



association of family
health teams of ontario

A Performance-Oriented Model for Primary Care

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:

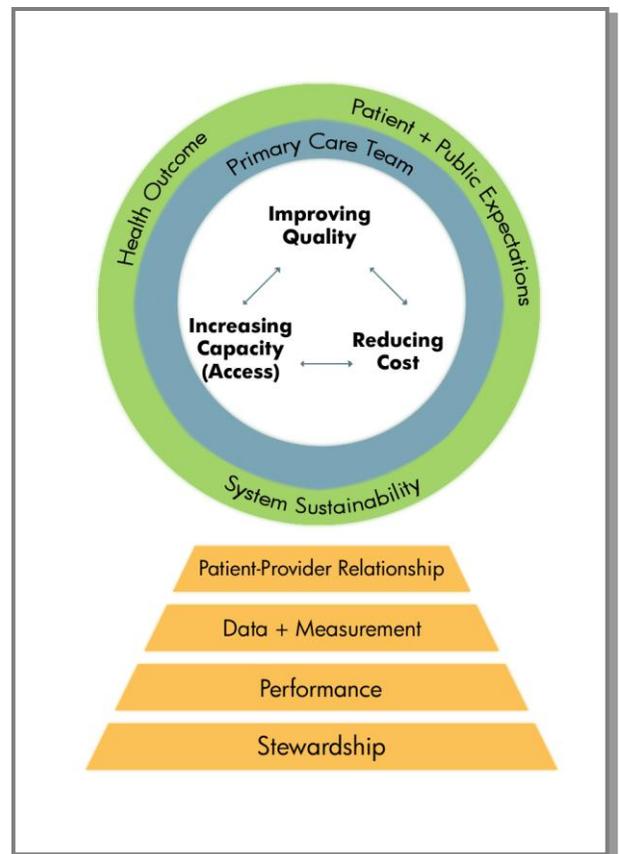
- Optimize health outcomes for patients and populations
- Meet patient and public expectations
- Support a sustainable health care system

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 patientⁱ 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 levelⁱⁱ). 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.

ⁱ 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.

ⁱⁱ 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.