PRIMARY CARE IN ONTARIO: DRIVING DATA TO DECISIONS

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D2D: DATA TO DECISIONS ▶ 4.0

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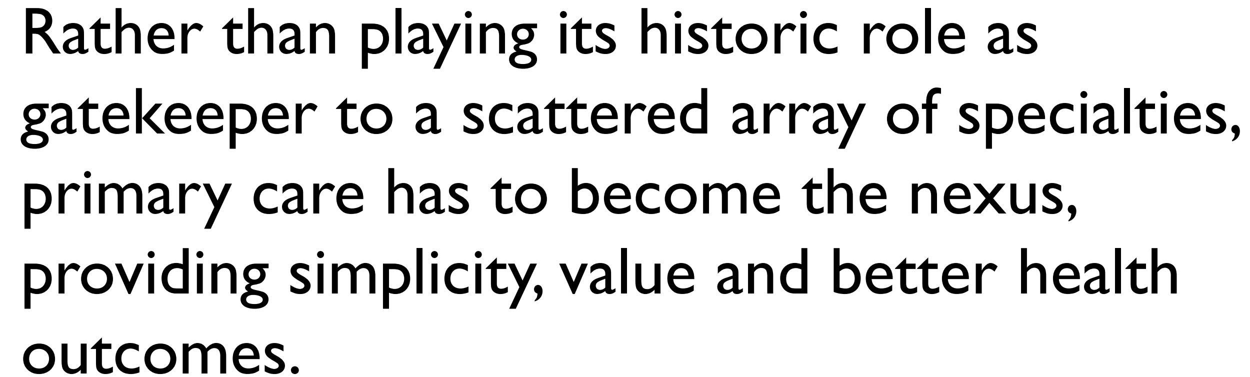

Rather than playing its historic role as gatekeeper to a scattered array of specialties, primary care has to become the nexus, providing simplicity, value and better health outcomes.

Primary care in the New Health Economy: Time for a makeover
PwC Health Research Institute, November 2015

- Learn about Primary Care in Ontario
- Data and context for measurement
- Understand what Data to Decision is
- Where is this going and what next?

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- Primary care in Ontario
- Family Health Teams
- Primary Care Data
- d2d Decisions to Data
- Learnings
- What's Next

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PRIMARY CARE IN ONTARIO

Primary care is a diverse sector with over 4,000 entities delivering health care to Ontarians. These include:

- 738 group practice models (FHO, FHN, FHG, RNPGA etc.)
- 7,562 physicians
- @ 3,000 solo practice physicians in fee-for-services or enhanced fee-for-service
- 186 Family Health Teams
- 26 Nurse Practitioner-led Clinics
- 79 midwifery practice groups
- 73 Community Health Centres
- 10 aboriginal health access centres
- Several specialized models

Ontario Physician Practice Models

Physician Group	Key Characteristic
Family Health Network (FHN)	A physician group whose billings are based on a capitation model
Family Health Organization (FHO)	A physician group whose billings are based on a more detailed capitation model; often a successor organization to a FHN
Rural and Northern Practice Group Association (RNPGA)	A physician group, operating with agreement terms that reflect the reality of family medicine in rural or northern settings.
Alternative Payment Plan/Alternate Funding Plan (APP/AFP)	A physician group, operating with agreement terms that reflect the reality of a non-traditional family practice setting. i.e. physicians working with inner city high needs population, or physicians in teaching hospital settings.
Blended Salary Model (BSM)	Physician compensation model is combined base salary and capitation.
Fee for Service	Physician compensation is based on submission of applicable billings codes from Schedule of Benefits Physician Services Under the Health Insurance Act RSO (October 1, 2005 (as most recently amended May 1, 2015)

