

Data to Decisions: What's meaningful to you?



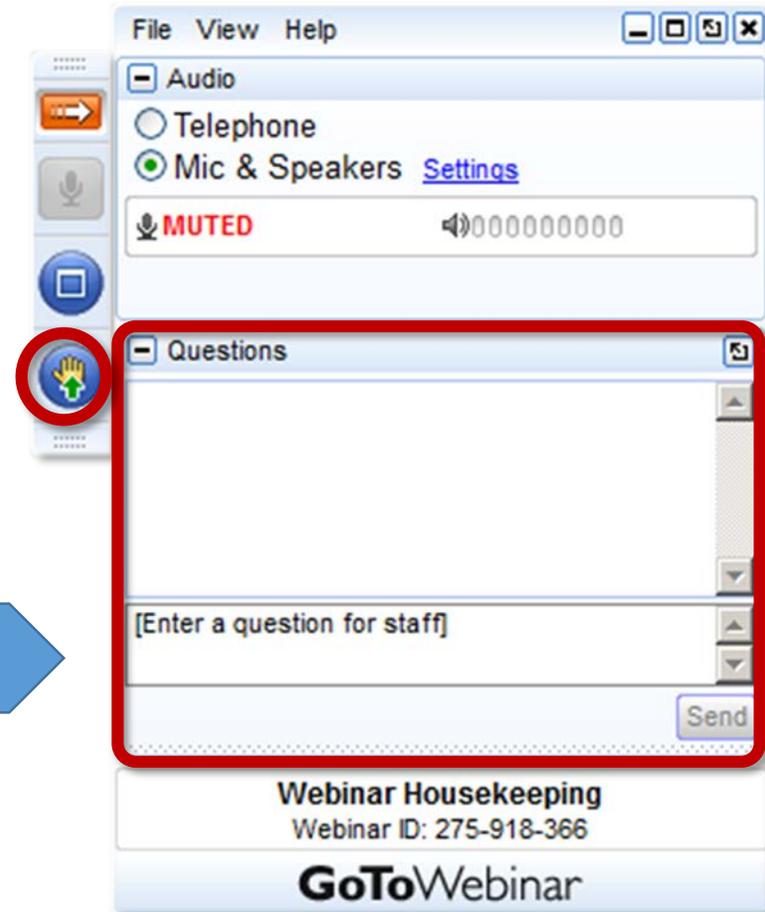
Webinar logistics

- **Echo on the line?**
 - Please mute yourself except when speaking. Use telephone OR computer but not both and use a headset (not speaker phone). We will mute you and help you via question pane until the echo is gone
- **You can't hear us?**
 - Please send us a message via the question pane (lower right corner of screen - see next slide).
- **We can't hear you?**
 - Unmute yourself. Send us a question via the question pane asking us to unmute you.
- **You have a question?**
 - Click on the "Raise your hand" button (see next slide) or send a question via the question pane
- **We ran out of time?**
 - Questions submitted during the webinar and any other questions received (via improve@afhto.ca) will be answered off line if we run out of time during the webinar.
- **Your colleagues couldn't join?**
 - The presentation and transcripts of questions/answers will be posted on AFHTO's members-only web page.

How to ask questions or speak during the webinar

Options:

- Raise your hand to be unmuted for verbal questions + comments.
- Write + submit your questions and comments using the Questions Panel



Questions panel

Goal of webinar

- By the end of the webinar, participants will
 - Know more about Data to Decisions 1.0: Advancing Primary Care (D2D 1.0)
 - Know where to go for even more information at D2D 1.0
 - Have enough information to vote on indicators for inclusion in D2D 1.0
 - Provide insight to AFHTO staff and Indicators Working Group to consider in planning for success with D2D 1.0

Overview

- Welcome and introductions
- **Why:** Strategic context
- **What:** Background on D2D 1.0: Advancing Primary Care
- **Who & When:** Member participation in D2D 1.0
- **How:** D2D 1.0 indicator selection
- **What's next:** Membership-wide vote on indicators
- Wrap up/Address questions

Introductions

- Ross Kirkconnell, Chair, QIDS Steering Committee of AFHTO
- Monique Hancock, Chair, Indicators Working Group (reporting to QSC)
- AFHTO Staff:
 - Angie Heydon, ED
 - Tim Burns, Provincial Lead, QIDS
 - Carol Mulder, Practice Lead, QIDS

WHY are we doing Data to Decisions (D2D) 1.0?

