

DISCUSSION PAPER

Primary Care Homes: Provincial Leadership in Essentials for Quality Improvement

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Introduction

As communities in the province implement primary care homes (PCHs) over the next three years, evidence from review of success literature in other jurisdictions convinces us there is a need to establish indicators to measure quality improvement (QI) with respect to triple aim goals. We are concerned that if these measures are not available, the PCH evolution in BC will fail to achieve its promise of a sustainable health system.

This discussion paper aims to set out some of these evidence needs, clarify what data could and should be analyzed, and make an argument for immediate GPSC, Ministry of Health, & Health Authority leadership in developing systems required.

Why Undertake Quality Improvement with respect to PCHs?

There is a strong feeling that PCHs are a key element in a more sustainable patient-centred health care system that achieves better health outcomes, greater patient and provider satisfaction, and stable or reduced per capita costs. Despite some mixed reviews,¹ overall evidence regarding the success of PCHs in achieving these outcomes in other jurisdictions is generally positive, but the degree of improvement offered with respect to triple aim goals is not always dramatic.^{2 3} PCHs seem like a logical solution to many of our current healthcare challenges, but without establishing appropriate metrics to measure success in advance, thereby allowing for the assessment of baseline data and quality improvement actions during implementation, it will be difficult to make course corrections to ensure that they provide better care, not just different care.

Given the magnitude of change in current health care delivery models and resourcing required to move toward PCHs, perhaps better described as “the size of the bet we are placing” in PCHs, there is an unequivocal need and opportunity to undertake this kind of systematic assessment, accompanied with strong QI tools targeted directly at PCH teams.

¹ Friedberg, M. W., Schneider, E. C., Rosenthal, M. B., Volpp, K. G. and Werner, R. M. (2014). “Association Between Participation in a Multipayer Medical Home intervention and Changes in Quality, Utilization and Costs of Care,” *JAMA*. 311(8):815-825.

² Neilsen, M., Gibson, A., Buelt, L., Grundy, P. and Grumach, K. (2015). *The Patient -Centered Medical Home's Impact on Cost and Quality: Annual Review of Evidence 2013-2014*. Patient-Centered Primary Care Collaborative.

³ Toward Optimized Practice. (2015). *Benefits of a Patient's Medical Home: A Literature Summary of 73 Articles (70 Peer Reviewed)*. www.topalbertadoctors.org.

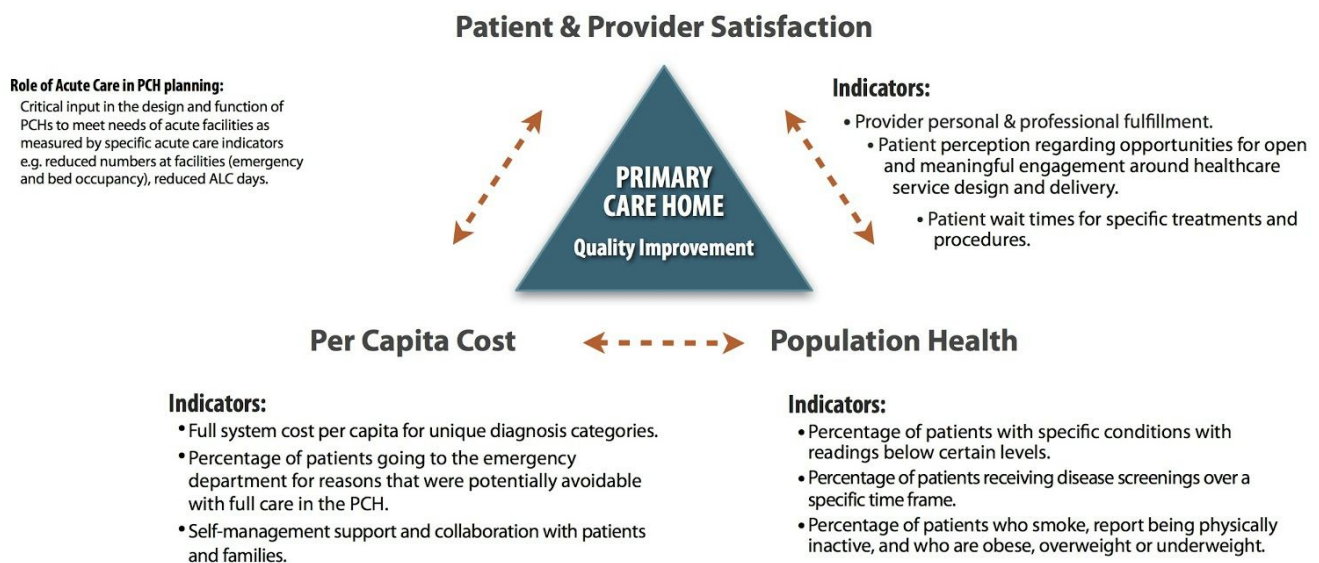
What Should be Measured?

