**EFFECTIVE GOVERNANCE**
FOR QUALITY AND PATIENT SAFETY

**afhto**

# STRATEGY AND MEANINGFUL MEASUREMENT

## THE ROLE OF THE BOARD

# Learning goal:
# Be able to …

- help the Board know how well the organization is doing on its strategic priorities and guide action to further improve performance
- Examine the importance of meaningful information and measurement as a foundation to governance decisions for quality and patient safety.

Boards need access to **meaningful and relevant measures** that they can use to **assess current performance and target improvement strategies**
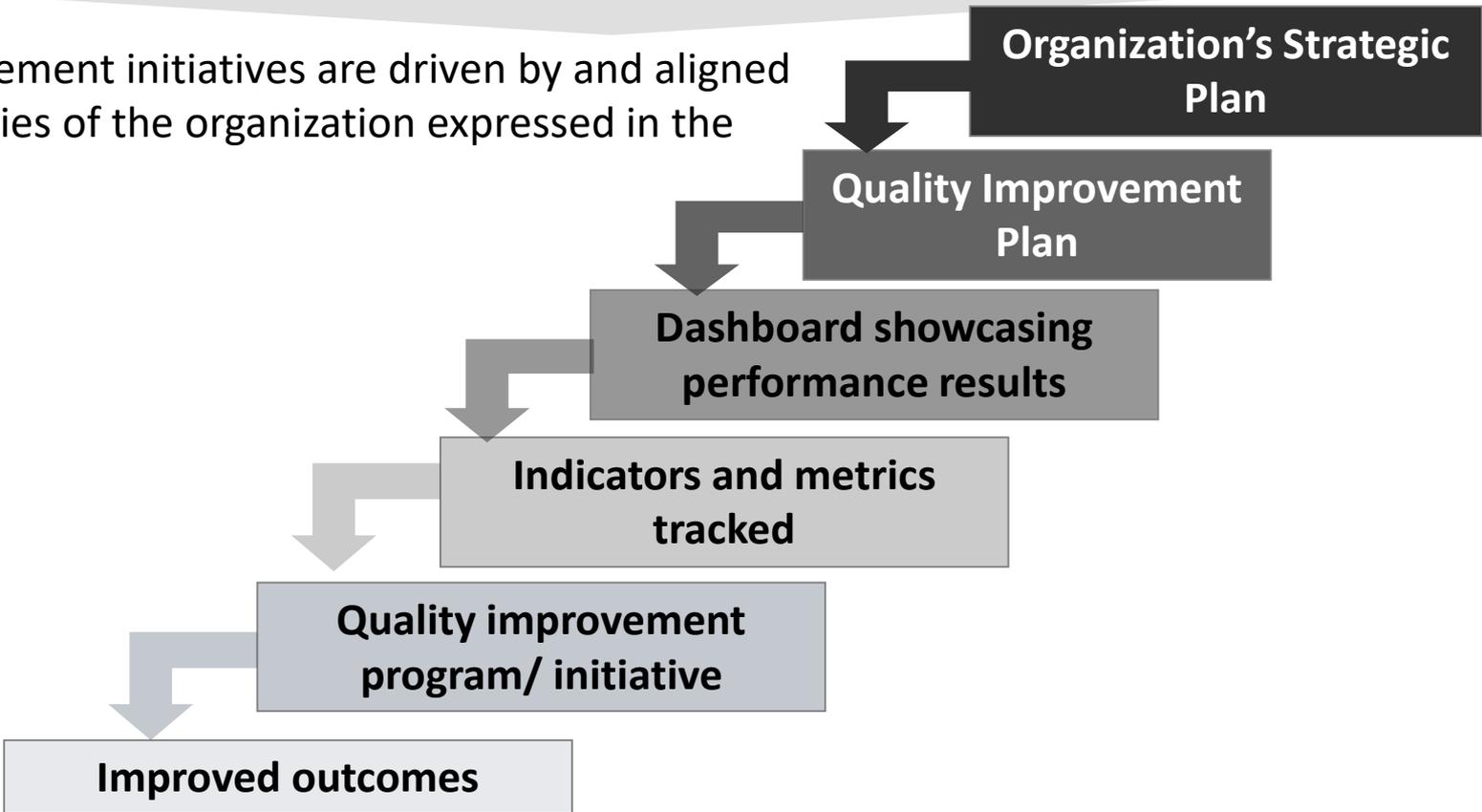
*"You can't improve what you don't measure and generally, whatever you measure...improves"*