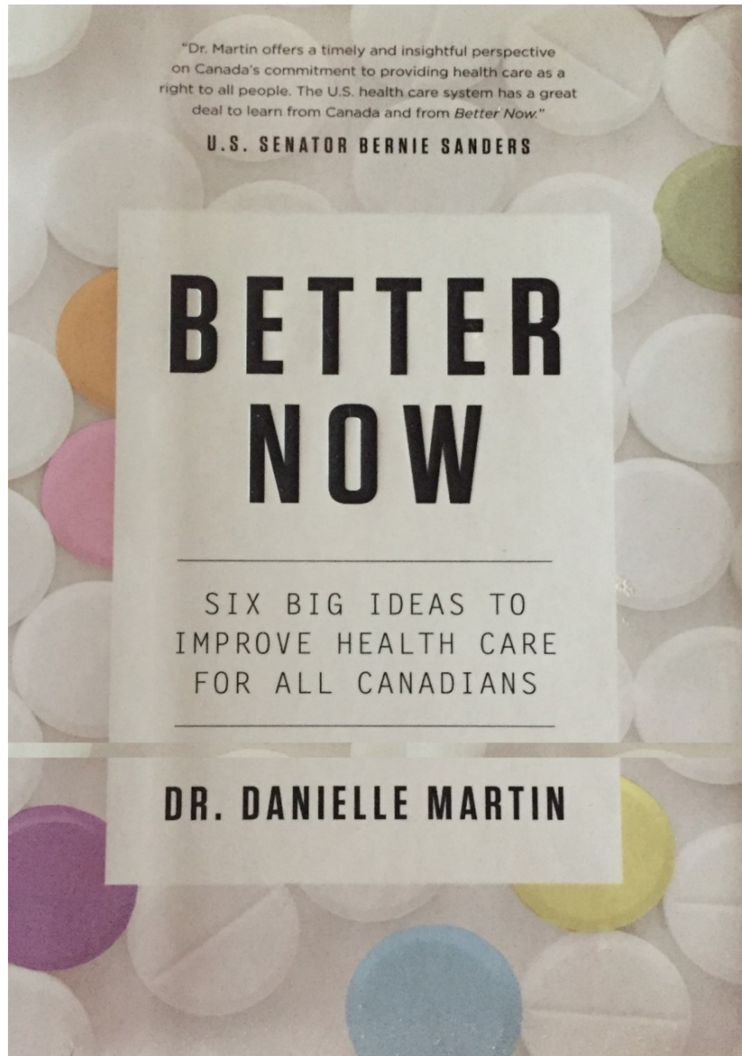
INTERPROFESSIONAL PRIMARY CARE TEAMS

- Teams include health care providers such as nurse practitioners, social workers, dieticians etc in addition to physicians
- Teams provide programs and services designed to help meet individual and community health needs
- Models include:
  - Community Health Centres
  - Aboriginal Health Access Centres
  - Nurse Practitioner Led Clinics
  - Family Health Teams

NOTES ABOUT DATA & MEASUREMENT

- All primary care physicians can receive;
  - Primary Care Practice Reports from Health Quality Ontario
  - Screening Activity Reports from Cancer Care Ontario
- Electronic Medical Record EMR capacity and utilization is quite varied.
- EMR vendors are consolidating.

DATA TO DECISIONS



Rewarding What Matters

You have probably heard the critique that you can't improve what you don't measure. In primary health care, part of our challenge is figuring out how to measure what matters, not just the things that are easily quantifiable.

A continuous relationship with a primary health care provider can positively affect health outcomes and reduce health system costs. So we need to find ways to measure those relationships.

To me, the most exciting measurement work going on in Canada is an Ontario project called D2D, or Data to Decisions. It started as the brainchild of an extraordinary family doctor from Oakville who is a self-declared data junkie. He's made it his mission to drag us all into an era of enlightened measurement in primary care.

As a regular churchgoer who sings in the choir, Dr. George Southey had thought a lot about the parallels between music, spirituality, and family medicine. In his mind, all three were grounded in the importance of listening. And when he listened to his patients, the same themes emerged over and over: the importance of access, a caring experience

AFHTO: CONTEXT

- 184 interdisciplinary primary care teams across Ontario, Canada
- Measurement is a strategic priority
  - to improve *and* demonstrate quality of team-based primary care
- Guided by Starfield principles
  - Relationship between patients and primary care providers is foundation of a sustainable healthcare system
- Data to Decisions (D2D)
  - Voluntary, membership-wide performance measurement initiative
  - 5 iterations since Oct 2014

D2D 4.1 INDICATORS

- Performance measures
  1. Colorectal cancer screening
  2. Cervical cancer screening
  3. Same/next day appointment
  4. Childhood immunization
  5. Patient involvement in decisions
  6. Regular care provider (individual/team)
  7. Readmissions
  8. Courteousness of office staff
  9. Reasonable wait for appointment
  10. Diabetes care
  11. Follow-up after hospitalization(exploratory)

- Peer categories
  1. LHIN
  2. Rural/urban
  3. Panel size
  4. Access to hospital data
  5. Teaching status
  6. EMR Data quality
- Roll-up measures
  1. Quality composite with drill-down
  2. Cost with sub-categories