AFHTO Vision

All Ontarians have timely access to high-quality and comprehensive primary care; care that is:

- informed by the social determinants of health – the conditions in which people are born, grow, live, work and age
- delivered by the right mix of health professionals, in partnership with patients, caregivers and the community
- anchored in an integrated health system, promoting good health and seamless care for patients
- sustainable – efficiently delivered and appropriately resourced to achieve expected outcomes

AFHTO Strategic Priorities

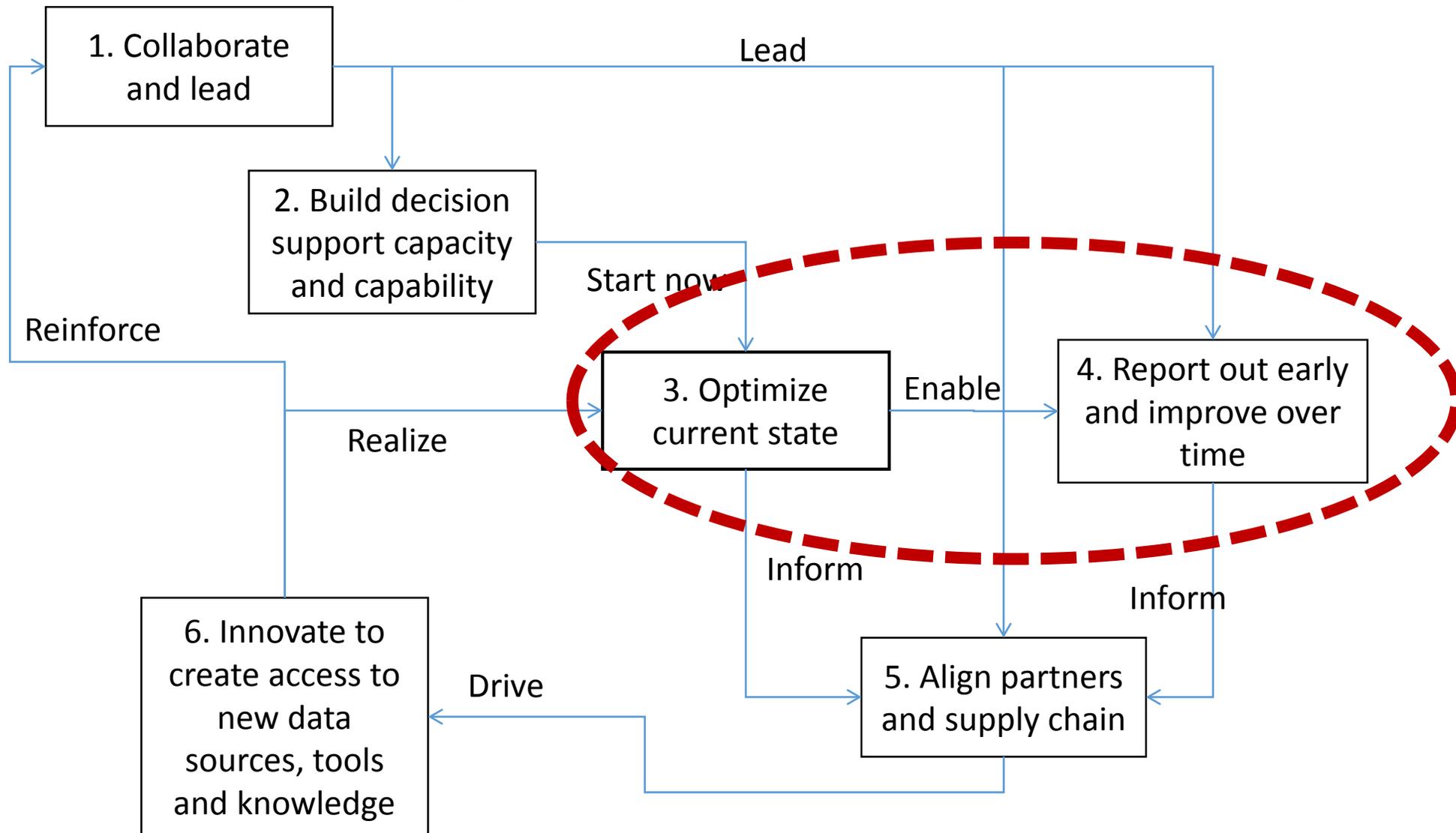
- Supporting FHTs to succeed with:
 - Governance
 - Quality / Use of data
 - Integration
 - Recruitment & Retention
- Promoting value of FHT model
- Engaging with members

