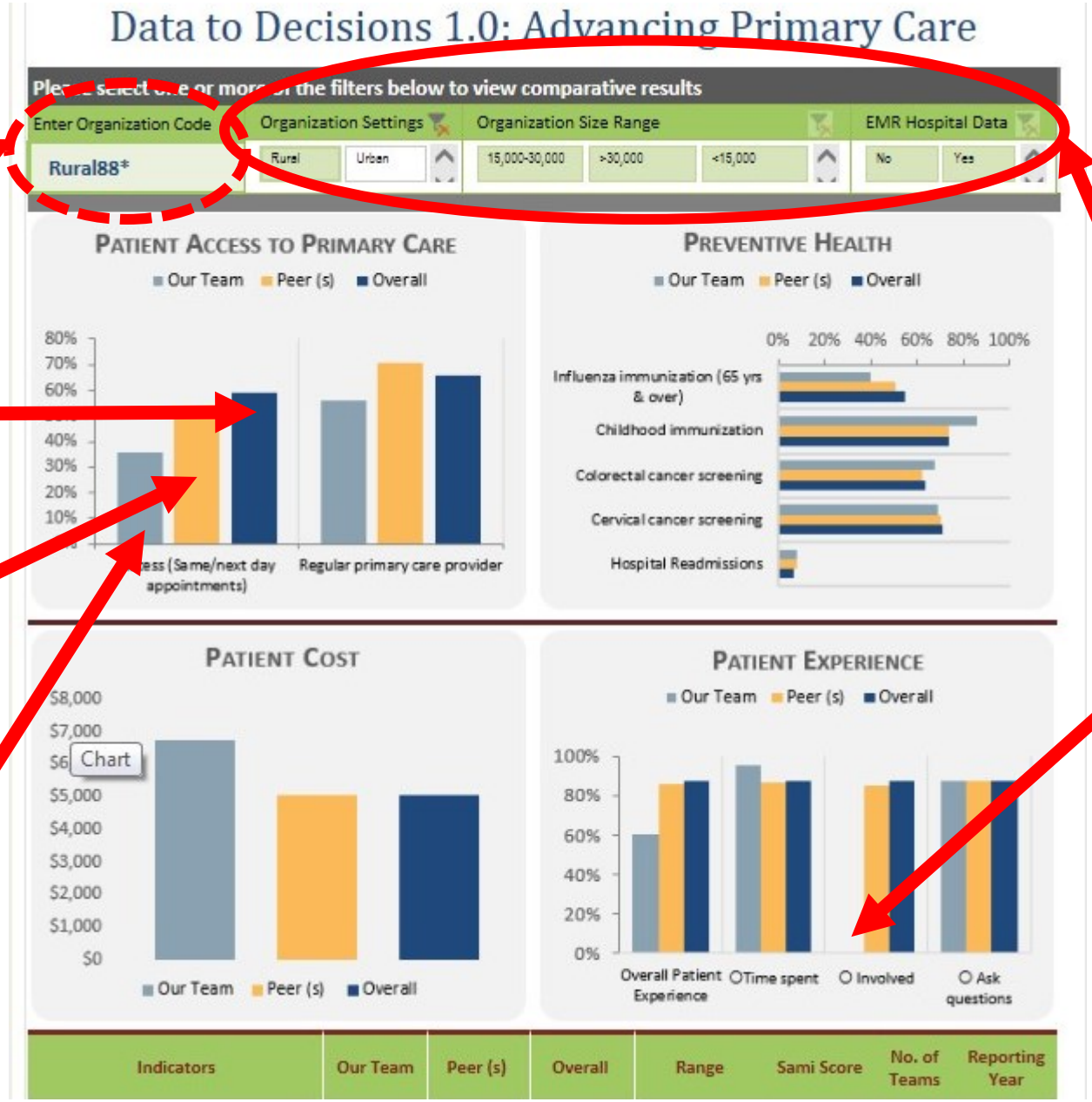
- Click on link:
  - http://www.afhto.ca/members-only/d2d-1-0/

The anonymous, 8-digit identifier code your team used to submit your data to D2D 1.0. If your team did not submit data, you will not have a code

Performance for all teams submitting data for this indicator. See table below for information about how many teams contributed data to each indicator.

Performance for "peer" group selected on the criteria in the top bar of the D2D report (solid circle above)

Performance for your team, if your team contributed data to D2D 1.0. If not, compare the peer and overall rates to data in your own data in documents such as QIP or MOHLTC reports.



Criteria for selecting peer groups. There are three characteristics to choose from: location (ie rural or urban), size (number of patients) and access to timely hospital information in your EMR. When one or more characteristics are selected, the bar graphs and data table (see next figure) change to illustrate the performance among the teams that have the characteristics you have selected.

