A No-Nonsense Guide
To
The Starfield Model

fresh care

Introduction:

This guide provides a simple, step by step guide to the Starfield Model. It is designed for the busy practice which wants feedback on performance but would rather see patients than dive into data.

Data geeks (like me) are welcome to read more about the model's history, rationale and other details by reading The Dorval Model available on the Dorval Medical Website[i].

The Model is in its infancy. At best, using the model to look at your performance will be provocative and give providers in a group a framework for discussion.

If the Model gains popularity groups will provide results which will change the model. We will discover what "normal" means for most of the indicators including the key indicators of Cost, Capacity and Quality (The Starfield Number). At present (and only as a starting point) Dorval Medical provides its data as a reference for the choice of indicators, indicator importance (weighting), measurement criteria and scoring rules[ii]. Don't worry, it is all on a spreadsheet that is free to use from our web site[iii]. Have support staff put your data in the indicator cells and the score calculated automatically by the spreadsheet.

Eventually there will be a council which evolves the framework as patients, providers, politics and everything else changes. They will be guided by the principle:

> **The framework provides the ability to compare practice performance amongst comprehensive primary care providers, using population expectations as a reference.**

Even as the framework changes over time, each measurement remains true to the principle at the time it was measured.

Framework Conventions:
1. Wherever possible, population opinion shapes the Framework.
2. All practices using the same framework will be able to compare performance in a way which is meaningful to providers and the population
3. It is desirable to publicly display group level results, but individual provider results will be confidential to the group
4. As the framework changes, the scoring for the Starfield Number remains out of 1,000
5. Practices providing data for some of the framework can report their results (out of 1,000) and an adjusted score (out of the indicators used) if they also indicate the amount of the framework they are using.
6. Groups should describe how they are counting the population they serve

Counting your practice population:
The indicators using the practice population should use a number which allows comparison with other practices. 1,000 twenty-five year old men are totally different from 1,000 elderly homeless people. Using simple head count makes comparison very difficult. This method should be avoided if possible.

An excellent way to count populations would be to use a method which adjusts the number according to the health status of the population. An example of such a system is the ACG system from Johns Hopkins[iv]. This system is commercial and might be unpalatable for the Province to use. Work on a similar adjustment system is currently being explored by ICES in Ontario.

All population adjustment system work the same way: the characteristics of the practice population is compared to the Ontario average characteristic. For example, if the practice was 20% more needy than the Ontario average, then the head count would be increased by 20%.

A crude adjustment is possible using the Ontario base rate table in all the FHO and FHN template contracts. Putting your practice numbers (from your reconciliation advice) into the table will convert the roster from head count to an adjusted head count. The Starfield Model spreadsheet has a tab where this task can be done. For now, this is probably the best way to count your patients for the model's indicators. It makes comparison more realistic.

What About Special Cases
No two practice populations are identical. Comparing performance between two practices is always going to be an estimate based on assumptions. The role of the Model is to make assumptions transparent

Special cases can use the Model but should reference the special nature of the practice. Examples include Teaching Practices, and practices with unusual needs including poverty and homelessness.

As more practices contribute their data, similar unusual practices might be able to find useful comparisons.

Using the Model

1. Get the spreadsheet and save it on a computer at your practice
2. Get your data
3. Set up processes for data collection
4. Enter your data in the spreadsheet
5. Considering your practice results with others

1. The spreadsheet can be obtained free of charge from the website of Dorval Medical

2. Data sources are listed on the spreadsheet. To contribute to all indicators in the Model you will need:
   a. Your FHO (or other Patient Enrollment Model) Reconciliation Advice from OHIP for Cost and Capacity indicators as well as indicator 6.
   b. Your FHT or CHC Budget to use in calculating Cost.
   c. Get the QIP data from the Ministry for indicators 10-16.
   d. Know the practice policy pertaining to indicators 18-21.
   e. Get your preventive care performance data from your choice of source (EMR, MoHLTC or P-Prompt).
   f. Some of Indicators 27-45 may already have data sources in you practice EMR. If not, some indicators can get data from ICES.
   g. Total Health System Cost can be obtained by ICES

3. Set up processes which provide data for your indicators
   a. A practice survey which asks the questions in indicators 1 – 5. We suggest using email, so collect patient email addresses in their EMR Record in a way that the EMR produces a list.
   b. Measuring weekly "Third Next Available Appointment" according to the sensitive method described on the spreadsheet required for indicator 17.
   c. Establish a way to record when Medication and Diagnosis Reconciliation are performed in a patient's care for Indicators 7-8. Your EMR Vendor will be able to help you.
   d. For Indicators 28, 30, 33-45 don't worry if your EMR currently doesn't allow data extraction. All together these indicators only contribute 14% of the total to the Starfield Number. You can add these as you go.

4. Enter the data monthly into the spreadsheet
   a. Indicator 17 should be measured weekly and takes about 1 minute per provider by support staff to collect the required data.

5. Within a group, each provider participating in the Model can act as a comparison for the others. This becomes the starting point for interesting discussion where efficiencies and effectiveness

can be shared. Sharing data with other practices allows the Model to improve. With more results, the normal values for indicators can be refined according to the Min and Max rules in the indicator spreadsheet. This gives greater understanding about what is possible in comprehensive primary care performance.

Performance Strategies

The Model measures three competing elements:
1. How well we provide services of comprehensive primary care – **Quality (The Starfield Number)**
2. To how many patients we provide services - **Capacity**
3. What our patients cost in the health system - **Cost**

Performance is the description of the three elements.

In Ontario we have a social obligation that all residents have access to a committed primary care practice. Given current numbers of doctors and the hours they work, a practice capacity of about 58 satisfies this responsibility.

The other two parameters can be the focus of strategies. These strategies can fall into 2 categories:
1. Optimize Quality
2. Optimize Cost

In the Optimize Quality strategy, the practice focusses on the highest achievable quality. This strategy would satisfy a desire to provide the best possible quality in the hope that the system will benefit in the long run by future savings.

In the Optimize Cost strategy, the practice assures quality but seeks to achieve the quality at the lowest cost. Clearly this strategy only makes sense if the practice holds itself accountable to assuring a reasonable level of quality. With this assurance in place, cost savings should be achievable. The advantage of this strategy is the cost saving is real and immediately achieved. Cost savings in healthcare allows other government portfolios to contribute to the powerful social determinates of health.

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[i] http://www.dorvalmedical.ca/wp-content/uploads/2012/01/The-Dorval-Model.pdf
[ii] http://www.dorvalmedical.ca/wp-content/uploads/2012/01/DMA-Performance-Indicators-July-2013.pdf
[iii] http://www.dorvalmedical.ca/wp-content/uploads/2012/01/Starfield-Framework-Indicators-and-Worksheet-July-2013.xls
[iv] http://acg.jhsph.org/