ADMIN data
Patient Survey data
EMR data

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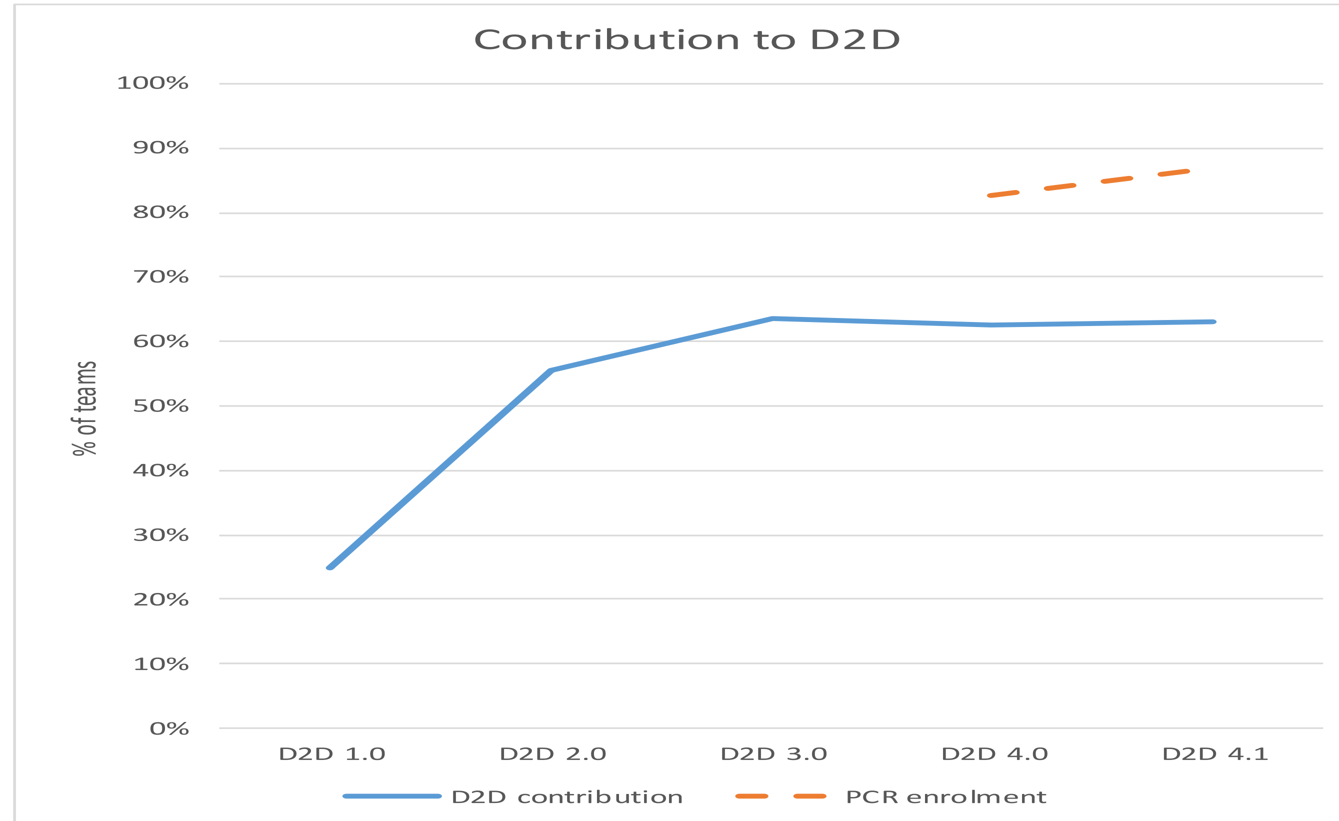
D2D PARTICIPATION: HIGH AND HOLDING

- 85% of teams contributed data to at least 1 iteration
- 62% for each of last 3 iterations with new teams each time
- 80% + enrolled in Primary Care Reports from HQO
- More data with each iteration