# Alignment of strategic priorities

Organization's mission and overall vision

Quality improvement initiatives are driven by and aligned with the priorities of the organization expressed in the strategic plan

**Organization's Strategic Plan**

**Quality Improvement Plan**

**Dashboard showcasing performance results**

**Indicators and metrics tracked**

**Quality improvement program/ initiative**

**Improved outcomes**

# In a sea of information and indicators, how are Boards supposed to keep track?

# Characteristics of Informative and Relevant Measures

- Are aligned with strategic priorities for quality and patient safety

- Start with a baseline, where we are now

- Are sensitive to the changes we seek to make

- Are timely, allowing us to observe changes close to when they happen

- Can be trended to show improvements over time

# Attributes of Informative and Relevant Measures

- Can be **benchmarked** against other relevant organizations (Who is the best?)

- Can be a composite of interrelated information (a **big dot**)

- Can also include a basic actual count of the most **direct** measures that personify performance
  - Deaths, complications, infections, complaints

- Can be established targets

# Dashboards/Scorecards for the Board

- Snapshot of organization - wide, outcome-driven measures associated with strategic areas

- Should be clear, easy to read/interpret and timely/updated on regular basis

- Boards should monitor indicators of clinical performance as they do financial performance.

# Becoming quality-literate

✓ Choose JUST A FEW indicators -- less is WAY more

✓ Make sure you can EASILY get the data: measuring progress should not distract from making progress

✓ Report often to see progress or lack thereof in time to make changes to improve (at least monthly, if possible)

✓ For help with choosing indicators and capturing data, refer to D2D, QIDSS, EMR Community of Practice and your peers

# Quality Improvement Plan

- Why do a QIP
    - <u>It's a good idea:</u> It provides direction to the ED and organization to ensure you all achieve your strategic priorities
    - <u>You have to:</u> FHTs, AHACs, NPLCs, CHCs are REQUIRED to submit Ministry QIP annually
- What is a QIP
    - Specific measures, timelines and targets related to the strategic priorities
    - Action-oriented and outcome-driven plan to guide activities of organization and focus attention of the Board on improving quality
    - QIP is mandatory but the contents of it are NOT

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# D2D 4.0

## Why focus on D2D?

- Informing sector-level measurement
- Supporting clinicians in improvement via interprofessional collaboration, patient engagement and building QI capacity
- D2D can provide a starting place by comparing to peers

## D2D Highlights:

- Contribution: Number of teams holding, number of indicators increasing
- Better EMR data quality
- Performance: no change in levels, possibly some decrease in variation
- What's next for teams: move beyond measurement!

## What's next for AFHTO:

- Member support for improvement
- Demonstrate value of AFHTO members as leaders in "generalist" patient-centered primary care

# LHIN-specific D2D contributors

| LHIN | # of D2D 4.0 entries | # of teams in LHIN | % | # of rostered patient reported by team |
|---|---|---|---|---|
| Did not report | 1 | | N/A | 106,956 |
| 1-Erie St. Clair | 8 | 11 | 73% | 187,219 |
| 2-South West | 15 | 20 | 75% | 358,807 |
| 3-Waterloo Wellington | 8 | 9 | 89% | 163,960 |
| 4-HNHB | 10 | 15 | 67% | 365,365 |
| 5-Central West | 0 | 6 | 0% | |
| 6-Mississauga Halton | 5 | 7 | 71% | 102,495 |
| 7-Toronto Central | 9 | 13 | 69% | 130,993 |
| 8-Central | 7 | 12 | 58% | 184,552 |
| 9-Central East | 8 | 10 | 80% | 88,366 |
| 10.South East | 11 | 15 | 73% | 135,151 |
| 11-Champlain | 8 | 19 | 42% | 90,856 |
| 12-Nth Sim. Muskoka | 3 | 6 | 50% | 128,722 |
| 13-North East | 19 | 27 | 70% | 117,326 |
| 14-North West | 3 | 15 | 20% | 13,929 |
| **Grand Total** | **115** | **185** | **62%** | **2,174,697** |

