afhto association of family health teams of ontario

Advancing a Performance-Oriented Model for Primary Care in Ontario

PROPOSAL SUMMARY

February 17, 2012

1 Problem statement / project goal

The Government of Ontario has the triple challenge of reining in growth in the cost of health care while continuing to improve the health of Ontarians and satisfying public expectations for our health system. The Drummond Commission has called for a target of a 2.5 per cent annual increase in health care funding, and listed over 100 recommendations centred on evidence, integration, greater emphasis on prevention and primary care, and productivity achieved through a focus on outcomes. The *Excellent Care for All Act* proclaims the need for quality in health care and public support for our health system. *Ontario's Action Plan for Health Care* announces the goal – "to make Ontario the healthiest place in North America to grow up and grow old." To do so, it calls for:

1. Support to become healthier
2. Faster access and a stronger link to family health care
3. The right care, at the right time, in the right place

Performance measurement – and measuring the most critical aspects of performance – is key to all of the above. Unfortunately, this is sorely lacking in primary care in Ontario. The Auditor General's recent report rebuked government for its inability to assess the extent of value resulting from its increased investment in primary care.[i] Primary care organizations struggle to collect and track the data needed for improvement programs.[ii] While quality improvement is based on evidence and tests of change, it remains impossible to objectively identify which primary care organizations are high performers or low performers,[iii] creating a challenge for learning what's working or not working to improve primary care delivery. The Ministry expects that moving to a performance reporting system in primary care will take at least 3 – 5 years.[iv]

While there are initiatives underway to develop system-wide performance reporting through organizations such as the Canadian Institute for Health Information (CIHI), Health Quality Ontario (HQO), the Institute for Clinical Evaluative Sciences (ICES) and Canadian Primary Care Sentinel Surveillance Network (CPCSSN), critical gaps remain to be addressed. The gaps to be addressed through the proposed project include:

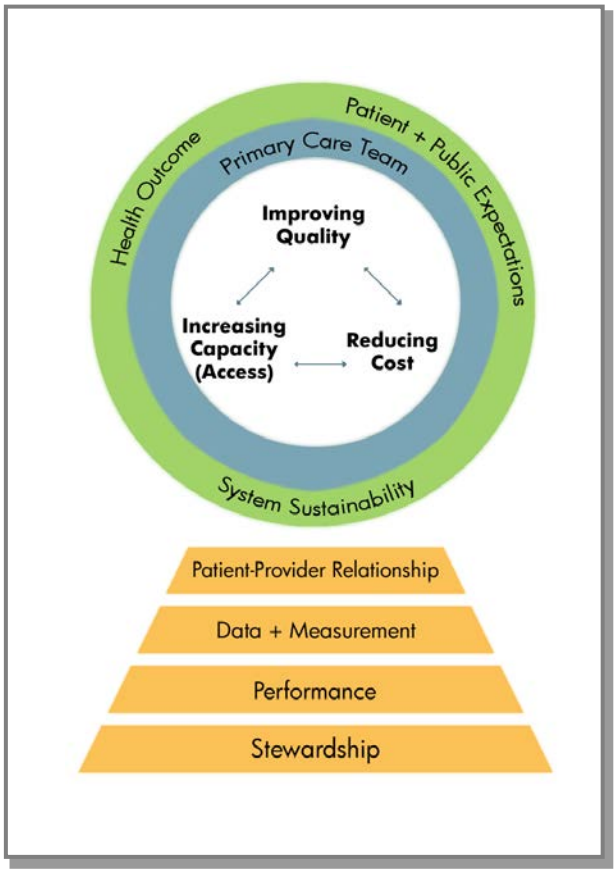
- The capacity of primary care teams to make the IT/IM investments needed to capture and report data.
- The capacity of primary care teams to capture data consistently and reliably – to avoid the problem of "garbage in, garbage out".
- The need to systematically identify and factor patient expectations and experience into the measurement system, to keep it responsive to the public's evolving needs and hopes for care in our health system.
- Most importantly of all, the ability to capture critical data needed to promote sustainable, high quality performance in primary care for all Ontarians. This includes the quality indicators developed through CIHI's work in developing pan-Canadian efforts, and goes beyond to include measurement and improvement in:
    - Practice capacity – to ensure timely access to primary care
    - Cost – to optimize organization and resource use in primary care delivery as well as use of other health system resources.

To close these gaps, the Association of Family Health Teams of Ontario (AFHTO) is proposing a pilot project that would support primary care teams to capture and report a set of data elements for tracking **quality**, **capacity** and **cost**, and to assess the resulting improvement made by these teams in these three dimensions. To give priority to results that matter most to patients, a sample of patients across the pilot teams will be invited to participate in a poll on their expectations for their primary care, which will be reflected in the weightings to be used in measurement.

Given the initiatives already underway in the province, the governance, organization, roles and accountabilities related to of this project would be developed with the Ministry of Health and Long-Term Care, AFHTO and other participants. To this end, CIHI, HQO and CPCSSN have provided letters of support for this project.