Three Asks for MPPs

To continue improving outcomes and deliver savings, we are asking all of the political parties to:

1. Expand access to family care teams to all Ontarians as soon as possible.
2. Enhance value by investing in the ability of family care teams to track access, quality and costs, allowing them to do more to improve care.
3. Enable recruiting of professionals by ensuring that family care teams are able to compete with hospitals and institutions for the best professionals.

QIDS Strategy



WHAT is D2D 1.0?

What is D2D 1.0?

- 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 will help you
 - Know where your team stands relative to your peers
 - Celebrate the successes of your team
 - Know where to start to advance quality of care in your health team



Poll: Are you getting enough information?

- I am getting enough information from my data to advance primary care in my health team.
 - Strongly agree
 - Agree
 - Indifferent
 - Disagree
 - Strongly disagree

WHAT D2D is *NOT*

- Everything we ***SHOULD*** do
- The ANSWER – it's more like a question
 - a first step, not a destination
- A replacement for your existing reports
 - *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

How will D2D 1.0 help?

- D2D 1.0 will help you
 - Find out where your team stands relative to your peers on data that matter most to you
 - Give your team good reason to celebrate your successes
 - Potentially valuable in recruitment and retention
 - Help your team see where to start to advance quality of care within your own team

WHO is doing D2D 1.0?

How can I be involved in D2D 1.0?

- D2D 1.0 is designed for and by AFHTO members – therefore...
- There are *many* ways to participate in D2D 1.0
 - Participation is completely voluntary. All AFHTO members are invited but NOT required to contribute data. Besides contributing data, there are MANY other ways to participate – therefore...
- The work you decide to put into D2D 1.0 is up to you!
 - If one level of participation is beyond your resources, you can choose to participate in a different, less-resource-intensive way

How can our health team participate?

- Participation is completely voluntary
- There are many ways to participate
 - *Provide comments and ask questions:* eg today!
 - *Vote on indicators:* starting tomorrow
 - *Discuss with your QIDSS:* already in progress...
 - *Track D2D 1.0 indicators locally:* test extractions 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

How much work will D2D 1.0 be?



- D2D 1.0 will only include data that are already available
- You and your health team decide how much effort you can afford to contribute to the project (see different ways of participating)
- The focus of D2D 1.0 is on the areas where our collective efforts between health teams *overlap* so we can all get more value out of this work



“Now just hold your horses, everyone.... Let’s let it run for a minute or so and see if it gets any colder.”

WHEN is D2D happening?

When is the D2D 1.0 project happening ?

- **When did the project start?**

- AFHTO`s Board approved D2D 1.0 in Feb -- it was introduced to members March 2014

- **When will D2D 1.0 be done?**

- D2D 1.0 will be released in time for the annual AFHTO conference, Oct 15-16, 2014

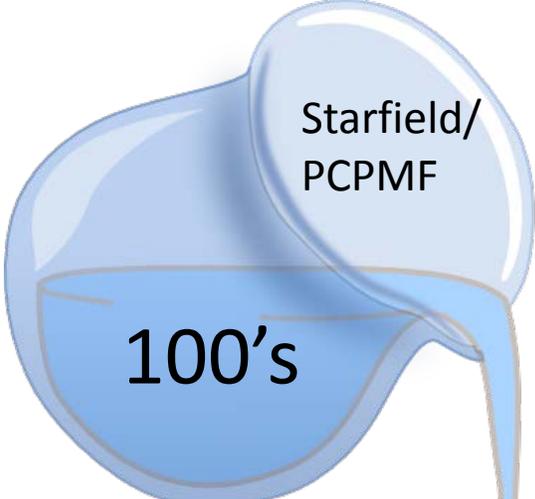
- **What's next?**

- All AFHTO members are invited to vote on the indicators to be included in the report.