# D2D 4.0 contributors

all 4
30%

first time
7%

1.0 and/or
2.0

3.0 and
4.0
58%
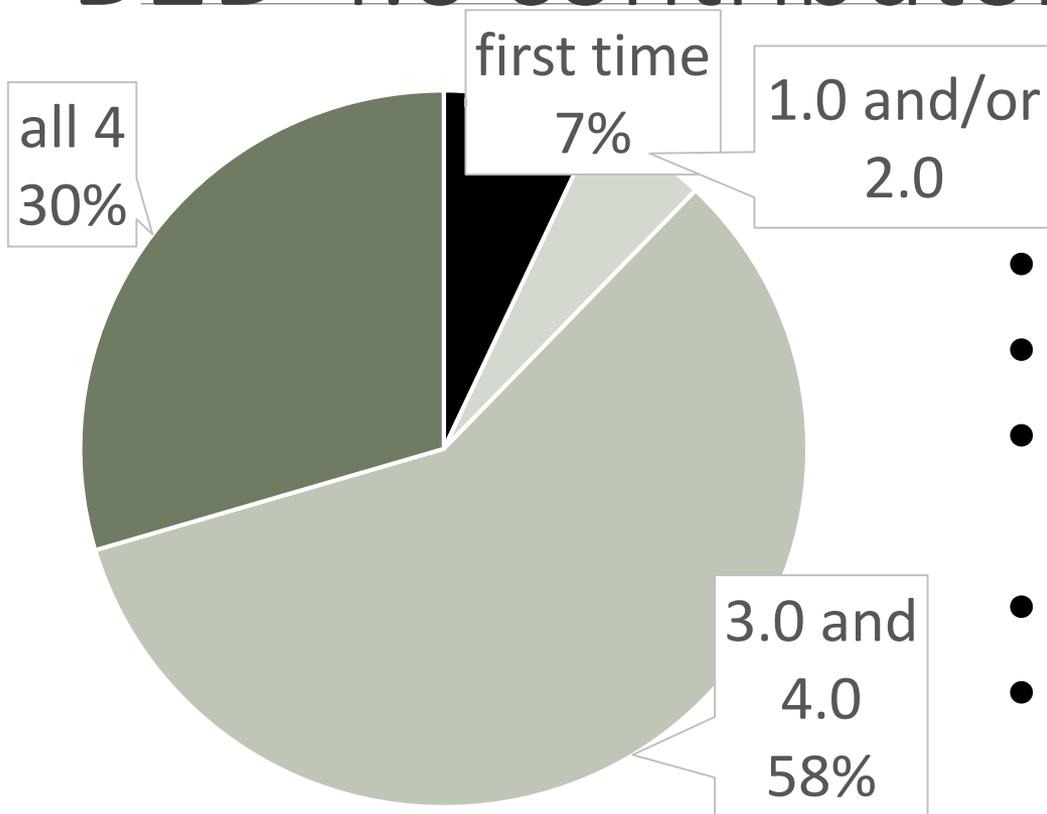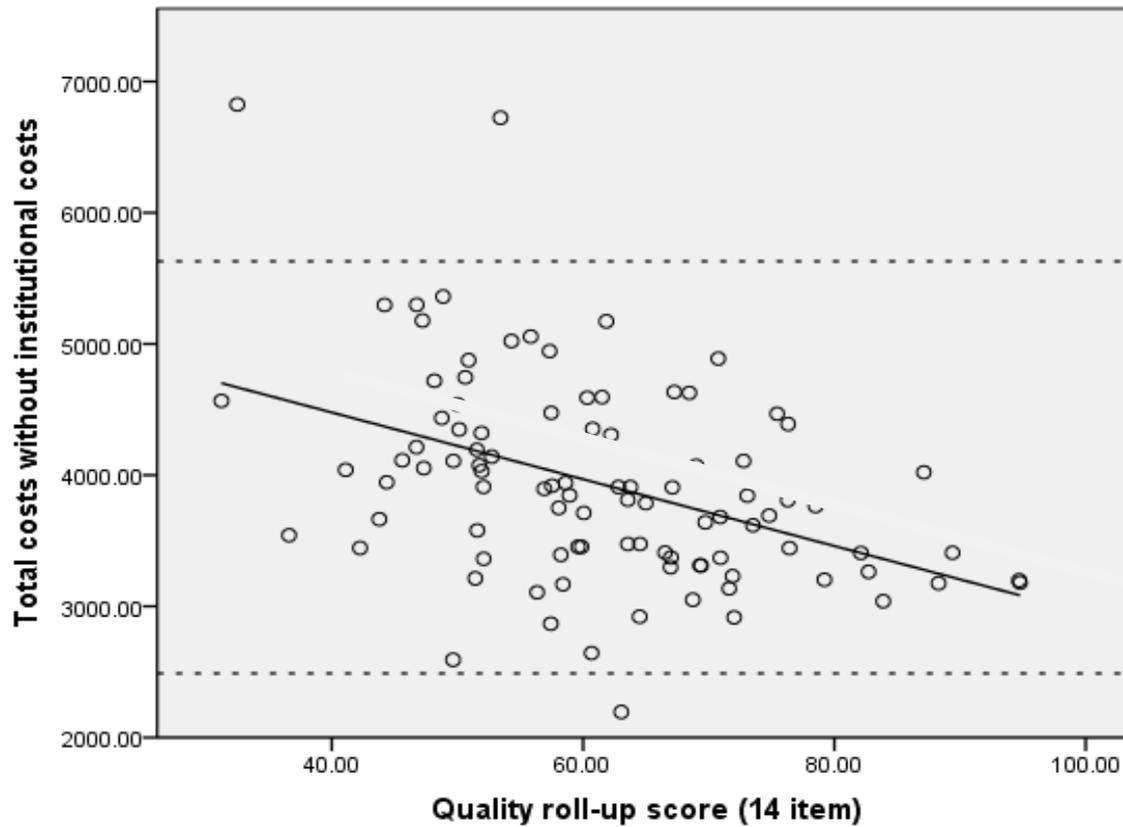
- All 4 iterations: 30%
- D2D 3.0 & 4.0: 58%
- D2D 1.0 or 2.0 (but not 3.0): 5%
- First time: 7%
- ANY iteration of D2D: 83%

