Frequently Asked Questions about *Data to Decisions 1.0: Advancing Primary Care*
Updated May 8th, 2014

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What is the rationale for *D2D 1.0?*

What is Data to Decisions 1.0: Advancing primary care?

*Data to decisions 1.0: Advancing primary care (**D2D 1.0**)* is a summary of members' practice data on indicators that are meaningful and comparable and will set them up for improving care. ***D2D 1.0*** will summarize data from AFHTO member organizations on a small number of primary care indicators (possibly less than 10), selected on the basis of their relevance for decisions to improve quality, comparability of measures and current availability of data for as many teams as possible.

Why are we creating Data to Decisions 1.0: Advancing Primary care?

This novel membership-wide reporting exercise is about *acceleration not duplication*. It will help illustrate the leadership provided by team-based interprofessional primary care organizations and the way forward for measurement and quality improvement infrastructure in the sector. ***D2D 1.0*** builds on the extremely promising progress being made toward defining a measurement framework for Ontario's primary care system. One example is the Primary Care Performance Measurement Framework (PCPMF), which Health Quality Ontario (HQO) is expected to complete and report on in mid-2014. Another is the Starfield model adopted by the AFHTO board, which builds upon the foundation provided by the HQO framework to create a better understanding of overall quality and capacity in primary, care and total cost of care for a patient population. Some AFHTO members are already working on practical demonstrations of the Starfield model through QIDS Innovation projects.

D2D 1.0 is essentially a practical, useful readiness assessment for and pilot test of primary care measurement models such as Starfield and HQO`s PCPMF.

How will *D2D 1.0* help me?

The expedited and collective voluntary report across the membership will magnify the impact of local of individual teams on the culture of quality in primary care. Because it is being so closely informed by front line experience, it is very well positioned to inform the approach to measurement in primary care and help to ensure it stays focused on indicators that are *meaningful* to AFHTO members, not just *possible* to measure. On an even more practical note, it is also our goal that participation in ***D2D 1.0*** will make it easier and more efficient for you to meet on-going measurement and reporting requirements.

D2D 1.0 will provide you with data about how your team stands relative to your peers, making it easier to identify and thus celebrate the successes of your team. Some members have noted that this information could be helpful in recruiting and retaining staff. It will also point your team towards the next place to focus to advance quality of care in your health team.

What is the ultimate goal/purpose of D2D? Are we looking to build a framework or common ground across FHTs?

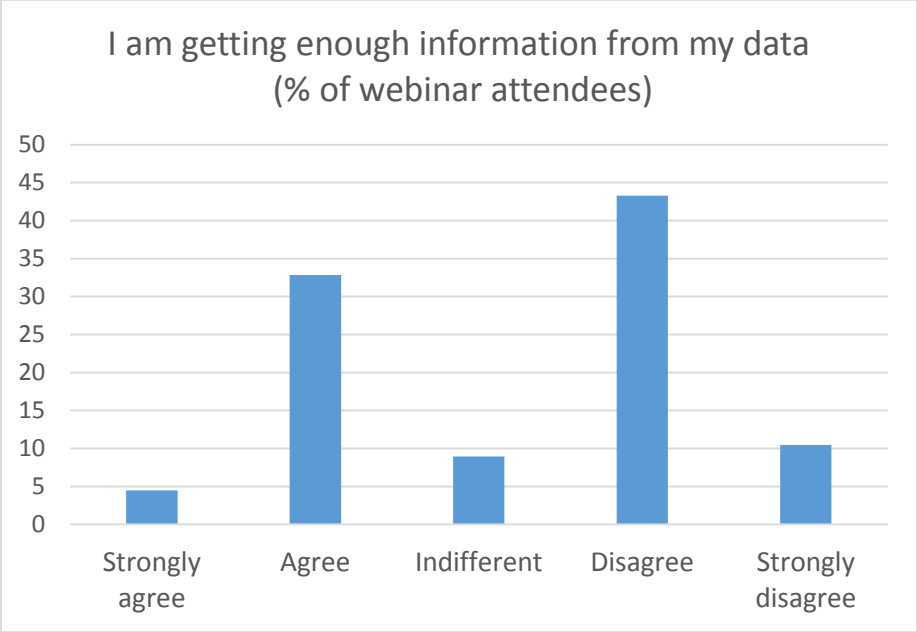
D2D 1.0 is a summary of primary care data that are currently available, comparable and mean the most to members in their efforts to advance quality of care for their patients. D2D 1.0 is intended to help measure and demonstrate the value of the interprofessional team model that is fundamental to AFHTO members.

