# Kootenay Boundary PCN QI and Evaluation Framework – FINAL

*May 2019; Updated May 2021*

This document outlines the Quality Improvement (QI) and evaluation approach for the Kootenay Boundary Primary Care Network (PCN). This is a living document and will continue to be adjusted as PCN implementation proceeds to reflect changing priorities within the PCN, the realities of data collection and analysis and emerging factors.

### Quality Improvement (QI) and Evaluation

Quality improvement (QI) is a systematic process to use data and teamwork to identify and implement change and improve organizational quality. In simple terms, it’s about trying to figure out how things are going in a project, an organization, or a workflow and identify ways to make things better. Ideally it is a continuous process, allowing teams to reflect on how they are doing regularly and make adjustments as they go along. Evaluation occurs on a formative (during implementation) and summative (after implementation) basis to help understand where projects were successful in meeting desired outcomes and where they were not. Formative evaluation allows for changes in approach during implementation in order to better meet outcomes. Although QI is often more informal using less robust data to make quick course corrections, while evaluation tends to use methods that are more rigorous and research-oriented, evaluation and QI are intertwined and often use the same indicators and datasets.

### Why do QI and Evaluation?

Quality improvement (QI) is one of the pillars of the patient medical home put forth by the College of Family Physicians of Canada and the General Practice Services Committee of BC. It is a critical component of high-functioning primary care around the world, particularly in places such as Alaska and Oregon who have utilized QI in primary care to reduce system utilization and total costs of care, while improving patient centred care and provider satisfaction.

Patient Medical Homes and Primary Care Networks (PMH/PCNs) are seen as a 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 PMH/PCNs resolve the challenges that they are intended to. Given the magnitude of change in current health care delivery models, there is an unequivocal need and opportunity to undertake this kind of systematic assessment.

QI and evaluation help us to answer questions such as will increasing access and attachment for patients via PCN implementation reduce the number of CTAS 4 and 5 visits at emergency departments, thereby reducing system costs? Or does having a social worker reduce physician workload while at the same time improving patient health? QI and evaluation use data to answer these questions and a myriad of other questions, so we know that the changes we are making to primary care are improvements.

### Domains of Measurement

The core domains of measurement for the Kootenay Boundary PCN are based on an analysis of the Quadruple Aim, The BC Ministry of Health (MoH) Primary Care Network Core Attributes[[1]](#footnote-1), the BC General Practice Services Committee (GPSC) Patient Medical Home Evaluation Framework and the BC Health Quality Matrix Dimensions of Quality. For an overview of the analysis undertaken to determine these domains of measurement, please see Appendix B. A further domain “enabling structures” was identified during PCN implementation and includes governance and change management structures and processes. The core domains for PCN evaluation are:

1. Primary care inputs and supports
2. Enabling structures
3. Attachment
4. Access
5. Quality of Care
6. Provider Experience
7. Patient Outcomes
8. System Utilization

The KB PCN preliminary logic model can be found in Appendix C.

### KB PCN Indicators

Progress on KB PCN implementation will be monitored based on the indicators outlined in Table 1. These indicators have been organized based on the domains of measurement, and include indicators outlined in the KB PCN MoH funding letters and indicators required to gain an understanding of progress towards primary care transformation. **Indicators that were initially indicated to be required by the Ministry of Health in PCN funding letters are starred.** Appendix D includes potential future indicators. Indicators for which data collection has not yet started are shaded.