**afhto** D2D: DATA TO DECISIONS

Quality Roll-up score: Ontario and AFHTO members D2D 2.0
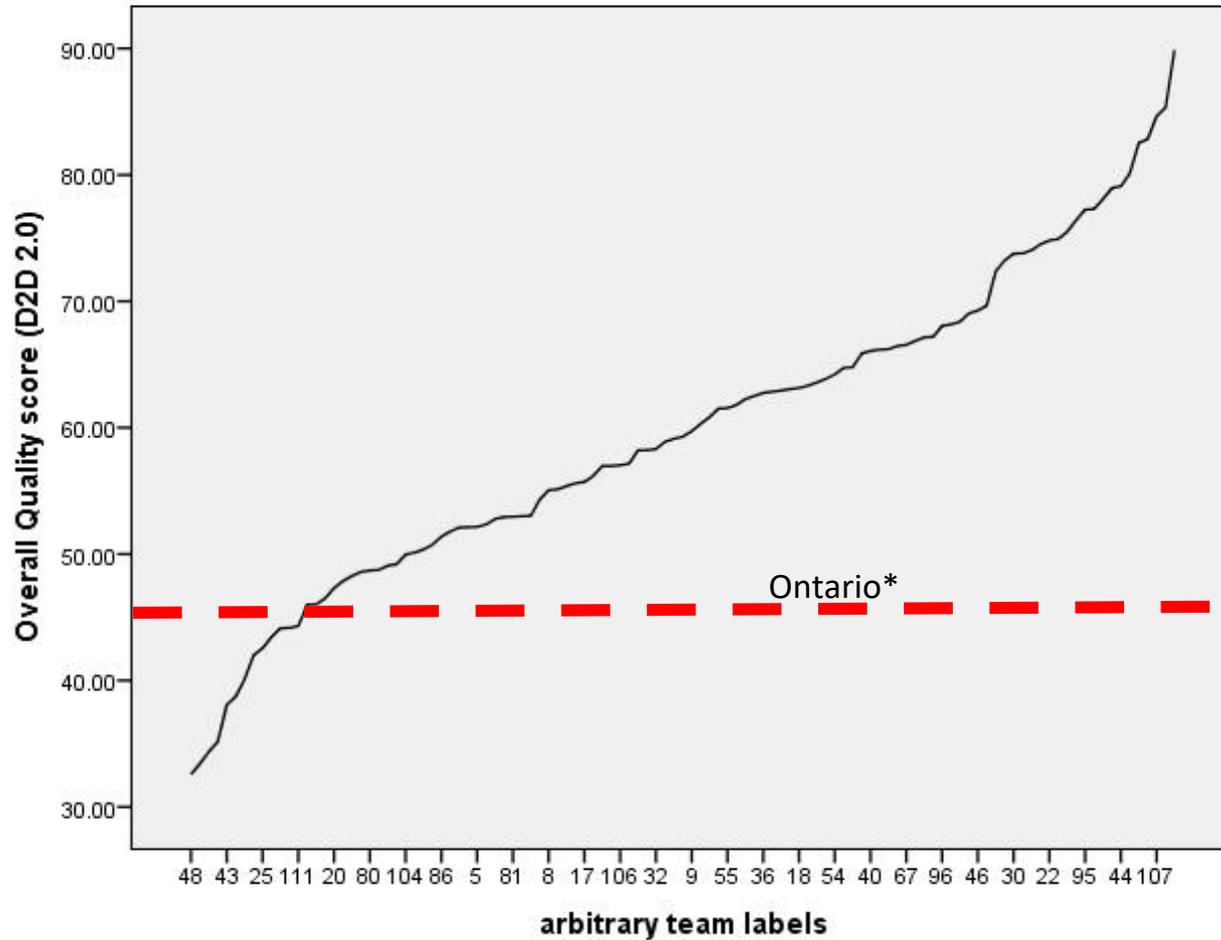
Ontario*