Isn't this duplicating the work of HQO, ICES, OMD et al?

D2D 1.0 is essentially a practical, useful readiness assessment for and pilot test of primary care measurement models such as Starfield and HQO`s PCPMF. It has its base in the work to date to define models for measurement in primary care such as the HQO PCPMF, the Starfield model and CIHI's ongoing work with "pick lists", to name a few. These frameworks form the baseline set of indicators for potential inclusion in ***D2D 1.0***. It represents the first step in a journey towards increasingly meaningful, sophisticated and comprehensive measurement processes in primary care, possibly through subsequent iterations or eventual transition to another vehicle.

What if I am already getting enough information from my data to advance primary care in my health team?

A quick poll of nearly 100 AFHTO members on a recent teleconference demonstrated that some members are indeed satisfied with the information they are getting from their data (see graph below). And over half of the members on the call disagreed – they need more information. This is the need that D2D 1.0 is intended to address. It may also be useful for those who are getting enough information from their own data in that it will make it easier to see how they compare to their peers.



Is D2D 1.0 a replacement for existing reports?

No. MOHLTC reports are still required. They are different from D2D 1.0 as they are about accountability and focus on process measures such as service volumes and spending, vs quality outcomes. QIP reports (submitted to HQO) are still required. D2D 1.0 is intended to streamline some of the effort involved QIP reporting as well as increase consistency between QIP reports so they are more useful.

As AFHTO members become more aligned with each other and demonstrate meaningful use of selected indicators, we will also be in a better position to influence the evolution of measurement and reporting frameworks generally.

What is the "1.0" about?

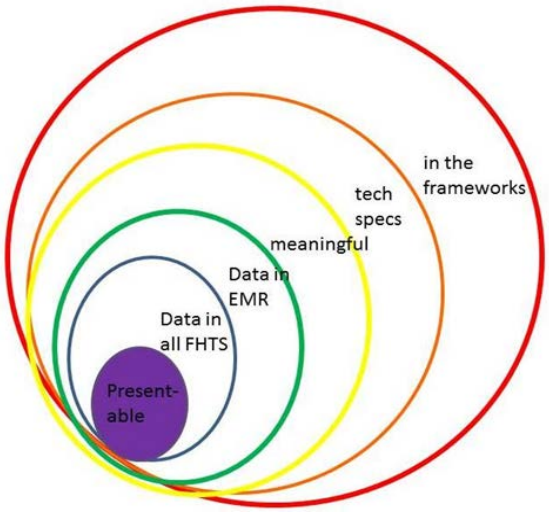
D2D 1.0 is a "STARTegy," a strategy for *getting started* to take advantage of current readiness and build momentum. It is a first step in the journey towards increasingly meaningful, sophisticated and comprehensive measurement processes in primary care, possibly through subsequent iterations or eventual transition to another vehicle. ***D2D 1.0*** is essentially a practical, broad readiness assessment for and pilot test of primary care measurement models such as Starfield and HQO`s PCPMF.

What indicators are in *D2D 1.0?*

How are the indicators being selected for *D2D 1.0?*

Figure 1 (above) shows the general approach to selection of indicators. It illustrates that ***D2D 1.0*** is the coming together of several ongoing work streams of the QIDS program and other efforts within and beyond AFHTO membership, all aimed at building capacity for measurement and improvement of quality of care. It has its base in the work to date to define models for measurement in primary care such as the HQO PCPMF, the Starfield model and ongoing work by the Canadian Institute for Healthcare Improvement (CIHI) with "pick lists", to name a few. These frameworks form the baseline set of indicators for potential inclusion in ***D2D 1.0***. The process of distilling these indicators into a short-list will be guided by the QIDS Steering Committee through the Indicators Working Group, with the majority of the work carried out by QIDSS working directly with teams and the innovation projects that had been funded by the QIDS program.