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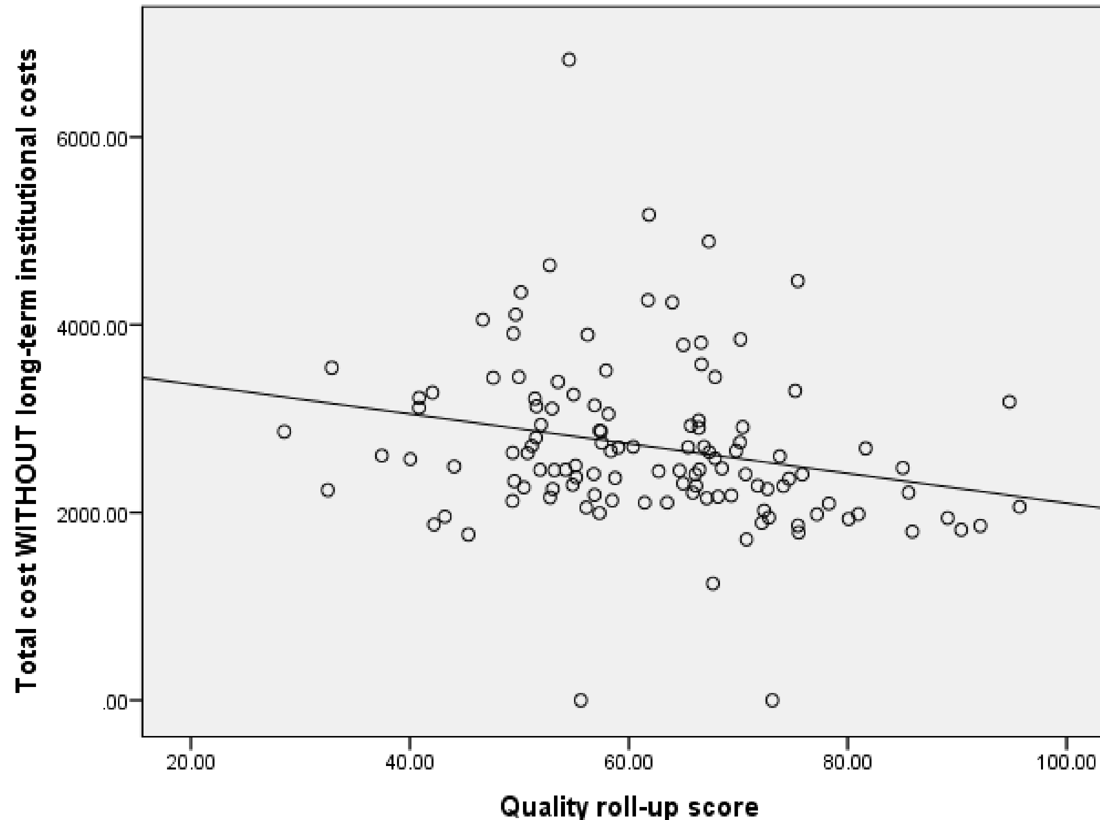
QUALITY AND COST

QUALITY AND COST



Simple correlation (not considering patient complexity etc) comparing the team's overall Quality roll-up score with the average total (unadjusted) per-capita healthcare costs of their patients (based on the most complete record from each of 155 teams contributing data D2D 2.0 to D2D 4.1)

- Patient of teams with higher quality have lower overall healthcare costs
- Quality explains just under 50% of variation in cost, taking patient complexity and rurality into account
- NB: For ease in illustration, graph shows SIMPLE relationship between quality and cost (NOT taking complexity and rurality into account). Therefore the relationship does not appear to be as strong as it is (ie slope of the line is not as steep as it would be with complexity and rurality accounted for)

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AFHTO'S VIEW OF QUALITY

- Quality roll-up indicator
- Alternative to "body-part" measures:
  - "You are more than your joints, your gastrointestinal system and your hormones"
- Incorporate patient priorities

http://www.burnabynow.com/community/health/five-reasons-why-you-need-a-family-doctor-1.408917