* Ontario score based on publicly available aggregate data

# Quality and cost

# In a world with better EMR data…

D2D can more confidently include EMR-based indicators to be more current and locally relevant than admin-data-based indicators

NPLCs can contribute data to D2D for more indicators than they could for admin-data-based indicators

Creates opportunity for D2D to become more meaningful as more patient-centered, clinically meaningful data is entered into and extracted from EMR

- ◦ Patient choice about immunization and cancer screening
- ◦ Individualized targets for blood sugar levels
- ◦ Patient-reported progress in self-management of chronic conditions
- ◦ Follow-up after hospitalization

# Follow-up after hospitalization

History:
- First considered and rejected for D2D 1.0 because billing-data-based indicator not acceptable to members
- AFHTO developed consensus definition by D2D 3.0: any intervention by any clinician, assuming timely notification of discharge
- New definition to be part of 2017-18 QIP package (see HQO announcement shortly)

Access to data
- 51 teams contributed data and/or stories
- Tracking hospital discharge information: substantial work-arounds continue
- Tracking of follow-up: variation in tracking follow-ups persists in spite of availability of standardized processes/queries

Performance
- 66% of hospitalized patients followed up by team vs 33% based on physician billing data

Next steps
- Continue to advocate for standardized tracking of follow-up in EMR
- Continue to advocate for timely discharge information dissemination from hospitals: engage patients in the discharge process (PODS)

# Use D2D to help ALL members collectively and individually

Individually: AFHTO uses D2D to help at the local team level by:

◦ Facilitating even better access to data eg EMR data quality

◦ Supporting clinicians in improvement via interprofessional collaboration, patient engagement and building QI capacity

Collectively: AFHTO uses D2D to help ALL members by:

◦ Showcasing value of AFHTO members in the broader sector

◦ Equipping LHINs to incorporate a "generalist" comprehensive view of primary care in Patients First planning

◦ Informing sector-level measurement: eg Follow-up after hospitalization in QIP

# What are we learning from D2D?

- AFHTO members are measuring!
  - Quality roll-up indicator reflects quality according to what matters to patients
  - Quality measured in this way is also associated with lower per capita costs
- AFHTO members are leading
  - With use of EMR data to reflect what the WHOLE team is doing (eg. diabetes care)
  - With actual measurement of EMR data quality!
- Physician leadership is making a difference
  - Made it possible to explore data about human resources capacity
- AFHTO members are well equipped to move from measuring to improving quality

