

Patient Centric Indicator Evaluation Process

Rationale

The traditional approach to measuring quality in primary care is to establish and implement a process for the careful selection of indicators related to the various services and attributes associated with the discipline. This process had resulted in indicator sets produced by McMaster University (5 volumes Quality in Family Practice), the Canadian Institute of Health Informatics (2 iterations of indicators), the Quality Outcomes Framework of the United Kingdom, and a similar process in underway within Health Quality Ontario.

Multiple indicator scores cannot be consistently interpreted to allow comparison between practices. As a means of providing a selection of Key Performance Indicators (KPI) this traditional methodology makes sense. In a management framework where primary care has a functioning system of management and accountability, KPI's provide a focus for improvement while the overall direction of primary care is kept on track by other management forces such as the command control system.

The situation in Ontario and the other Canadian provinces is unusual due to the lack of a functioning system of management and accountability between the system and the primary care providers. Without management and accountability, KPIs and incentives risk creating unintended behaviours. This imbalance in management might explain trends over the past 30 years. The focus on fee-for-service may have contributed to the exodus from comprehensive primary care to narrow focus, high volume transaction based care (walk in clinics). The focus on rostering "orphaned" patients may have contributed to rostering patients but not providing adequate access.

Feedback which fully reflects the purpose of comprehensive primary care will avoid distorting provider behaviour. Providers in comprehensive primary care generally believe that their service is characterized as a long term relationship with patients providing a broad range of services. Starfield and Hollander both hypothesized that it is the primary care patient provider relationship which leads to significant system benefit (improved quality, improved equity, and reduced cost). It would appear that reflecting the patient provider relationship is a key to creating a meaningful composite indicator.

The goal of accurately reflecting the relationship from a large number of indicators needs a process allowing the creation of a composite indicator. Ontario's philosophy of patient centricity provides the rationale to use patient population opinion in the creation of the composite indicator.

Patient opinions might be used to weight the relative value of indicators to create the composite indicator. The scope of comprehensive primary care is so large that directly weighting each indicator to the relationship might produce inconsistent results. A possible solution is to use patient opinion to assess the weighting of the relationship's key attributes. Each indicator can be assessed on how the indicator reflects the attributes of the relationship.

The following method creates a composite indicator for quality in comprehensive primary care with a two-step process: weighting the relationship to the four key attributes (Access, Knowledge, Trust and Sensitivity) and the weighting of multiple indicators to the four attributes.

The ultimate test of the composite indicator lies with two questions. Does the measure of quality reflect the purpose of comprehensive primary care and does the measure of quality allow meaningful comparison between practices in order to guide practices in quality improvement?

Creating a Composite Indicator of comprehensive primary care using the Relationship Attributes of Access, Knowledge, Trust and Sensitivity

Patients express expectations in the following process:

- a. Attribute Value
 - i. The practice population is polled to determine the relative value of the four main attributes of the relationship: Access, Trust, Knowledge, and Sensitivity. The sum of all four attributes is adjusted to be 1,000 points. (Dynamic)
- b. Indicator Selection
 - i. The initial indicator set for the Dorval Model came from sources including Quality Improvement and Innovation Partnership (**QIIP**), the Quality Improvement Plan manual (**QIP**), the Quality Outcomes Framework (**QOF**), and the primary care indicator set of the Canadian Institute for Health Information (**CIHI**).
 - ii. Indicators are determined to be redundant if they ask a similar question, receive similar weightings and achieve similar scores. Redundant indicators are removed from the framework.
 - iii. After the Indicator Value process (below), only the top 30 indicators for any of the 4 attributes are kept in the framework.
 - iv. Potential new indicators (from any source) are subjected to the Indicator Value process and compete with existing indicators for inclusion by being in the top 30 indicators for any of the 4 attributes.
- c. Indicator Value¹
 - i. Indicator value polling requires some content understanding and repeated iterations of an hour long process. For this reason, this process is performed by a selection of patients willing to participate and devote the time.
 - ii. Each indicator is evaluated on how well it reflects patient value in the patient provider relationship. Method (Likert scale 1-5) (Dynamic).
 - iii. Each indicator is evaluated on how well it reflects each of the four attributes. Method (Likert scale 0-5) (Dynamic)
 - iv. Each indicator maximum threshold is set by polling opinion of the point that excellence is achieved. Method – patient polling. (Dynamic)
 - v. Each indicator minimum threshold is set by polling opinion of the point of minimum achievement. Method – patient polling (Dynamic)
 - vi. Indicator Scores are proportionally adjusted to result in the attribute values from section a i above.
 - vii. The Scores for indicators are aggregated by how they contribute to the four attributes to produce a score for the four attributes of Access, Trust, Knowledge, and Sensitivity.
 - viii. The Quality composite indicator is the sum of all weighted scores (maximum score of 1,000)

¹ The spreadsheet required for this process is available on the Dorval Medical Web site <http://www.dorvalmedical.ca/wp-content/uploads/2013/11/Starfield-Framework-Indicators-and-Worksheet-2013-11.xls>