HOW is D2D 1.0 being created?

Selecting indicators: The alchemy of D2D 1.0

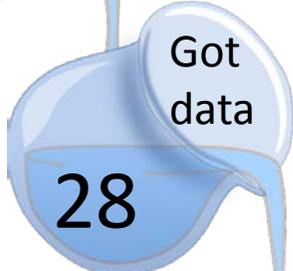
Extensive consultation
(physicians,
administrators, etc)



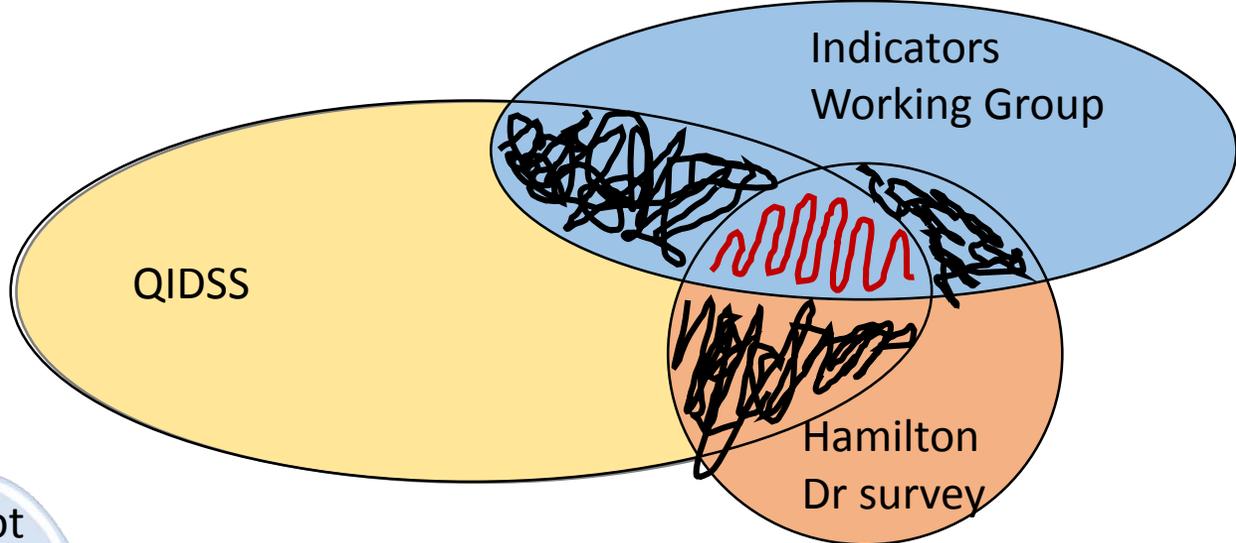
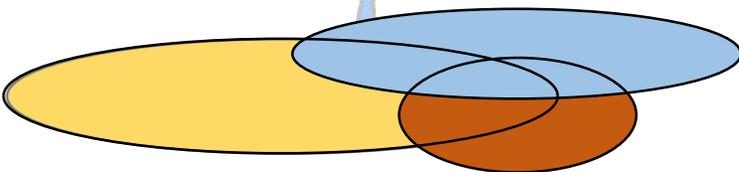
existing reports defined by
physicians, (eg CPCSSN,
EMRald), Dorval, HQO,
Champlain FHTs



QIDSS, admin
sources



What matters most



11 0

Group 1 Indicators (best 2 of 3)