Table 1: PCN Indicators

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Domain** | **Indicator** | **Approach** | **Freq[[2]](#footnote-2)** | **Clinic Workload** |
| **1. Primary care inputs and supports** | # of, FTE, and type of PCN team members (including PCN management) hired and removed from KB PCN clinics\* | Provided by PCN Lead | Every 28 days | None |
| FTE Ratio of PCN team members to primary care providers (PCPs) in each PCN clinic | Team member data provided by PCN Lead; Clinic data provided in clinic quarterly attachment reports | Quarterly | Clinic MOA 0.5 hrs 4x/year |
|
|
| PCN basic statistics\*   * # of clinics within PCN geography * # of clinics participating in PCN * # of physicians participating in PCN * # of PCN clinics with primary care teams | Provided by PCN Lead | Quarterly | None |
| # of PCN clinics participating in a clinical network (sites working together to provide extended services, e.g. call groups or phone advice)\* | Compiled by PCN QI Lead via PCN clinic input | Annually | Not yet started |
| # of patient encounters (visits) by GP/NP by day (average) and by quarter | Primary care clinic EMR queries and IH Administrative data for IH clinics (MSP data access to be explored) | Quarterly | Clinic MOA 0.5 hrs 4x/year |
| # of patient encounters (visits) by allied health, nurses and health coordinators in KB PCN by provider type, and total, by day (average) and by quarter\*[[3]](#footnote-3) | Primary care clinic EMR queries, IH Administrative data for IH clinics, PCN team stats | Quarterly | PCN team members 0.5 hrs 4x/year |
| # of patient encounters (visits) for mental health/and or substance use reasons by allied health by KB PCN by provider type, and total, by day (average) and by quarter\* | Not yet determined as this was just added to funding letter for fiscal year 2021/22. Possible through e-stats for SWs | Quarterly | Not yet started |
| # unique patients served by allied health, nurses and health coordinators in KB PCN by provider type, and total, by day (average) and by quarter\* | Primary care clinic EMR queries, IH Administrative data for IH clinics, PCN team stats | Quarterly | PCN team members 0.5 hrs 4x/year |
| # each encounter type allied health, nurses and health coordinators in KB PCN by provider type, and total, by day (average) and by quarter\* | Primary care clinic EMR queries, IH Administrative data for IH clinics, PCN team stats, MoH nurse encounter data | Quarterly | PCN team members 0.5 hrs 4x/year |
| Comprehensiveness team members roles and extent to which they are working top of scope | PCN provider survey/interviews undertaken by PCN QI Lead | Annually | PCN team members 0.5 hr every 2 yrs |
| # of times each PCP has used team-based care billing codes 14077, 14076, 14029, 14019 | Primary care clinic EMR queries and IH Administrative data for IH clinics | Annually | Not yet started |
| **2. Enabling Structures** | PCN Change Team:   * Team Climate * Perception of successes and challenges | Team Climate Inventory completion; interviews undertaken by PCN QI Lead | Annual | None |
| PCN Steering Committee:   * Membership * Meetings to date * Team Climate | Team Climate Inventory completion; PCN Steering Committee meeting minutes | Annual | None |
| PCN learning lab structures established and meetings held:   * PCN staff learning lab * PCN whole PCN learning lab * PCN MOA learning lab * PCN clinic learning lab | Learning lab agendas and administrative data | Quarterly | None |
| PCN communication to patients regarding how to access care, appropriate utilization and patient survey results\* | PCN administrative data | Quarterly | None |
| Cultural safety and humility supports including training of providers and Aboriginal representation in PCN structures | PCN administrative data | Quarterly | None |
| **3. Attachment** | # of clinics and providers accepting patients in KB by (Community Health Service Area) CHSA\* | PCN clinic quarterly attachment survey completion | Quarterly | MOA 0.50 hrs 4x/year |
| # of new patients attached via KB PCN clinics\*:   * Total attachment from Health Connect Registry * Total attachment from $0 Fee Code * Net panel size changes by CHSA * # of new patients attached by pre-PCN clinicians * Panel size/FTE | Health Connect Registry stats; MSP $0 fee billing code; Health Connect Registry; PCN clinic quarterly attachment survey completion | Quarterly | No additional |
| % of KB population who currently have a regular PCP by type of PCP provider | MoH attachment algorithm | Timing uncertain | None |
| # of patients awaiting attachment in KB\* | Health Connect Registry reports and Kootenay Boundary Patient Experience Survey | Quarterly | None |
| **4. Access** | # of same day appointments per PCP available in each PCN clinic for sample days | Collected by PCN admin via phone calls to PCN clinics for 8 sample days | Biannually | MOA 0.25 hrs 8x/year |
| # of patients accommodated within 24 hours and # turned away per day for urgent appointments for sample days | Collected by PCN admin via phone calls to PCN clinics for 8 sample days | Biannually | No additional |
| Patient experience getting a same/next day appt when they need one/ #/% of patients who report being able to access a provider when they need to\* | Kootenay Boundary Patient Experience Survey | Every two years | Limited; Have patient survey avail in clinic |
