

# Learning how to get lucky: enablers of high performing primary care teams

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## Context:

Ontario's primary care teams have built a solid culture of performance measurement, with an average of 110 teams voluntarily contributing data to over 7 iterations of a performance measurement report in 3.5 years. They are now equipped to use this measurement capacity to achieve ever better performance.

## Objective:

Identify enablers of performance to help teams learn from and take action on their measurement data to improve performance in quality and healthcare system cost.

## Study Design:

Observational study.

## Participants:

Interdisciplinary primary care teams, members of the Association of Family Health Teams of Ontario, serving approximately 25% of the population of Ontario, Canada.

## Dataset:

Data contributed by teams to Data to Decisions (D2D) describing patient experience, preventive measures and healthcare utilization, among other performance indicators. The dataset also includes team characteristics such as panel size, patient socioeconomic status and quality improvement activities, among others.

## Outcome Measures:

Association of team characteristics with quality of care (composite score) and per capita healthcare system costs.

## Results:

Multivariate regression of team characteristics and performance for 68 rural and 100 urban teams showed:

- Quality of care was related to patient panel characteristics (size, percent of seniors, low-income patients) and electronic information integration with hospital (R-square 0.409 -0.617, urban & rural teams respectively).
- Per capita healthcare costs (especially for diagnostic testing and home care services etc) were related to the factors above, quality and two additional characteristics particularly relevant to team structure: number of team sites and physician-based board (R-square 0.551-0.659, rural & urban teams respectively).
- Relationships with quality improvement activities, physician engagement, EMR maturity and interdisciplinary staff complement were weak, possibly due to lack of power.

## Conclusions:

Teams with high performance are not just lucky. Some factors related to better quality and cost may well be out of the team's control. However, other factors like single vs multi-site design, EMR management and governance structures, are amenable to change. At the very least, these associations are hints for further exploration via qualitative methods to learn more about exactly how teams collaborate to achieve high performance and learn to be lucky in achieving better performance.

## Learning objectives

1. List management and design characteristics that primary care teams could address to help achieve better quality and/or reduce overall healthcare system costs for their patients.
2. Describe differences between rural and urban teams in terms of factors related to performance.
3. List characteristics that appear to be worth further exploration in understanding what makes a high performing primary care team.