Figure 1: Indicator selection



Contributing to and sharing knowledge related to ***D2D 1.0*** is intended to support and strengthen the efforts of individual QIDSS as they address their local priorities. In turn, ***D2D 1.0*** will benefit from the real-time practical intelligence of QIDSS regarding the administrative burden and overall feasibility of implementing primary care measurement on the front lines.

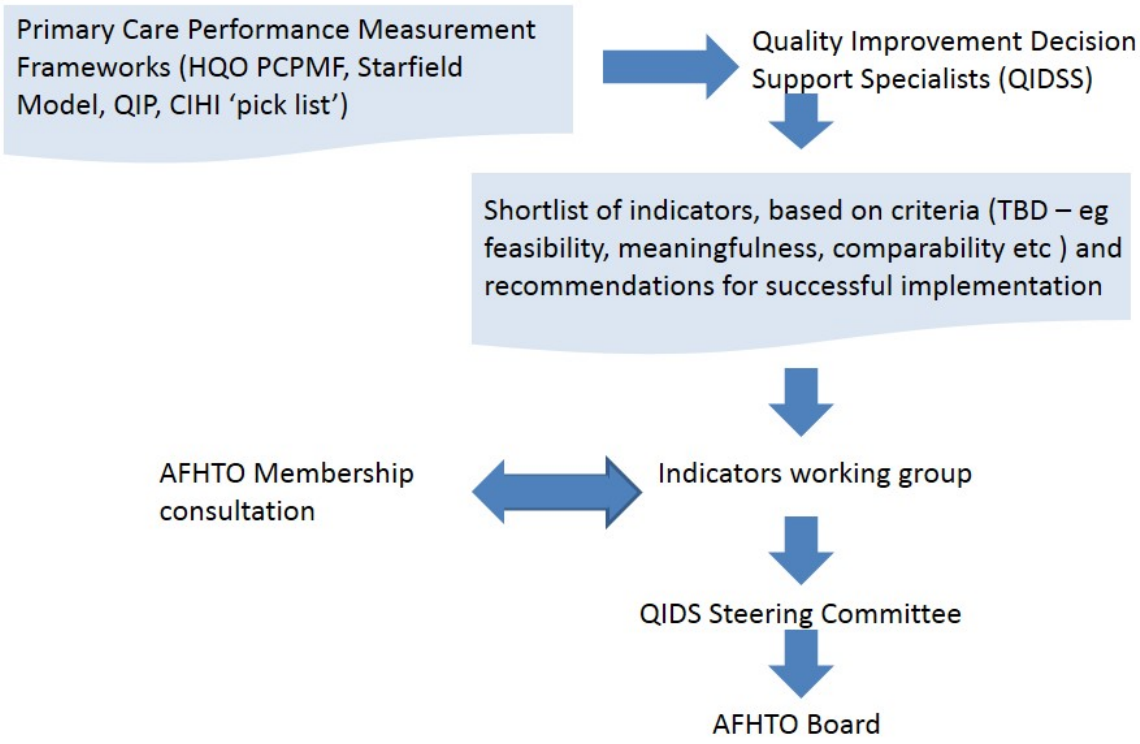
The criteria for selection of indicators are listed below. As with any exercise in action learning, application of the criteria may result in refinement.

- The indicator is "feasible", meaning that there is a clear definition or specification (either formal or consensus) and that at least 50% of QIDSS report that data are currently available in the teams they support (ie about 75 FHTs) and that data extraction will require MINIMAL administrative burden
- The indicator is meaningful to clinicians (the recommendation of QIDSS needs to be informed by work/consultation with the staff of the teams they support)
- The indicator aligns with one of the Starfield model components: quality, capacity and total cost of care, and also reflects team-level performance (vs provider-specific)
- The indicator measures something that clinicians are interested in comparing
- The indicator contributes to a balance between patient perception and objective indicators
- Decisions about including the indicator (or not) can be made by Apr 30, 2014
- The indicator is included in HQO's PCPMF and therefore, by definition, is evidence-based.

What is the decision making process for *D2D 1.0*?

The decision-making process for ***D2D 1.0*** is shown in Figure 2.

Figure 2: Decision making process



Who is voting -- Is it only voting members?

The voting (or survey) process is open to all members. Votes are non-identifying. Voters' are requested to identify their LHIN to enable the Indicators Working Group to get a sense of geographic representation in the responses. You are also free to decide how to complete the survey, for example whether individually or working through the questions as a group.