| # of days to third next available routine appointment for sample weeks | Collected by PCN admin via phone calls to PCN clinics for 8 sample days | Biannually | No additional |
| # of all types of appointments in a quarterbooked at each of the following target intervals, by provider (including Most Responsible Providers (MRP) and PCN team members:   * Same day * Next day * 2-7 days * 8-14 days * 15-31 days * 31-100 days | EMR data analytics tool | Quarterly | MOA 0.5 hours 4x/year |
| Hours of access of PCN clinics/ #/% of PCN clinics that offer extended hours\* | PCN clinic quarterly attachment survey completion | Quarterly | No additional |
| **5. Quality of Care** | % of PCN clinics that have:   * Checklist for preventative practices (counselling, screening, immunization) to carry out according to guidelines * Reminder system to invite patients to have recommended screening tests (e.g. Pap, FIT) | PCN team input at the PCN learning lab | Annually | Not yet started |
| % of providers' patients' encounters that are with their Most Responsible Provider (MRP) within a month | EMR data analytics tool - methodology under development | Quarterly | No additional |
| % of asymptomatic adults in patient panel between ages of 50-74 who have been screened for Colorectal cancer utilising either of the following tests:  · Hemoccult test (gFOBT or FIT) in the past 2 yrs  · Colonoscopy within the past 5 yrs | EMR data analytics tool - methodology under development | Quarterly | No additional |
| % of adults age 18+ and age 45+ that have had hypertension screening via a blood pressure measurement recorded in the EMR in the last five years | EMR data analytics tool - methodology under development | Quarterly | No additional |
| % of active patients with depression and have had at least one encounter with MRP recorded in the EMR in the past 12 months | EMR data analytics tool - methodology under development | Quarterly | No additional |
| % of patients of age <65 and age 65+ on 1-2, 3-5, 5-10 and 10+ medications | EMR data analytics tool- methodology under development | Quarterly | No additional |
| % of patients all age 18 to 65 and 65+ on at least one opioid medication/opioid in combination with benzodiazepine | EMR data analytics tool- methodology under development | Quarterly | No additional |
| % of patients of age 70 to 79 and 80 to 89 with record of a MOST form completed in EMR | EMR data analytics tool- methodology under development | Quarterly | No additional |
| Provision of:  · Childhood immunizations  · Perinatal services\* | No methodology - data was to be provided by MoH | Annually | None |
| CVD Screening rates\* | No methodology - data was to be provided by MoH | Annually | None |
| Mechanisms for coordination of care between PCPs and diagnostic services, hospital care, specialty care and SCSPs including: informal exchanges, care protocols for specific client groups/issues and care discussion meetings\* | PCN team input at the PCN learning lab | Annually | Not yet started |
| % of PCN clinics that have used used registries and data in the last 12 months to:  · Do needs-based planning  · Support patients with chronic conditions  · Support vulnerable SDoH patients | PCN team input at the PCN learning lab | Annually | Not yet started |
| Patient experience/ satisfaction with:  · access to care  · patient-centred care  · care coordination/system navigation\*  · quality of care  · self-management support  · team-based care  · cultural safety\* | KB Patient Experience Survey | Every 2 years | Limited; Have patient survey avail in clinic |
| Clinical team experience/ satisfaction with:  · patient-centred care  · care coordination/system navigation\*  · quality of care  · self-management support  · team-based care  · cultural safety\*  · virtual care options\*  · comprehensive care\*[[4]](#footnote-4) | PCN provider surveys and interviews, PMH assessment tool; PCN clinical team experiences shared at PCN Learning Lab | Ad hoc | All clinical team members 1-2 hrs every 2 yrs |
| **6. Provider Experience** | Average score on Mini-Z burnout survey burnout question and happiness question for PCPs across PCN clinics | KB Division Annual Member Survey | Every 2 years | No additional time |
| Provider experiences of communication, shared leadership, and scope of practice/time commitments in teams | Interviews with providers by PCN QI Lead | Annually | No additional time |
| KB PCN Team Assessment scores across PCN clinics | KB PCN Team Assessment Survey | Annually | All team members; no additional time |
| **7. Patient outcomes** | Patient self-report outcomes on standardized assessments e.g. SF-36, GAD-7, PHQ-9 | Greenspace | Quarterly | None; use of forms integrated into clinical work |
| Patient success stories | Patient outcome success stories submitted by patients and PCN providers | Quarterly | PCN team members 1 hour/year |
|
| **8. System Utilization** | # of CTAS 4 and 5 visits by attached and unattached KB patients to EDs (by PCN clinic and region-wide) | Administrative data from Interior Health | Quarterly | None |
| Hospitalization rates including rate per 1000 population, ALOS, total inpatient cases, total inpatient days, ALC days | Administrative data from Interior Health | Quarterly | None |