1. Breast, cervical, colorectal cancer screening
2. (QIP indicator) Primary care follow up visit with physician within 7 days of discharge
3. Reduce admissions to hospitals for Ambulatory Care Sensitive Conditions
4. Patient experience -- various questions
5. Childhood immunizations
6. (QIP indicator) % of patients reporting same/next day appointments
7. # no shows of patients
8. 18-month-old development check
9. Smoking cessation advice
10. Appropriate *process* of care for diabetics, hypertension and IHD patients
11. Reviews of patients with chronic diseases

Other indicators

Group 2: administrative data members might not be aware of

1. Reduced number of 30 day readmissions
2. Continuity of care
3. Lower acuity ED visits
4. Comprehensiveness of care
5. Cost of care
6. Access bonus (% of max)
7. Specialist visits

Group 3: data that MAY be available in health team

1. Influenza immunization rate
2. Advanced access 3rd next appt.
3. House calls
4. % of week with direct office access
5. % on Coumadin with INR 2-3 in past 60 days
6. % appointments booked on the same or previous day (from scheduling data)
7. Outcomes for diabetics, hypertension and IHD patients.
8. Follow up by a primary care provider via phone or visit within 7 days of discharge

How will the list of indicators be finalized?

- AFHTO members will vote!
- IWG recommendation to QIDS Steering Committee late May
- Criteria for final list
 - Meaningful: **AFHTO members vote**, previous votes, innovation project results, PCPMF, external partners etc
 - Available: successful “test” extractions May-June, QIDSS input
 - Breadth: based on # of teams contributing data by Jun 30, 2014
- QIDS Steering Committee decision mid June

Who will help me extract &/or contribute data?

- QIDSS will be available to partnerships and will help via
 - Their day job! Daily efforts to support Quality Improvement
 - Responding to needs of health teams for data
 - Collaborating with peers (via QIDSS forums)
 - Accessing support from EMR vendors through Communities of Practice
 - Seeking/receiving guidance from Vendor/Supply Chain of QIDS Steering Ctte
- AFHTO QIDS program staff
- Your fellow AFHTO members

When I submit our data, who will see it?

- All health-team level data will be anonymized in D2D 1.0
 - Only you and report production staff will know which data is yours.
- PRIVACY
 - There is no information that identifies patients so no risk of breach of *private* information.
- CONFIDENTIALITY
 - There is information specific to health teams so a confidentiality agreement will be implemented to ensure there is no breach of *confidential* information
- OMD is the production partner.
 - Long and reliable history of working with and protecting confidential data about primary care providers.

What's next with D2D 1.0?

Members vote on indicators

- Electronic survey of 26 indicators (about 20 minutes)
- Launch Apr 23, closes on May 5, 2014 6:00 am
 - Confirm acceptability of deadline via poll
- Survey design informed by 2 previous iterations (IWG & QIDSS)
- Asks which indicators you are interested in using AND your sense of the availability of data now – ie what matters most to you
- Please vote even if you are not sure
 - a “not sure” vote is very valuable information!

Question re: interest in using the indicators

- For the following indicators [listed in survey], please choose the best description of your team:
 - Our team is currently monitoring or otherwise using this indicator
 - Members of our team are asking for data on this indicator
 - There has been no discussion in our team about using this indicator
 - Some members of our team have concerns about using this indicator
 - Our team dismisses this indicator outright
 - I don't know how our team feels about using this indicator

Question re: data availability

- For the following indicators [listed in survey], please indicate your best sense of the availability of data for your team:
 - we can access data for this indicator
 - we can access data for a RELATED CONCEPT (eg different wording, patient group etc)
 - we don't know if we can access data for this indicator
 - we have been trying but can't access data yet for this indicator
 - we don't have access to data for this indicator
- Example of real-time learning
 - Question format informed by the experience of the “Starfield” innovation project (led by George Southey and Rick Glazier)

Poll

- Will you be able to vote by 6:00 am May 5, 2014
 - Yes
 - No, but could do by May 8, 2014
 - No, not even by May 8, 2014
 - Not sure

After the members vote...