How will the list of indicators to be included in D2D 1.0 be finalized?

The final list of D2D 1.0 indicators will be based on the following criteria:

- Meaningful: AFHTO members vote, previous votes by QIDSS and Indicators working group, innovation project results, input from external partners
- Available: successful "test" extractions May-June, QIDSS input
- Breadth: # of teams able to contribute data by Jun 30, 2014

Indicators which are considered meaningful but for which data are not currently available will be addressed by the QIDS program and the Vendor/Supply Chain management committee and others to explore ways to improve access to the data for subsequent iterations of D2D.

What is the short list of indicators that AFHTO members are voting on?

Hundreds of indicators are potentially available to primary care organizations. To get to the shortlist for member voting, the Indicator Working Group started with the "menu" of indicators defined by the Starfield and HQO Primary Care Performance Measurement Frameworks as these have a sound basis in research. Shortlisting involved identifying the smaller subset of 43 indicators already in use in leading examples of analytical reports in organizations such as CPCSSN, ICES (EMRALD), Dorval Family Health Team (Starfield model) and Health Quality Ontario. Members are invited to vote on a final short list of 26 indicators developed in consultation with the Indicator Working Group and QIDS Specialists drawing on their direct knowledge of local data availability and feasibility. Two set of indicators are presented, based on the above prioritization process.

a) High priority
    i. Breast, cervical, colorectal cancer screening
    ii. (QIP indicator) Primary care follow up visit with physician within 7 days of discharge
    iii. Reduce admissions to hospitals for Ambulatory Care Sensitive Conditions
    iv. Patient experience -- various questions
    v. Childhood immunizations
    vi. (QIP indicator) % of patients reporting same/next day appointments
    vii. # no shows of patients
    viii. 18-month-old development check
    ix. Smoking cessation advice
    x. Appropriate *process* of care for diabetics, hypertension and IHD patients
    xi. Reviews of patients with chronic diseases
b) Other indicators for which data may be available
    i. Reduced number of 30 day readmissions
    ii. Continuity of care
    iii. Lower acuity ED visits
    iv. Comprehensiveness of care
    v. Cost of care
    vi. Access bonus (% of max)
    vii. Specialist visits
    viii. Influenza immunization rate
    ix. Advanced access 3rd next appt.
    x. House calls
    xi. % of week with direct office access
    xii. % on Coumadin with INR 2-3 in past 60 days
    xiii. % appointments booked on the same or previous day (from scheduling data)
    xiv. Outcomes for diabetics, hypertension and IHD patients.
    xv. Follow up by a primary care provider via phone or visit within 7 days of discharge

Will we get a copy of these indicators?

Yes. See the detailed data dictionary .

Where are the formal, technical specifications and definitions for the D2D 1.0 indicators?

The definitions as they exist circa early May 2014 are documented for consideration of members in the voting process. They were presented at the level of detail and refinement used in the source reports from which the indicators were derived. This was intended to avoid misrepresenting the content of the existing reports. More detailed technical specifications will be derived from emerging knowledge about data availability and ongoing discussions with HQO to ensure alignment with the PCPMF.

How well do the technical specifications and definitions of D2D 1.0 indicators line up with standard definitions used by others (eg HQO's PCPMF)?

Circa April 2014, PCPMF was still compiling a full list of indicators and technical specifications. Weekly collaboration between D2D 1.0 and PCPMF project team leads focuses on minimizing any gaps in the inventories of indicators and/or definitions of both projects, given the "work in progress" nature and pace of both projects. The technical specifications for D2D 1.0 will comply with those used in PCPMF EXCEPT

- if data to generate the indicator as defined by PCPMF is not available
- if AFHTO members suggest modification to the PCPMF specification needs to meet the "meaningful" criterion for D2D 1.0.

As noted above, technical specifications will be documented for each indicator in D2D 1.0, with gaps from other standards noted, if any.

How is the process defined for "Appropriate *process* of care for diabetics, hypertension and IHD patients"

See the detailed data dictionary for more specificity.

Could the indicator about INR ranges be changed to measure "in range" (2-3 or 2.5-3.5) based on the patient/provider parameters instead of the actual numbers?