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### Indicator Data Access and Storage

The data for PCN QI and evaluation to measure the KB PCN indicators will come from many sources, including PCN clinics, Interior Health and the Ministry of Health. PCN clinics will be expected to do some clinic-specific data collection. The clinic workload column identifies the amount of work that will be required of various PCN team members in association with data collection for the indicators. Although there are many indicators, many of them do not require any work on the part of clinics. The total estimated hours for QI data collection **per year** is about 10-15 hours for nurses and social workers, 4-7 hours for physicians and NPs and 4-7 hours for MOAs. Supports will be provided to clinics (tools, coaching, technical support) to do this work.

PCN clinics will be expected to implement data analytics tools such as CPCSSN, HDC, and/or Greenspace. CPCSSN is the Canadian Primary Care Sentinel Surveillance Network and HDC is the Health Data Collaborative. Both CPCSSN and HDC are programs that extract patient data from clinic EMRs and allow for analysis of various indicators within the clinic by providers to facilitate clinic quality improvement. Greenspace is a software program that allows nurses and allied health care providers to track their activities with specific patient populations (mental health and chronic disease) and allows these patient populations to provide self-report data on their health, functionality and quality of life. Other programs that provide similar data will be evaluated in the PCN learning lab before a final product is chosen.

PCN data access will be enabled by an Information Sharing Agreement between the KB Division and each individual PCN clinic as well as the KB Division and Interior Health. No patient personal information will be shared. Provider and clinic-specific information will be stored securely on Sync.com, and will only be accessible by those individuals identified in the Information Sharing Agreement who have signed confidentiality agreements.

### Indicator Reporting

Indicator data will be compiled, analyzed and brought to the PCN Learning Lab and PCN Steering Committee for discussion and action quarterly by the PCN QI Lead who will also be responsible for compiling data from Interior Health and the Ministry of Health. Indicator results will be reported out in aggregate at a regional level across all the PCNs in Kootenay Boundary, but individual clinics will have access to their own data where relevant. If data from PCN clinics is to be presented in a disaggregate form (such as, for example, to compare wait times for routine appointments or urgent access at a regional level), it will be done in a manner whereby individual clinics or primary care providers cannot be identified. See the most recent [quarterly report here](https://docs.google.com/document/d/1t7ZFpQZyt2opXXlixUmNfJTA7XoNcdMSFzXUFNh8hUQ/edit).

Additional Clinic QI Activities

In addition to collecting data in association with the above PCN indicators, PCN clinics will be encouraged to include QI as a component to reflect on their practices and evaluation data and conduct QI cycles (see Appendix E for more information on QI cycles). They will also be expected to send representatives to the PCN learning lab to participate in QI work (QI work is only a small portion of the learning lab work and is outlined further in PCN learning lab documentation). See PCN Learning Lab [Backgrounder](https://docs.google.com/document/d/1CH5yIdrpy6ATb9MTn-c7jKzbiTfFOv58_ZfaNPk-ZHw/edit) for details. Support will be provided for clinics at all phases of this process from the KB Division PCN change management team, and PCN QI Coordinators. The Practice Support Program will also provide assistance in panel management.

### Appendix A: BC PCN Core Attributes

Kootenay Boundary (KB) PCN QI and evaluation will be guided by the eight provincial-level PCN core attributes outlined in the table below that indicate the key changes that PCN implementation is intended to achieve.

|  |
| --- |
| **Primary Care Network Core Attributes** |
| 1. Process for ensuring all people in a community have access to quality primary care, and are **attached** within a PCN. |
| 2. Provision of **extended hours of care** including early mornings, evenings and weekends. |
| 3. Provision of **same day access** for urgently needed care through the PCN or an Urgent Primary Care Centre. |
| 4. Access to advice and information **virtually** (e.g. online, text, e-mail) and face to face. |
| 5. Provision of **comprehensive primary care services** through networking of PMHs with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care. |
| 6. **Coordination of care** with diagnostic services, hospital care, specialty care and specialized community services for all patients and with particular emphasis on those with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in community. |
| 7. **Clear communication** within the network of providers and to the public to create awareness about and appropriate use of services. |
| 8. Care is **culturally safe and appropriate**. |