There was no single team that contributed data for ALL the indicators. The graphs and data table will have "blanks" for "our team" performance for any indicators not submitted by that team.

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Peer performance will be the same as "Overall" performance until a peer group is selected (see figure above)

SAMI score applies to the peer group. SAMI score was included in data received from ICES as part of the D2D 1.0 data submission process. Teams that did not request these data can do so in the next iteration. Click the link for more information.

Indicators, with hyperlinks leading to more detailed information about definition, considerations for interpretation, suggestions for evaluating and improving data quality and resources for improving processes of care.

Overall patient experience is the average value of the 3 patient experience indicators listed below the heading: time spent, involved and ask questions. See descriptions of individual indicators for more details.

The "Our Team" column will be blank until the team enters its anonymous 8-digit code (see figure above). Teams that did not submit data to D2D 1.0 can refer to their own local reports in lieu of referring to the "Our Team" column for comparison purposes.

Indicators	Our Team	Peer (s)	Overall	Range	Sami Score	No. of Teams	Reporting Year
Access (Same/next day appointments)		59%	59%	16% - 100%	1.06	33	2014
Regular primary care provider		66%	66%	28% - 84%	1.02	28	2013
Overall Patient Experience		87%	87%	0% - 100%	1.08	34	2014
oTime spent		87%	87%	67% - 99%	1.07	34	2014
o Involved		88%	88%	79% - 99%	1.08	33	2014
o Ask questions		87%	87%	70% - 100%	1.08	35	2014
Influenza immunization (65 yrs & over)		55%	55%	17% - 84%	1.07	40	2014
Childhood immunization		74%	74%	21% - 100%	1.03	31	2014
Colorectal cancer screening		64%	64%	50% - 77%	1.04	31	2013
Cervical cancer screening		71%	71%	31% - 82%	1.04	32	2013
Hospital Readmissions		6%	6%	3% - 20%	1.04	18	2013
Cost per patient		$5,047.77	$5,048	$2473 - $7175	1.03	28	2013

Because the data came from different sources, they reflect different fiscal years. 2014 refers to the fiscal year ending in 2014 (ie Apr 1 2013-Mar 31, 2014).

Although 50 teams submitted data to D2D 1.0, not all teams submitted data for all indicators. The number of teams refers to the "Overall" performance and does not change as peer groups are selected.

The range represents the minimum and maximum values observed among all teams submitting data

AFHTO's valued partner in producing the inaugural Data to Decisions report

Example: review of Cervical Cancer screening

- What is the matter with the data?
  - Some of our patients get their tests done in hospital
- How many of them do you think do this?
- What do you think the rate is among that group?
  - All of them – ie everyone whose test is submitted to hospital lab has been screened so screening rate is 100% in that group
- What is your target? Where do you want to be?
  - Average/Above average/Better than last year/ 100%?

Impact calculator

Microsoft Excel
Worksheet

Poll

- Approximately how far is your cancer screening rate based on your EMR compared to the rate reported by CCO?
  - Our EMR-based rate is likely within 10% of the CCO rate
  - Our EMR-based rate is likely within 50% of the CCO rate
  - Our EMR-based rate isn’t even close to the CCO rate
  - Don’t know

Cost data: Why include it?

- New to primary care providers
- Already being used in research and policy – eg high-cost users and Healthlinks program decisions
- Need to better understand and monitor it to be able to measure, improve and thus promote the value of our model of care
  - Starfield: Jurisdictions with a strong primary care system as the foundation for their health system have better outcomes for patients and lower costs.

Excerpts from “Interpretive notes”

- At approximately $50,000 per patients, a small number of LTC patients can skew average cost of approximately $5,000
- Current cost data are not adjusted for demographics of patient population of AFHTO organizations
- Comparable cost data are not available to AFHTO members for other models or NPLCs

Impact of including cost

- Next iteration of cost calculations will include costs for interprofessional teams in the algorithm (currently, not included)
- Next iteration of cost will also adjust for patient demographics
- Cost indicator will be added to next iteration of physician and team profiles produced by ICES (available approximately Mar 2015)
  - profiles are available to more than 10000 docs in EVERY model – including in profiles is therefore a first step in comparing between models

Additional information

- Visit D2D 1.0
- Visit members only page on AFHTO web site
- Discuss with physicians attending the physician networking session (see profession-based programs)
- Discuss with staff and Board members attending the Governance workshop
- Consider attending the "Performance measurement: why bother" presentation (see D6-b)
- Contact
  - Carol Mulder, QIDS provincial lead
  - Monique Hancock, Chair, Indicators Working Group
  - Ross Kirkconnell, Chair, QSC
  - QIDSS: they're EVERYWHERE!
  - Each other

Questions and comments

Thanks!