The indicator is presented as it is expressed in the source document (Starfield model). If the indicator is selected for inclusion in D2D 1.0, the detailed technical specification will attempt to incorporate this suggestion, pending availability of the data necessary to operationalize it.

Please clarify the indicator: Outcomes for diabetics, hypertension and IHD patients

See the detailed data dictionary for more specificity.

What is IHD?

Ischemic Heart Disease.

Who is involved in *D2D 1.0*?

Who is *D2D 1.0* for?

The report will be available to all members at an anonymous organization level and to external stakeholders and partners at an aggregate level. Participation is entirely voluntary. Data provided to generate the reports will be consolidated by a third party, not AFHTO itself, thereby assuring participants of control and confidentiality. It will be distributed to participants in September and presented in aggregate at this year's annual convention in October.

How do I get involved?

D2D 1.0 is designed for and by AFHTO members. Participation is completely voluntary. All AFHTO members are invited to participate in a variety of ways. Besides contributing data (which is also completely voluntary), members may choose to participate in the following ways:

- Provide comments and ask questions in webinar and teleconferences or directly to AFHTO QIDS program staff, Carol Mulder or Tim Burns.
- Vote on indicators via the online survey Apr 24-May 8, 2014.
- Discuss with your QIDSS
- Track D2D 1.0 indicators locally through test extractions of data after indicators are selected
- Contribute your data to D2D 1.0, after you review your test extracts (if any)
- Plan for D2D **2.0**: any time

What if I am not ready to participate yet?

D2D 1.0 will include data ONLY from teams that wish to submit it. The threshold for including an indicator in the report is availability from at least 75 teams, if possible. If there are not enough teams that are ready or able to submit data for the first iteration, the indicator will be deferred to subsequent iterations (ie D2D 2.0). So all teams can decide for themselves if and when they are ready to submit data.

What EXACTLY are QIDSS expected to do for D2D 1.0?

QIDSS are actively involved in supporting health teams engage in QI. D2D 1.0 is a way of identifying and leveraging the areas where the individual work of QIDSS overlaps with others to increase the value of those overlaps for the membership as a whole. Among the specific activities QIDSS may be involved in (pending discussion and agreement with their own health teams) are the following:

i. Vote on the long list of 43 indicators: This will be a survey monkey that takes about 30 minutes to complete. The survey will take place mid-April. It will provide AFHTO members with the best estimate of how feasible it is to get data for each of the indicators on the list. QIDSS have already received the list to consider in advance, if they wish.

ii. Access data for the short list of indicators: In late May, the QIDSS will be asked to attempt to access data for the indicators on the short list. We expect that some QIDSS may be able to access data for some but not all indicators on the short list for some but not all FHTs in their partnership. This is perfectly fine - the final report will simply reflect the number of FHTs contributing data for each indicator (anonymously, of course). The goal of the project is to learn clearly

what is currently possibly in terms of getting data to advance primary care. So there is no pressure to deliver data when it is not possible to do so, either due to time, technical and/or permission-related reasons. QIDSS and their FHTs will decide how much effort to put into getting data for any or all of the indicators from any or all the FHTs in your partnership.

iii. Review the resulting data: QIDSS are producing the data so they will be the first ones to review the results, likely in mid-June. They will be the best equipped to comment on whether the results match what they submitted. QIDSS will decide with their FHTs how much time to devote to this review, given that the report will be anonymous and is intended to be a "starting point" to support QI at the local FHT level. You may choose not to spend a lot of time reviewing the initial results at this stage in your FHTs' progress with QI.

iv. Recommend which indicators make the "final cut": By the end of June, QIDSS will be asked to offer an opinion about which of the indicators should make the final cut for inclusion in D2D 1.0, based on the initial results. These indicators may remain on the table for your local work. They may also be part of D2D 2.0 or later iterations. You and your FHTs will decide how much effort you can spare to contribute your opinion regarding what should remain in this first member-wide set of data to support decisions in advancing primary care.

v. Helping people use the data to advance primary care: When D2D 1.0 is released in Oct 2014, QIDSS will likely be among those helping FHT staff use the data for quality improvement. Again, you and your FHTs will decide how much time you will devote to using D2D 1.0.

What about my workload?