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### Appendix B: Kootenay Boundary PCN QI and Evaluation Domain Identification

In determining a framework for Kootenay Boundary (KB) PCN QI and evaluation that divides the data and indicators to be collected into “domains” or categories, several existing frameworks were considered. These include:

· The Quadruple Aim;

· The Canadian Institute for Health Information (CIHI) Pan-Canadian Primary Health Care (PHC) Indicators;

· Health Quality Council of Alberta metric categories;

· The BC Ministry of Health (MoH) Primary Care Network Core Attributes;

· The BC General Practice Services Committee (GPSC) Patient Medical Home Evaluation Framework; and

· The BC Health Quality Matrix Dimensions of Quality.

These five frameworks are presented side by side in Table 1.

There are overlaps among all of these frameworks. For example, most include some reflection on patient experience, most include some reflection of quality of care and/or delivery of preventative services. However there are also differences. Only two include explicit reference to total costs of care, although others include system utilization, which can be a proxy for costs of care. There are differences in how population health is framed – some suggest that it is the actual outcome of population health that matters, while others focus on measuring delivery of preventative services (both screening and chronic disease treatment) with the assumption that better delivery of preventative services increases population health.

The frameworks also differ in terms of the lens through which the measure is being considered e.g. patient experience of access, patient experience of quality of care, provider experience of access, objective measures of access. Access is part of experience, but it also relates to population health, just as much as preventative care delivery does. Without access, population health would be negatively affected. It also relates to total cost of care because, without access to primary care, use of tertiary care rises (both for urgent/emergent issues, and for long term issues as a result of reduced overall health). Recognizing this, CIHI has chosen to repeat certain indicators within multiple domains. In many cases, all of the quadruple aims are relevant to the domains that could be measured in conjunction with primary care. Likewise, not all of the frameworks include system utilization, such as ED visits or hospitalization, because they are not primary care, but rather are a reflection of primary care.

Table 1:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **IHI Quadruple Aim** | **CIHI Pan-Canadian PHC Indicator Domains** | **Health Quality Council of Alberta Metric categories** | **PCN Attributes** | **PMH Evaluation Domains** | **BC Health Quality Matrix Dimensions of Quality** |
| Patient experience;  Population health;  Provider experience;  Total costs of care. | Access to PHC through a regular provider;  24/7 access to PHC;  Patient-centred PHC;  Quality in PHC;  Comprehensive care, preventative health and chronic condition management;  Continuity through integration and coordination;  Enhancing population orientation;  PCH inputs and supports. | Practice characteristics;  Panel characteristics;  Preventative care and imaging;  Chronic conditions and frequent diagnoses;  Pharmaceutical use;  System utilization. | Attachment;  Extended hours of care;  Same day access;  Virtual care;  Comprehensive primary care services;  Coordination of care;  Communication regarding PCN services;  Culturally safe and appropriate care. | Patient experience;  Access;  Physician experience;  Cost. | Acceptability;  Appropriateness;  Accessibility;  Safety;  Effectiveness;  Equity;  Efficiency. |

Focusing primarily on the Quadruple aim and PCN attributes as anchoring frameworks, it seems that the following are the key domains that should be tracked in KB’s PCN work, along with potential sub-domains to illustrate what is included in the domain (Table 2). Some of the sub-domains will be relevant to PCN work and some will not. Sub-domains that are not relevant to PCN work are listed in this table to provide a fulsome picture of what the domain includes.