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# From Data to Action!
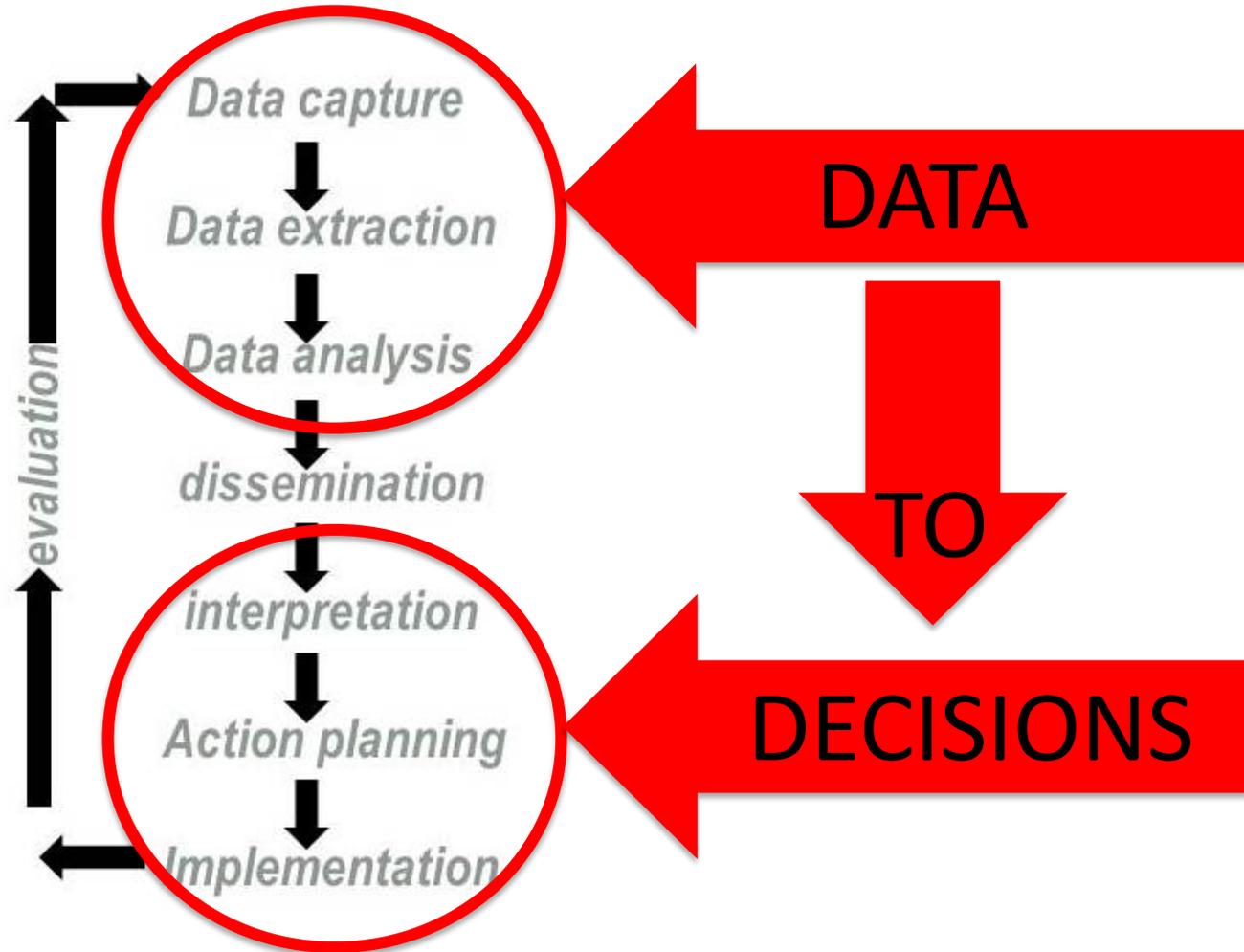
# Alignment: QIP, PCPMF and manageable, meaningful measurement

| D2D | PCPMF | QIP |
|---|---|---|
| Health care system cost | yes | no |
| Same/next day appointments | yes | yes |
| Reasonable wait for appointment | no | no |
| Patient involved in care | yes | yes |
| Patient satisfaction with office staff | yes | no |
| Childhood immunization (rostered and all children) | yes | no |
| Colorectal cancer screening | yes | yes |
| Cervical cancer screening | yes | yes |
| Readmissions to hospital | yes | yes |
| Regular primary care provider (individual and team) | yes | no |
| Diabetes care | Sort of | Sort of |
| Time spent delivering care (exploratory indicator in D2D 3.0) | Sort of | no |
| 7-day follow-up  (Exploratory indicator in D2D 2.0) | Sort of | Sort of |

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## Building a Mosaic:
### Using team-level data to increase provincial consistency in primary care program planning.
Jamie Sample and Carol Mulder, Association of Family Health Teams of Ontario

This project outlines a way to support and spread efforts to measure quality in a way that balances the need for local, timely, relevant data useful to improve quality with the need for consistent standardized data to demonstrate collective value.