The process of distilling these indicators into a short-list will be guided by the QIDS Steering Committee through the Indicators Working Group, with the majority of the work carried out by QIDSS working directly with their teams and the innovation projects already funded by the QIDS program. The timelines are aggressive – QIDSS have already started this work and recognize their collective ability to deliver will be pushed to the limit. The provincial QIDS team continues to work with QIDSS to find ways to manage expectations and otherwise support this work wherever possible. Contributing to and sharing knowledge related to ***D2D 1.0*** is intended to support and strengthen the efforts of individual QIDSS as they address their local priorities. In turn, ***D2D 1.0*** will benefit from the real-time practical intelligence of QIDSS regarding the administrative burden and overall feasibility of implementing primary care measurement on the front lines.

Implementing meaningful measurement is both a technical and cultural challenge. It takes considerable effort and resources. However, AFHTO members have a unique “secret weapon” in the form of the recently recruited cadre of more than 30 QIDSS. It was expected that each QIDSS would make a difference in the local FHTs with whom they work. ***D2D 1.0*** capitalizes on this excellent work of individual QIDSS, to build synergy between them and increase their impact and efficiency locally and across the membership.

The amount of effort involved in D2D 1.0 is up to each health team. If one level of participation (see "how do I get involved) is beyond your resources, choose to participate in a different, less-resource-intense way. Having said that, D2D 1.0 will only include data that are already available. The focus is on the areas where *existing* efforts between health teams *overlap* so we can all get more value out of the work that is already being done.

What does D2D 1.0 have to do with the work QIDSS are already expected to do for FHTs?

Through the increasing sharing between QIDSS, there appears to be some overlap in the kinds of data people are interested in and, even more exciting, the solutions for getting at these data. D2D 1.0 is all about those overlaps. Some of the work QIDSS are doing will be included in that overlap. In that case, D2D 1.0 will help move your local work along. Some of the work QIDSS are doing will not be included in that overlap. It could be that D2D 1.0 will not do much to help that work advance right now – but it might give you a chance to put that topic on the list for D2D 2.0! If there is nothing you are doing that overlaps with D2D 1.0, then you and your FHTs may decide to continue your local work and simply observe D2D 1.0, and join in on D2D 2.0 or later iterations that overlap more with your priorities.

Is D2D intended to support FHT's who have QIDSS? Or will it involve FHT's who function well without one?

All AFHTO members are invited to participate in D2D 1.0. Health teams that are not currently part of a QIDSS partnership may choose to rely on their own existing staff to participate in and contribute data to D2D 1.0 or may choose to connect with AFHTO QIDS program staff for advice and suggestions to help with their participation. See "How do I get involved".

How many FHTs have indicated an interest in supplying data?

The indicators to be included in D2D 1.0 have not yet been selected so it is not possible for members to decide yet if they are willing and/or able to contribute data. Once the indicator list has been finalized (early June), it is expected that members will be more able to declare and follow through on their interest and ability to contribute data.

How is *D2D 1.0* being created?

What will *D2D 1.0* look like and how will it be shared?

The goal of measurement in primary care is to continually advance the quality of care. In keeping with that goal, the audience for ***D2D 1.0*** is first and foremost the members of AFHTO so they can use it to support their own local efforts for QI. AFHTO members will be able to see how they compare with other (anonymized) teams that are similar to them on a variety of characteristics. An aggregated membership-wide report (with no team-specific data) will be produced to support AFHTO's work with the Ministry and stakeholders to give evidence of what AFHTO members are able to achieve and inform the approach to measurement across the primary care sector. Figure 3 illustrates proposed views of the report.

Figure 3: Draft views of *D2D 1.0*

D2D 1.0: External-facing view

indicator	Aggregate performance (mean, median)	Range (or Confidence interval)	Number of FHTs reporting
A	53%	41-58%	180
B	9 days	4-20 days	80

D2D 1.0: Internal, membership view

FHT (anonymized)	Indicator A	Indicator B	FHT characteristic (eg rural)	FHT characteristic (eg large)
FHT 1	28%	6 days	yes	no
FHT 2	41%	4 days	no	yes
All FHTs	53% (41-58%)	9 days (4-20 days)		

Who will see the data from my health team?