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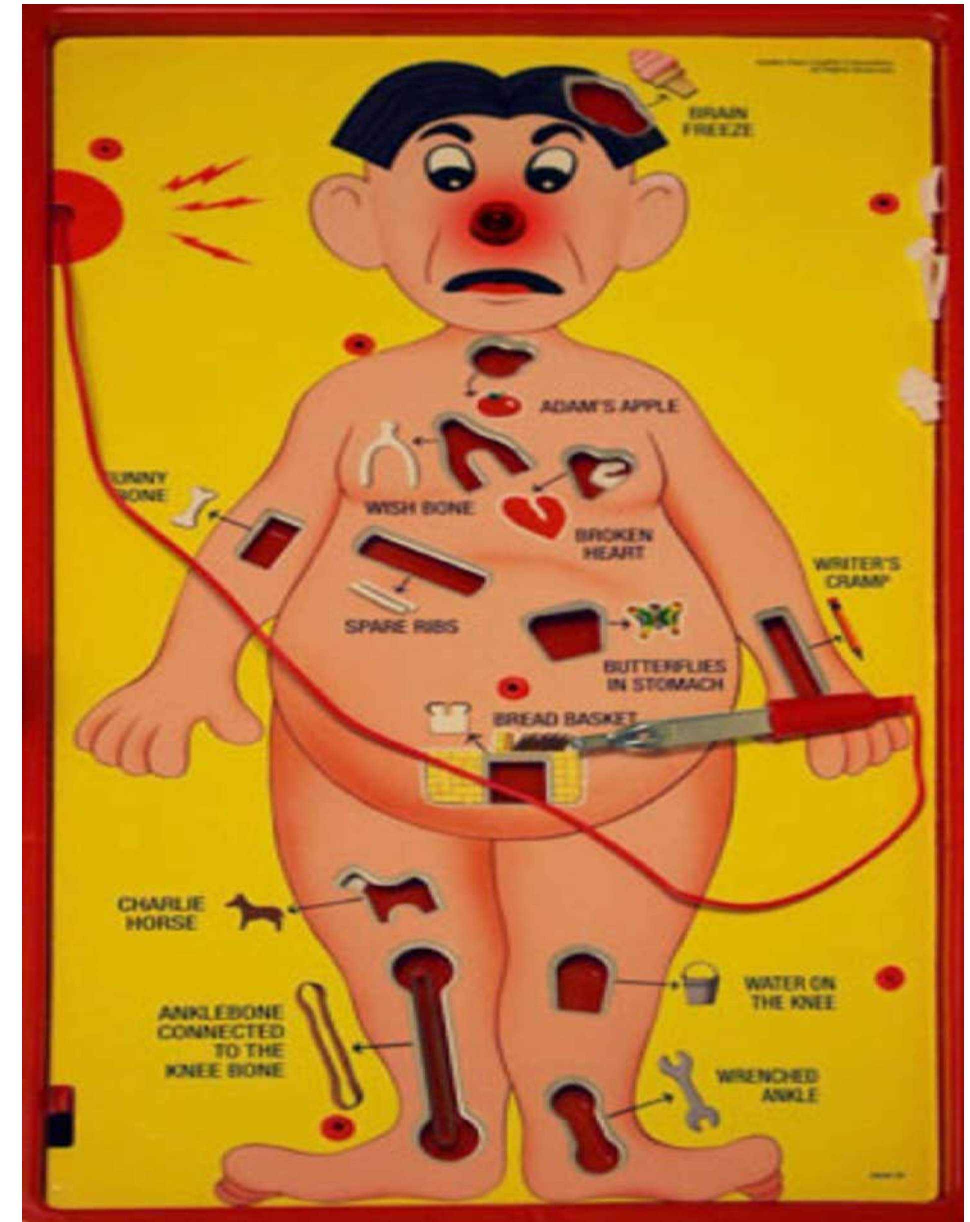
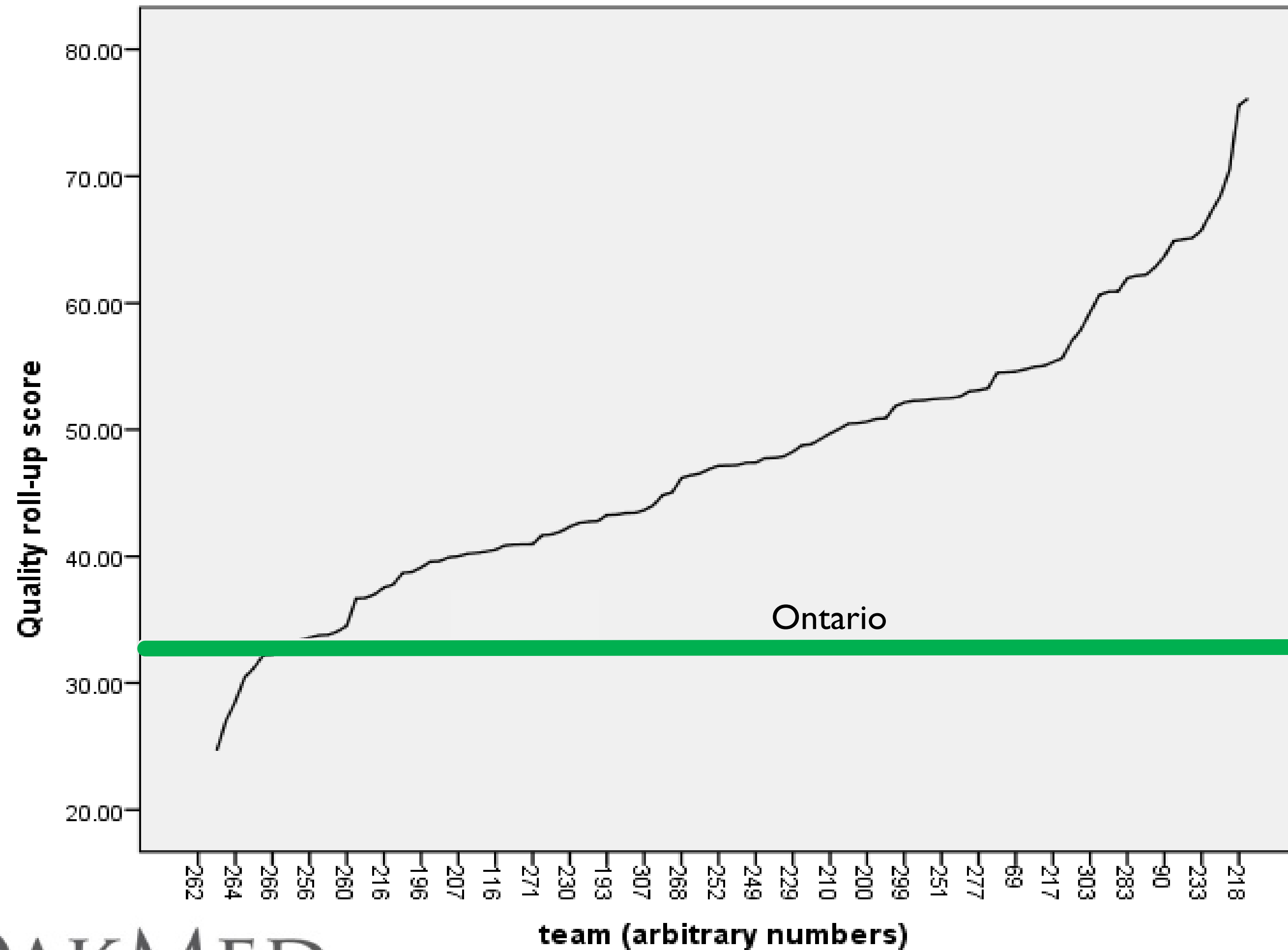