## Objectives

• Stimulate dialogue about how teams use data to track progress of efforts to deliver quality primary care

• Identify all the components of the "mosaic" of measures used to track programs at a local level.

• Facilitate consistency and focus on outcomes (vs. process indicators) in choosing indicators

## Description

AFHTO developed the "mosaic" catalogue of indicators following these steps:

• **Convene a working group** of QIDS Specialists, Executive Directors and MOHLTC representatives.

• **Compile a list** of indicators included in previous reports of teams to MOHLTC (via Schedule A of MOHLTC-FHT contract).

• **Assess level of evidence** supporting each indicator (if any). Strong evidence, for example, was inclusion in HQO's Primary Care Performance Measurement Framework or clinical guidelines.

• **Display the resulting catalogue** of indicators in an interactive spreadsheet to show relevant indicators for each main primary care program area, sorted according to type, frequency and level of known evidence.

## Results



1,150 Raw Indicators → 98 Unique Concepts → 13 Clinical Programs

The raw indicators were gathered from team Schedule A submissions, sorted into unique concepts and grouped into clinical programs.

Each indicator was identified as either an outcome measure or process measure.

| Outcome indicators 62% | Process indicators 38% |
|---|---|



57% | 21% | 15% | 6%
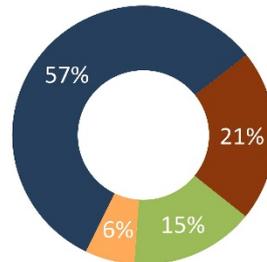
The 98 unique concepts were further classified based on the evidence supporting their use.

■ Stong Evidence   ■ Moderate
■ Weak/Not found   ■ N/A

### Screen shot of Schedule A Indicator Catalogue

| Consolidated priorities | Smoking and Addictions | |
|---|---|---|
| **Count of Consensus indicator label** | | |
| **CONSENSUS INDICATORS** | evidence grade | Total |
| ⊕ process/activity measure | | 23 |
| ⊟ % of people in program who have reduced smoking | ⊕ moderate evidence | 9 |
| ⊟ % of patient to be offered smoking cessation | ⊕ moderate evidence | 3 |
| ⊟ ? | ⊕ evidence not yet found | 2 |
| ⊟ % of patients self identifying as satisfied after a group session | ⊕ strong evidence | 1 |
| ⊟ % of people in program who are on smoking cessation medication | ⊕ moderate evidence | 1 |
| **Grand Total** | | 39 |

## Conclusion

The exercise has:
• Increased participation of front-line providers in increasing the consistency of measurement.
• Supported local enthusiasm for team-based quality improvement initiatives and better access to and use of EMR data.

The resulting catalogue shows that it is possible to:
• Find an effective alternative to prescriptive or top-down approaches which can perversely increase resistance rather than encourage consistency.
• Leverage pockets of excellence in use of evidence-based indicators

**Implications for performance measurement in primary care**
Front line primary care providers are willing and able to develop and use consistent, standardized, evidence-based measurement systems that are developed *by* them and *with* them, not just *for* them.

## Next Steps

• Increase use of the catalogue for program planning and evaluation
• Collaborate with clinicians to update the evidence base for each indicator.
• Refresh the catalogue to monitor for increasing consistency and standardization in measures.

For more information, contact the QIDS program (improve@afhto.ca)

afhto | D2D: DATA TO DECISIONS ▶ 4.0

# Key Questions & Reflection: Strategy & Meaningful Measurement

1. **How are we using data to drive improvement? Can we do this better?**

*(share your experiences + approach)*

- How are we tracking progress on our priorities?

- How does our performance stack up against our peers?

- How are we evaluating FHT programs to demonstrate value?

- How is the team aligned and engaged in QI efforts?

# Key Questions & Reflection: Strategy & Meaningful Measurement

2. **What are the LHIN's key primary care metrics, both regionally and sub regionally?**

   - Are these the right ones?

3. **FHTs could support the collection of transparent and relevant regional and sub regional Primary Care Data. To do this, FHT Boards will need to be committed to transparency and accountability. Is your organization comfortable with supporting the LHIN with transparent, meaningful Primary Care data?**

4. **What is ONE thing we can do to improve quality by Tuesday? (Keep it simple!)**

# THANK YOU!



"What if we don't change at all ... and something magical just happens?"