All health-team level data will be anonymized in D2D 1.0. Only you and report production staff will know which data is yours. There is no information that identifies patients so no risk of breach of ***private*** information. However, there is information specific to health teams so a confidentiality agreement will be implemented to ensure there is no breach of ***confidential*** information. OntarioMD, AFHTO's production partner for D2D 1.0, has a long and reliable history of working with and protecting confidential data about primary care providers.

Will we be submitting individual provider or aggregate data for the FHT?

The D2D 1.0 report will present data at the health team level, not the individual provider level. Data will therefore be submitted at the team level.

How much will it cost to participate in *D2D 1.0* or get a report?

Nothing more than your ongoing interest and enthusiasm for meaningful, practical and membership-driven data to support quality improvement!

What if we don't know how to capture the data? How can we get help?

Health teams currently in a QIDSS partnership are encouraged to leverage the collective efforts of the QIDSS across the province for help in getting access to data. Health teams not in a QIDSS partnership are encouraged to contact AFHTO QIDS program staff (Carol, Tim, Jenya, Denise). Also, recall that D2D 1.0 is based on data that are CURRENTLY available. This means that indicators for which data are not readily available will NOT be in D2D 1.0, even if the indicator is considered to be meaningful and/or important. These indicators are being tracked by the Vendor/Supply chain management committee. They will be guiding the ongoing work of the EMR Communities of Practice and the QIDSS to address and resolve the challenges in capturing or accessing the data to improve the chances that the indicator could be included in subsequent iterations of D2D.

Who will help with data extraction and contribution to D2D 1.0?

Health teams involved in a QIDSS partnerships may get help via their QIDSS in the following ways:

- Responding to needs of health teams for data
- Collaborating with peers (via QIDSS forums) to improve access to and quality of data
- Accessing support from EMR vendors through Communities of Practice
- Seeking/receiving guidance from Vendor/Supply Chain of QIDS Steering Ctte

Health teams that are not currently part of a QIDSS partnership may choose to rely on their own existing staff to participate in and contribute data to D2D 1.0 or may choose to connect with AFHTO QIDS program staff for advice and suggestions to help with their participation.

Who will hold the data?

The data submitted by each team will be assembled by a third party acting on behalf of the members under a confidentiality agreement not to disclose the identity of any team. The QIDS Steering Committee, via the Indicators Working Group, is pleased to accept the offer of Ontario MD to do this work on behalf of AFHTO members.

Do EMR vendors and OntarioMD understand what is being asked of the EMRs? It is critical that these parties understand the current functionality requirements. FHTs look to OntarioMD certification as a mark that it will meet FHT needs.

The QIDS program is actively collaborating with OntarioMD specifically to address the needs of AFHTO members with respect to EMR functionality. There is a representative from OntarioMD on the QIDS Steering Committee, the Indicators Working Group and the Vendor/Supply Chain Management subcommittee. In addition, OntarioMD is the production partner for D2D 1.0. This degree of collaboration is intentional and proving to be rewarding in better understanding how AFHTO and OntarioMD can better understand and meet needs of primary care providers in terms EMR functionality.

When is D2D 1.0 happening?

AFHTO`s Board approved D2D 1.0 in Feb and it was introduced to members in March 2014. D2D 1.0 will be released in time for the annual AFHTO conference, Oct 15-16, 2014.

More information

Where can I find more information about D2D 1.0?

Check this FAQ for updates and see webinar slides, data dictionary, standard presentation, etc. for more information.

Is there a handout or standard presentation about D2D 1.0 I can share with interested people?

Yes. Please find it here.

What is EMRALD and how do we enroll in it?

The Electronic Medical Record Administrative Data Linked Database (EMRALD) is housed at ICES. It consists of clinically relevant information derived from electronic medical records (EMRs) maintained by family physicians practicing in Ontario. This EMR data can be linked to administrative health databases held at ICES. Currently, EMRALD contains data contributed voluntarily by more than 300 family physicians (representing more than 300,000 patients). Participation is currently limited to physicians who use Practice Solutions EMR software and have had their system for a minimum of two years. Expansion to include OSCAR users is under development. Participating in EMRALD requires little time or effort by physicians and their support staff. Contact Dr. Karen Tu at 416-480-4055, ext. 3871 or emrald@ices.on.ca for more information about EMRALD or follow this link http://www.ices.on.ca/Research/Research-programs/Primary-Care-and-Population-Health/EMRALD

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