- Early May
 - Membership-wide update of initial observations from the vote
 - QIDSS (and others) initiate test extractions and review of data quality to refine earlier estimates of feasibility
- Late May
 - Indicators Working Group recommend final short list to QSC
 - Complete Privacy Impact Assessment (focussed on protecting confidentiality)
- Early June
 - QSC confirm final list of indicators
- Late June
 - Contributing health teams submit data to production partner

Wrap up/questions

- Posting of audio recording and slide deck

For more information

- Tim Burns, Provincial Lead, QIDS program tim.burns@afhto.ca
- Carol Mulder, Practice Lead, QIDS program carol.mulder@afhto.ca

Closing Poll

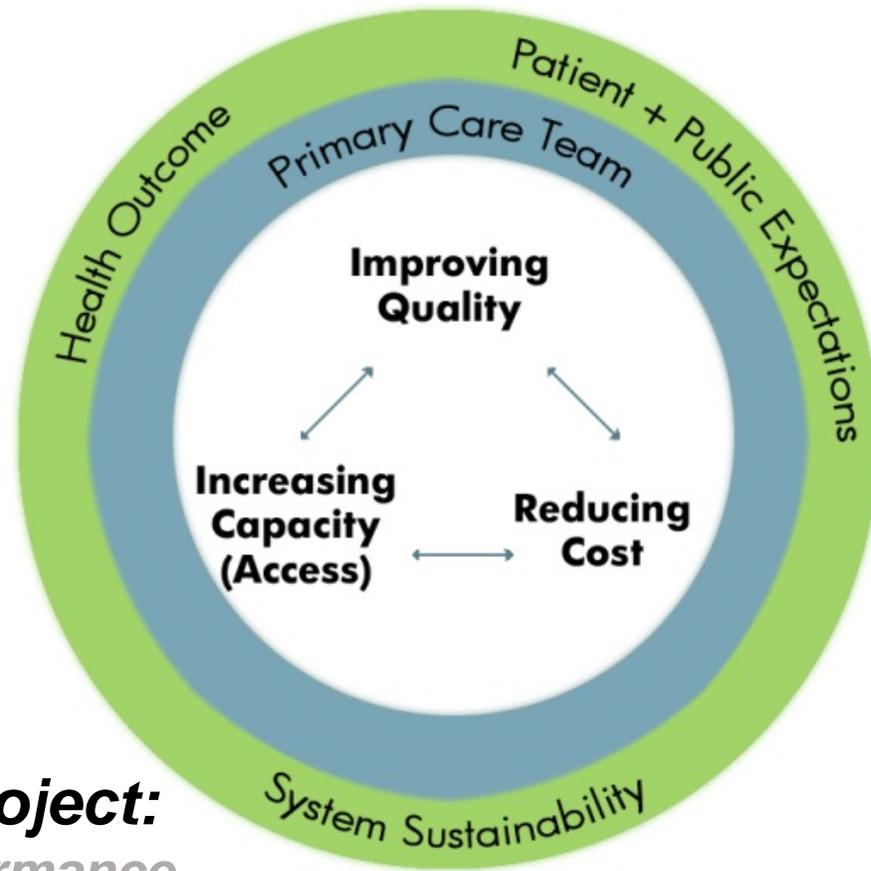
To what extent has this webinar been useful to you?