2 The Performance-Oriented Model for Primary Care

2.1 Overview of the Model



Comprehensive primary care is the foundation of a sustainable, responsive health care system in Ontario. The goals of comprehensive primary care are to:

- Optimize health outcomes for patients and populations
- Meet patient and public expectations
- Support a sustainable health care system

The focus of the primary care team is therefore to:

- Improve quality
- Increase capacity to assure access for patients
- Reduce cost – at the team level and the system level

To be able to optimize performance of primary care teams, the foundation must be set to:

- Support the fundamental relationship between patients and their primary care team
- Enable primary care teams to collect and report data efficiently
- Encourage and reinforce excellence in team performance
- Provide the feedback needed to promote stewardship of health system resources beyond the Primary Care Team

The key components of this model are as follows:

- Measurement is for **teams providing comprehensive primary care** to a defined patient population.
- Measurement is **focused on outcomes and processes**, not activities and transactions.
- Performance is measured in terms of **quality**, **capacity** and **cost** (depicted in the model above).
- Assessing "quality" requires simultaneous measurement of multiple indicators. In order to track overall quality over all of these dimensions, a **weighted score** is developed. The weighting is informed through **patient engagement**. This is done across a sample of patients across the primary care teams to get their input on what they value in their care, and the results will inform the choice of indicators, their weightings, and thresholds.
- **Indicators** are defined by a representative body that negotiates and refines the selection and weighting of the indicators, always referring back to the relative values that the population expressed. This establishes a uniform measurement system for all of the teams.
- The measurement system is **dynamic**, adapting to changing public expectations and evolving scientific evidence, thereby increasing accuracy over time.
- **Source data** must be reported. This would entail reporting on each rostered patient[v] on all discrete data elements necessary to generate the desired indicator outcomes. This enables:
  - Multiple ways of analysing data and indicators.
  - Efficient verification of the accuracy of data.
  - The agency receiving data can easily analyse the source data using standard commercial "industrial intelligence" applications.
  - EMR vendors do not have to analyse data.
- Teams receive financial **support** to access the goods and services they require **to collect and submit such data**. Funds could be used for such things as EMR upgrades, electronic devices, data clerk, decision support analyst, project management. The team's accountability is to deliver the data as a condition of funding; choices about the support needed to do so is up to the team.
- **Reporting** to the participants is **at the team level** (not the provider level[vi]). Teams could receive provider level performance data confidentially for their internal use only. Reports will also be delivered to MOHLTC and the steering body for the pilot, with level of analysis to be determined in consultation.

3 Project proposal

3.1 Project overview

The pilot project will recruit 10 comprehensive primary care organizations willing to implement the components of the Performance-Oriented Model for Primary Care, as outlined in section 2.1, i.e. source data to be collected to report on measures of quality, capacity and cost, aggregated into a score that has been weighted based on the results of patient polling. Teams will be paid for their data at a fixed rate per patient ($6 is recommended) and reporting will done at the team level.

The 10 teams will likely include 6-8 FHTs and 2-4 other primary care groups, such as FHGs, FHOs or NPLCs in order to assess feasibility across several primary care settings.

3.2 Project goals

1. To determine the extent to which the pilot primary care teams (FHTs and other models) are able to report a reliable and verifiable data set on a regular basis (monthly or quarterly) sufficient to provide the key measures needed to improve health outcomes and patient experience (access) while reducing practice-level and system-level costs.
2. Once teams are reporting the full data set, to evaluate the extent to which measurable improvement is achieved in quality, capacity and cost.
3. To gain insight into how the performance results could be used to share innovative ideas to achieve better performance amongst the pilot teams.
4. To evaluate the supports needed by FHTs to improve data quality and sustain reporting, and how to spread this capacity across primary care in Ontario.
5. To engage patients in the pilot primary care teams (and ultimately, Ontarians in general if the project is spread) in the opportunity to influence primary care performance through the expression of expectations and the selection of performance indicators.
6. To inform the public of group level achievement in performance with the ability to understand performance from a high to a granular level with trends over time.

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[i] http://www.auditor.on.ca/en/reports_2011_en.htm

[ii] Per discussions with the senior management of Health Quality Ontario's quality improvement partnership for primary care (QIIP).

[iii] Per discussion with lead for primary care research at ICES, Feb.7, 2012.

[iv] Per correspondence with contact in Premier's Office, Feb.9, 2012.

[v] Ideally, patient data would be linkable to be able to look at system costs (hosp admissions, ED use, lab/DI and drug costs would need identifiable data. CIHI has authority to collect and in Ontario clinicians are permitted to submit. First step in the project would be to work out roles and accountabilities for organizations such as CIHI, HQO and ICES, which will determine the appropriate way to manage patient data.

[vi] Data available through CIHI's PHC-VRS can be reported at both the team and the provider levels. The pilot would be collecting additional data and reporting back on individual indicators and weighted scores at the team level only.