The impact of getting started:

Developing a more meaningful way to measure performance in primary care.

Carol Mulder,, on behalf of and with thanks to members of the Association of Family Health Teams of Ontario

Start here! Start now! This project applies Activity Theory to the problem of meaningful measurement in primary care. It shows what happens when a voluntary performance report is introduced as a ***means*** of improving meaningfulness of measurement. .

The problem

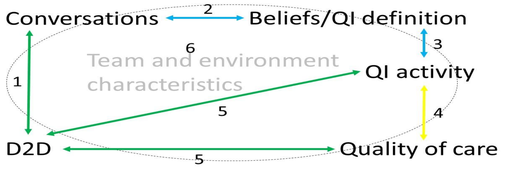
<u>Vicious cycle:</u> Low provider engagement in performance measurement makes it hard to make measurement meaningful enough to increase engagement.

The Setting

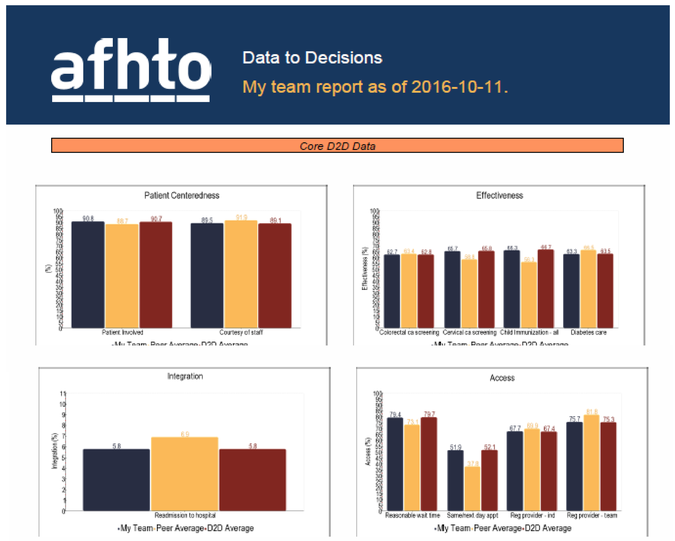
- 184 interdisciplinary primary care teams
- +/- 2,000 physicians & 2,200 interdisciplinary healthcare professionals
- +/- 3 million patients (25% of Ontarians)

The approach: Activity theory

- <u>Premise</u>: Introducing an artefact in the form of a process or concrete object triggers change, independent of the original or eventual function of the artefact (Engestrom, 2000).
- <u>More plainly:</u> Doing something changes things
- Measure impact via ***developmental evaluation***, ideal method in the absence of known "best practice" (Patton, 2010).
- Guided by conceptual roadmap (below)



Data to Decisions (D2D): The Intervention aka "artefact"



Features

- ***Voluntary*** report of performance
- ***Small number*** of indicators ***selected by members***
- ***Multiple*** data sources: administrative, EMR, patient survey
- Anonymous ***comparison to peers***
- Support for ***data access***
- ***Explicit*** intent to evolve
- Focus on ***patient-provider relationship*** (ie Starfield's principles)
- ***NOT PERFECT***

The impact (so far)

The vicious cycle is breaking, with increasing participation and meaningfulness in measurement, as shown below:

- <u>Conversations:</u> 18% more teams are having monthly or more frequent discussions with physicians and boards about measurement
- <u>Voluntary participation</u>: 63% of members providing data to D2D 4.0 (vs <30% in D2D 1.0), nearly 80% enrolment in Primary Care Reports
- <u>EMR data quality</u>: 15% increase in D2D 4.0, more consistency and access through building and sharing standardized EMR queries
- <u>Influence</u>: D2D referenced in Ontario measurement priorities and EMR specifications
- <u>Sustainability:</u> D2D shows that patients of teams with higher quality care have lower per-capita healthcare costs.

The evolution (so far)

Changes in response to developmental evaluation include

1) Introduce new measures
   - quality roll-up indicator enables quality-cost analysis
   - EMR data quality indicator focuses attention on EMR
   - composite diabetes indicator leverages EMR data quality
2) Show trends over time for 63% of teams in 2+ D2D reports
3) Increase peer-peer learning by identifying region & unmasking teams to peers on request (99% & 55% of teams respectively)
4) Expand focus on moving ***beyond measurement*** to improvement

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afhto | D2D: DATA TO DECISIONS ▶ 4.0

Engeström, Y. (2000) Activity Theory as a Framework for Analyzing and Redesigning Work, Ergonomics 43(7): 960-74
Patton, M. Q. (2010) Developmental Evaluation: Applying complexity concepts to enhance innovation and use, Guilford Press