Identifying metrics of success for PCHs must be undertaken collaboratively by multidisciplinary teams of care providers and administrators to identify indicators that provide meaningful results and for which data can reasonably be collected. The foundational value behind this work is providing evidence-based data to PCH teams on a practice and system level that allows for reflection and subsequent change. Indicators must also focus on measures that we know will have the highest impact on the cost aspect of the triple aim. Representation from the acute sector would be required to assist with this focus on cost.

Examples of indicators could include:

PROVINCIAL PRIMARY CARE HOME

Quality Improvement Planning: Indicators to Ensure PCH Impact



Note: Indicators collected on practice and system levels and utilized to assess PCH performance relative to baselines and traditional service models, and to compare PCH outcomes at the local, regional and provincial level.

Please see Appendix A for further indicator examples, many of which have been utilized in Ontario. The Canadian Institute for Health Information has developed a set of 105 pan-Canadian primary health care indicators very similar to those developed in Ontario, that could also be utilized as a starting point.⁴ In Alberta, measures such as number of office visits, number of emergency department visits, and length of stay on hospital admission are already being utilized to compare primary care delivered through multidisciplinary teams in a PCH setting with more traditional models of practice.⁵

⁴ Canadian Institute for Health Information. (2012). Pan-Canadian Primary Health Care Indicator Update Report. https://secure.cihi.ca/free_products/Pan-Canadian_PHC_Indicator_Update_Report_en_web.pdf

⁵ Crowfoot Village Family Practice: Enhanced Care through Patient Based Funding and Multidisciplinary Teams. <https://www.cvfp.com/images/pdfs/CVFP-PatientStudy.pdf>

Data Sources

Data relating to patient and provider satisfaction and experiences can and should be collected at the PCH level. Guidance from provincial leadership is required only to set indicators relating to this aspect of the triple aim goals and require data sharing provincially and locally with patients.

Data required to develop measures of population health and system costs already exists in databases such as the Discharge Abstract Database, the Canadian Community Health Survey, the National Physician Survey, Electronic Medical Record data, the National Ambulatory Care Reporting System, Health Authority budgets and data, Medical Services Plan billing records, Healthideas, Provincial Health Services Authority Community Health Profiles, as well as other specialized health databases. To utilize this data though, it is critical that it be processed appropriately, compiled, and shared among the various stakeholders engaged in improving health care provision in BC, including the Ministry of Health, Health Authorities, Divisions of Family Practice, and Doctors of BC.

The Ministry of Health's Blue Matrix is an excellent example of a functional approach to this aggregation, and should be enhanced to address its gaps in expenditure related to the PCH, especially Health Authority expenditures on Community Services. The Nanaimo Division of Family Practice and Provincial Health Services Authority are advancing a project to enhance surveillance and outcome measurement for chronic disease and injury prevention, and the leadership being brought to this project should also be integrated into this work. The Health Data Coalition (combining MOIS Amcare and Physician Data Collaborative EMR aggregators) is also an integral piece of this conversation that will need to be involved to fully achieve this aim.

Data Presentation for QI

Of potentially greater import than securing the right data, is getting it to front-line practitioners in the PCH in conjunction with a process and in a format that stimulate QI. Initial thinking on the process challenge revolves around how teams would collectively embark on evidence-based reflection. The data presented could be used by the individual practitioners and their teams to reflect on their practice by using standard tools available from the College of Family Practitioners of Canada, or by using tools we could develop locally, which would facilitate quality improvement in the most effective way, through a continuing medical education process.