Quality Roll-up components (in descending patient priority)	Weight
% of patients involved in decisions about their care as much as they want	0.96
% of patients who had opportunity to ask questions	0.95
% of patients who felt providers spent enough time with them	0.95
% of patients who can book an appointment within a reasonable time	0.94
% of patients with readmission within 30 days after hospitalization	0.90
% of visits made to patients' regular primary care provider team	0.90
Emergency department visits per patient	0.87
Ambulatory care sensitive hospitalizations per 1000 patients	0.78
% of eligible patients screened for colorectal cancer	0.69
% of eligible patients screened for cervical cancer	0.69
% of eligible patients screened for Breast cancer	0.69
% of eligible patients with Diabetic management & assessment	0.69
% of eligible children immunized according to guidelines	0.52
% of patients able to get an appointment on the same or next day	0.38

QUALITY ROLL-UP SCORE DISTRIBUTION: AFHTO TEAMS



<u>Demographic Differences</u>

Patients of AFHTO teams are ***<u>less</u>*** likely

- to be immigrants
- to have many co-morbidities

and ***<u>more</u>*** likely

- to be older
- to live in rural settings
- to have higher income

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OAKMED'S JOURNEY WITH D2D

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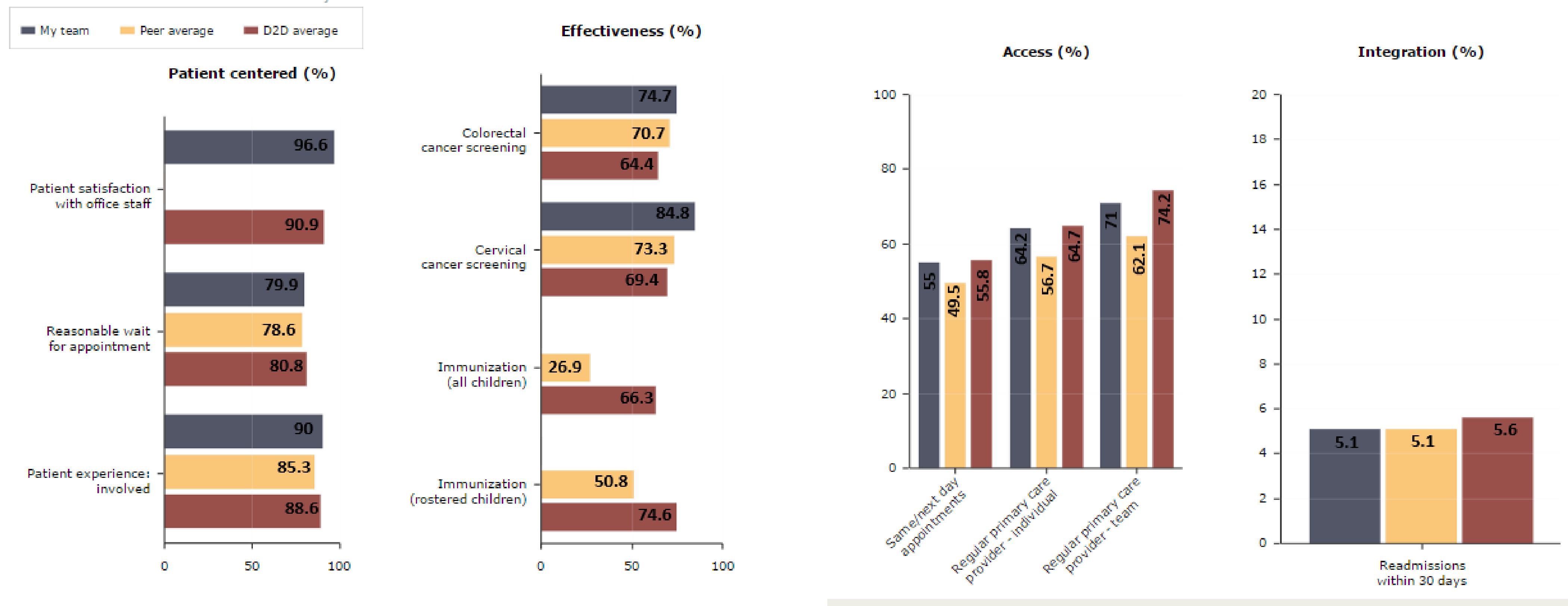
D2D 1.0 – WHERE WE STARTED

- Indicators were based of HQO's Quality Improvement Plan Indicators:



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- Our performance on D2D 1.0 indicated that OakMed was performing either above or at the peer average

- Raised a conversation around the relevance & meaningfulness of these indicators in a Family Health Team setting

- Feedback to AFHTO from all the FHT's resulted in further iterations of D2D that contained more meaningful measures valid in a FHT setting

  For example: In addition to the mandatory same day/next day appointment measure, an indicator surrounding a patient being able to book an appointment when needed (not necessarily on the same day) was added

D2D 4.1– HOW HAVE THE RESULTS HELPED?

- D2D 4.1 results have helped drive the conversation around Quality Improvement initiatives in OakMed
- D2D shows where you stack up against relevant peers, this has helped stimulate conversations and drive QI initiatives within OakMed
- Results from our D2D 4.1 submission have also helped us address creating standardized care approaches for immunizations, cancer screening and registry development
- D2D has also been used to identify gaps in our data and clinical processes