- Very helpful
- Helpful
- Somewhat helpful
- Not helpful

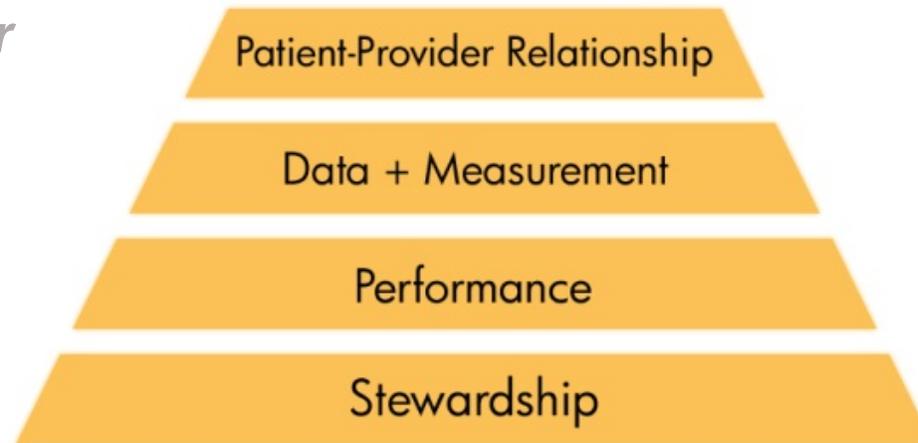
Additional materials

Links

- D2D 1.0 Frequently Asked Questions
 - <http://www.afhto.ca/wp-content/uploads/Frequently-Asked-Questions-about-D2D-1-0-Advancing-primary-care.pdf>
- QIDS Steering Committee Terms of Reference:
 - <http://www.afhto.ca/wp-content/uploads/Board-Approved-TOR-for-QSC-2013-09-11.pdf>
- Starfield model
 - <http://www.afhto.ca/wp-content/uploads/Valuing-comprehensive-primary-care.pdf>
- Primary Care Performance Measurement Framework
 - <http://www.hqontario.ca/public-reporting/primary-care>



***The Starfield Project:
Advancing a Performance-
Oriented Model for
Primary Care***



Starfield Philosophy and Model

- The Starfield *model* is an approach to performance measurement based on the Starfield *philosophy* that comprehensive primary care is the foundation of a sustainable, responsive health care system.
- The Starfield *philosophy* holds that “*the key components of primary care ... include access to and use of first-contact care, patient-focused (rather than disease-focused) care over time for defined populations, services that are comprehensive and timely, and coordination of care when patients need services elsewhere*”, with emphasis on *comprehensiveness*. Subsequent research has shown that investment in comprehensive primary care improves system quality, equity and healthcare system costs.
- The Starfield *model* of performance measurement aligns with the Starfield *philosophy* by tracking outcomes of care, capacity to provide care, the cost of delivering that care AND explicitly incorporating patient perspective in the measurement of performance. High scores on the Starfield *model* depend how well the Starfield *philosophy* of comprehensive primary care is incorporated into the practice. The model thus incents comprehensive delivery of primary care.
- ***Components of the Starfield model of performance measurement***
- Improving Quality (ie outcomes): The Starfield *model* currently tracks quality through a single composite indicator based on the scores for 60 specific components which include readmission rates to hospital, patient satisfaction with time spent by clinicians as well as many other indicators that appear in many other primary care performance measurement inventories. The nature of components and their contribution to the composite indicator will evolve as data availability and patient expectations change over time.
- Increasing Capacity (ie access): The Starfield *model* currently tracks capacity comparing the number of the patients served and the amount of time available to serve them. The nature of this indicator may evolve as more data related to system capacity become available.
- Cost: The Starfield *model* currently monitors system cost via the total acute care bed days over expected bed days, a measure that represents about 40% of total cost of care. As access to more complete data on cost improves, this measure may also evolve.
- Patient and public expectations: The Starfield *model* incorporates patient/public perspective into the calculation of the composite indicator for outcomes. Components that are more important to patients/public receive a higher weighting in the composite score. Weighting is updated from time to time.
- Implementation notes: *The Starfield model has been implemented in one FHT in Ontario. To participate in performance measurement via the Starfield model, a health team would collect data on the components of the Outcomes indicator (currently about 60). A health team may choose to conduct a one-time survey of their patients to determine what these weights should be or they could just use the weights derived from patients in the practice where the model was first implemented. They would then assign weights to each component of the composite Outcomes indicator, according to how important each component was to patients. This single composite score is then reported and displayed along with the other two indicators (Access and Cost) which are calculated according to simpler mathematical formulae, as noted above.*
- The Starfield model has been implemented by the Dorval Medical Family Health Team. Feasibility for extension of the model to other teams is being examined in the context of a QIDS Innovation Project and will be reported to AFHTO members and a knowledge transfer symposium for innovation projects, May 26, 2014.