The format challenge leads us to an exploration of ideas like customized (PCH level) quarterly dashboards that use advanced graphical communications to quickly present key data to the practitioner, comparing their practice with others, and/or system goals. Expertise in this latter arena has been demonstrated in Darcy Eyres and Brian Winsby's work around the GPSC Residential Care initiative, and is extensively employed in other sectors as diverse as avalanche awareness and franchise restaurants.

The Need for Timely Action

Several PCHs are already being implemented in BC. Within a year, we expect to see implementation of many more. Within two years, there should be hundreds evolving across the province. Evidence suggests that any PCH functioning without solid QI data (as described above) is unlikely to achieve the full spectrum of triple aim outcomes, and especially those related to cost. The need for QI data is immediate.

Next Steps

A multi-stakeholder effort is required to develop a province-wide QI framework for PCHs. Given the importance of this initiative, and the current structures and systems of data collection and ownership in the province, this initiative will require Championing by senior staff in the Ministry of Health, including the Deputy Ministry of Health (or relevant assistant deputy) and CEOs of the Health Authorities (or relevant VPs). Given representation at the GPSC table, it would be ideally positioned to bring leadership to coordination of the work required to pull this off. The work would require resourcing of staff with exceptional skills in research, project management, and QI.

To facilitate the achievement of the establishment of a practice- and system-level QI framework for PCHs, it is suggested that the approach could include the following:

- Establishing three working groups of experts with relevant skills, resources, and expertise to:
 - Develop indicators to measure triple aim goals related to PCHs;
 - Identify data sources and processes for aggregation; and
 - Develop a province-wide data presentation system.
- Convening a steering committee made up by representatives from the working groups to align and enhance progress among the working groups.

This discussion paper is being shared by the Kootenay Boundary Division with senior leadership in planning and practice improvement within the GPSC, Ministry of Health, and Interior Health Authority. **While the Kootenay Boundary Division is advancing this discussion paper, and looks forward to continuing to support it, Divisions are not positioned to lead the work required to address this issue. This initiative will have to be led at the provincial level.**

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APPENDIX A

Patient and Provider Satisfaction

- a. Provider relationship with self, colleagues and patients
- b. Provider personal and professional fulfillment
- c. Patient perception of health care provider credibility
- d. Level of patient trust in health care providers
- e. Patient satisfaction regarding health care provider responsiveness to community need
- f. Patient perception regarding opportunities for open and meaningful engagement around health care service design and delivery
- g. Patient wait times in office
- h. Patient wait times for specific treatments and procedures
- i. Percentage of patients who report that they were able to see their family physician/nurse practitioner on the same or next day (timely access)

Population Health

- a. Percentage of patients with specific conditions
- b. Percentage of patients with specific conditions who have been prescribed particular drugs
- c. Percentage of patients with specific conditions with readings (blood pressure, A1Cs, LDL cholesterol, albumin creatinine level, BMI) below certain levels
- d. Percentage of patients with specific conditions reporting having their symptoms under control
- e. Percentage of patients with specific conditions who have received specific tests, examinations, health behaviour discussions, or follow-up visits within a specific time frame
- f. Percentage of patients receiving disease screenings (mammograms, FOBT, colonoscopy, Pap smear) over a specific time frame
- g. Percentage of patients receiving specific vaccinations or who are fully vaccinated
- h. Percentage of patients who smoke, report being physically inactive, and who are obese, overweight or underweight
- i. Percentage of patients taking responsibility for their own health

Per Capita Cost

- a. Full system cost per capita for unique diagnosis categories (stratified by complexity)
- b. Proportion of expenditure for acute, residential care, community health care, and PCHs
- c. Percentage of patients going to the emergency department for reasons that were potentially avoidable with full care in the PCH (patient self-reported and CTAS 4&5 level documentation)
- d. Hospital stay duration and ALC rate
- e. Self-management support and collaboration with patients and families
- f. Unnecessary duplications in diagnostic tests and imaging

This is just a sampling of potential measures that could be utilized to undertake quality improvement with respect to PCHs in BC. Note that Ontario's Primary Care Performance Measurement (PCPM) Framework, when originally developed, included 112 practice-level measures and 179 system-level measures (92 are common to both levels) across nine domains (access, patient-centredness, integration, effectiveness, focus on population health, efficiency, safety, appropriate resources, and equity). Note also that data is only currently available in Ontario for 13% of practice-level measures and 41% of the system-level measures, but that Health Quality Ontario, which oversees the PCPM, is working systematically to address that.