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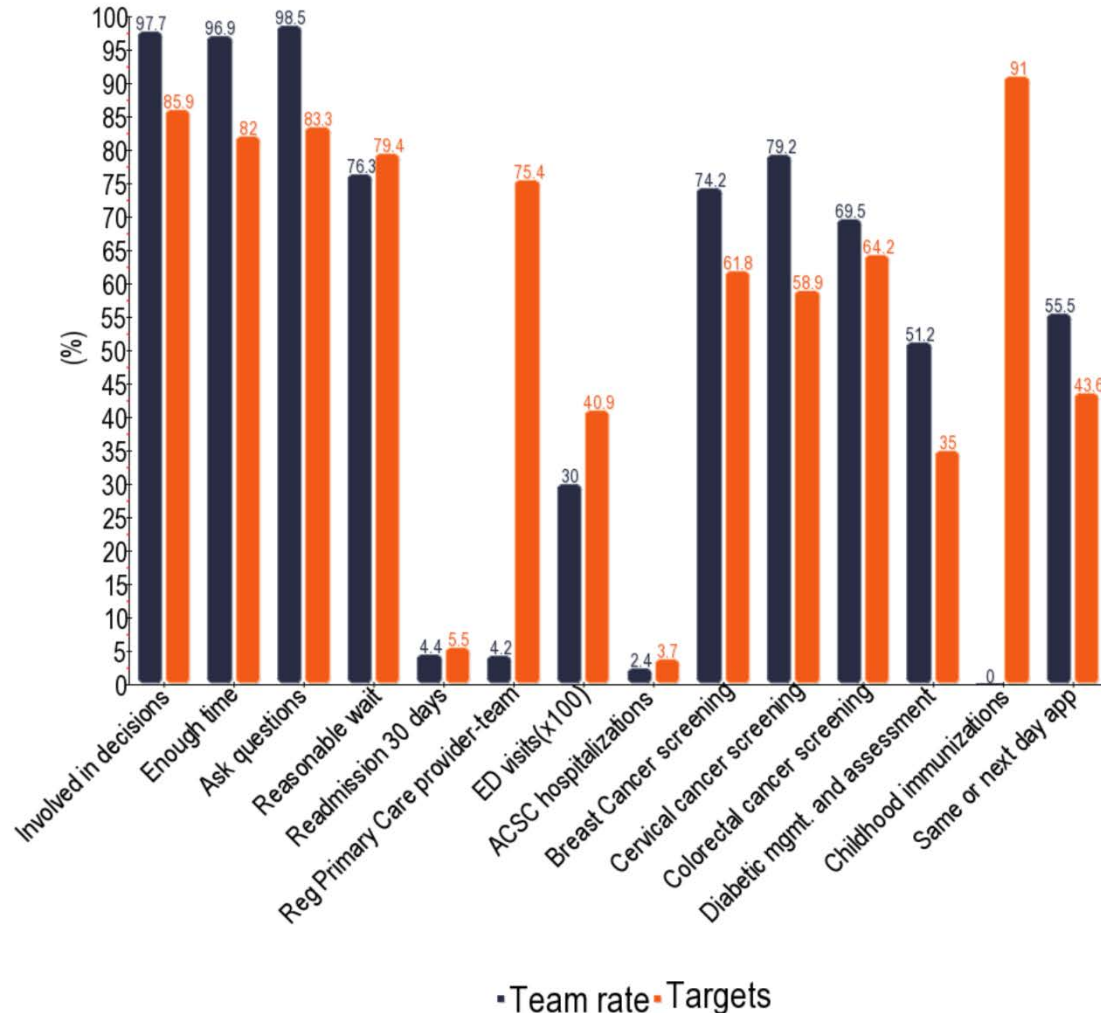
OAKMED D2D 4.1 RESULTS



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D2D 4.1: OUR CURRENT QI INITIATIVES

The Oakmed FHT has used D2D 4.1 results to spearhead the following initiatives:

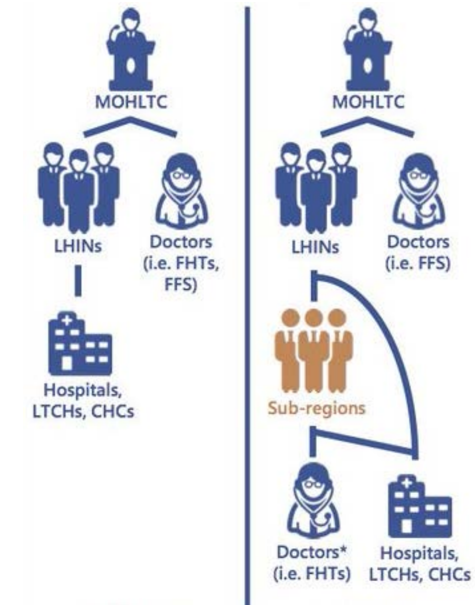
- **Diabetes Management:** We are working on establishing a baseline registry of our Diabetic patients, standardizing recall intervals for equality of access, and providing a system for our patients to receive rapid access and advice
- **EMR Data Quality:** Currently trying to standardize where cancer screening data is recorded within the EMR so that this information can be readily queried
- **Readmissions to Hospital:** Our RN is working to ensure that patients discharged from hospital receive the appropriate follow up care (via telephone, a different health care provider, or their primary care giver)
- **Cancer Screening/Childhood Immunizations:** Working within our EMR to ensure that all patients eligible for screening or immunization receive them in a timely fashion

- Build and improve on what we have.
- Increase participation.
- Improve data gathering and data integrity.
- Integrate with HQO and MOH measurement activity.

WHAT'S NEXT FOR FAMILY HEALTH TEAMS & PRIMARY CARE

BILL 41 PATIENTS FIRST ACT AN ACT TO AMEND VARIOUS ACTS IN THE INTERESTS OF PATIENT-CENTRED CARE

- Eliminate CCACs and merge with LHIN.
- Devolve all primary care health team funding from MoH to LHINs.
- Creation of subLHIN local planning regions (5-7) per LHIN.
- Increased funding for expanding access to primary care health care teams.
- Potential for much broader collaboration.



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