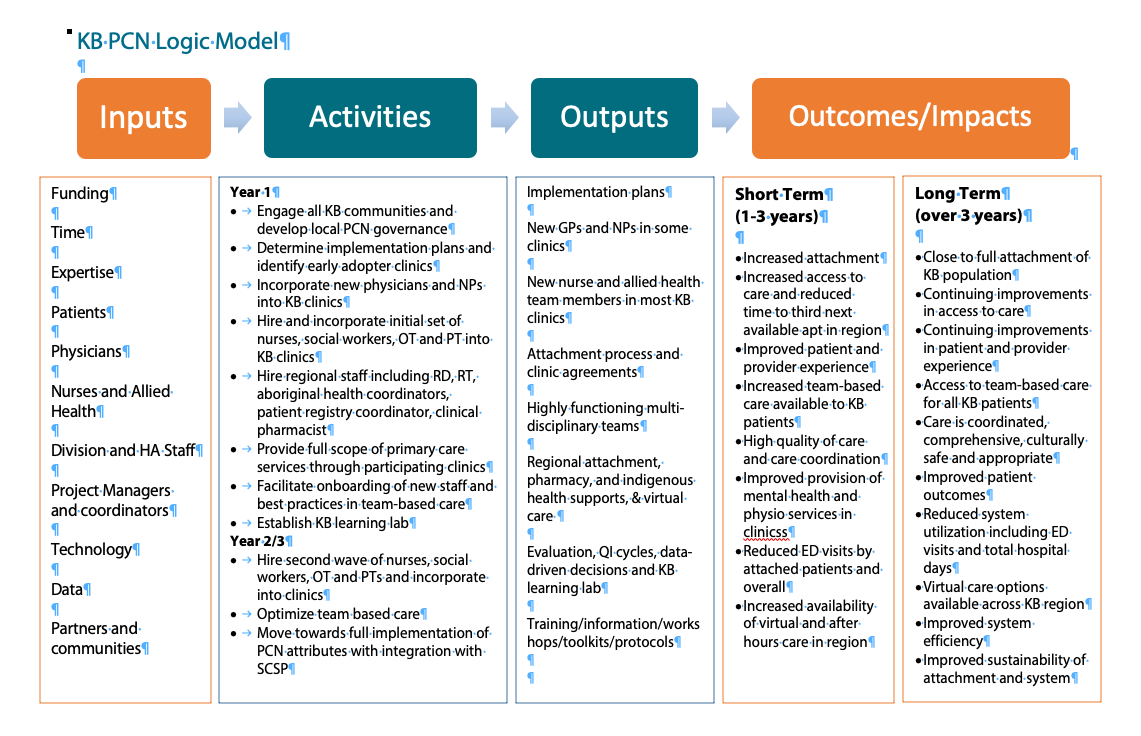
Table 2:

|  |  |  |
| --- | --- | --- |
| Domain/Sub-domains | Relevant PCN Attributes | Relevant Quadruple Aims |
| **Primary Care Inputs and Supports**  Number and types of providers  Ratios of most responsible providers to team members  Team climate and ability to work together | Attachment  Comprehensive primary care services  Coordination of care  Culturally safe & appropriate care | Patient experience  Population health  Provider experience  Total costs of care |
| **Attachment**  Attachment/Regular provider | Attachment |  |
| **Access**  Urgent same day/next day access  Access for routine appointments  Continuity of care/Access to regular provider  Access after regular business hours  Virtual access (phone, text, email, and videoconference)  Communication regarding services available | Extended hours of care  Same day access  Virtual care  Communication regarding PCN services | Patient experience  Population health  Provider experience  Total costs of care |
| **Quality of Care**  Patient-centred care  Culturally-safe, acceptable care  Equitable care  Team-based care  Comprehensiveness of care  Delivery of preventative care and chronic disease management (screenings, imaging, annual checks, vaccinations, counselling)  Pharmaceutical use  Population-oriented care  Coordination of care  Patient safety and adverse events  Resources for self-management  Time with primary care providers | Comprehensive primary care services  Coordination of care  Culturally safe & appropriate care | Patient experience  Population health  Provider experience  Total costs of care |
| **Patient Outcomes/Health**  Self-reported health, functionality and quality of life  Chronic disease-related outcomes (diabetes, hypertension, asthma, obesity)  Mortality rates  Birth weights  Disease prevalence and incidence  Rates of physical activity, obesity, smoking, heavy drinking |  | Patient experience  Population health |
| **Provider Experience**  Rate of burnout  Experience of joy and fulfillment in work  Experience of team-based care (communication, shared leadership, team dynamics) |  | Provider experience |
| **System Utilization**  ED utilization  Hospitalization rates  PCP visits  Specialist visits  Multi-disciplinary team visits |  | Total costs of care |
| **Total Costs of Care**  Total annual age-adjusted costs of care  Average cost per patient |  | Total costs of care |

There are multiple potential indicators in each domain. Key to selecting which indicators will be utilized for PCN evaluation will be to assess whether PCN implementation is likely to make a difference in the indicator. The overarching goals of PCN implementation are outlined in Appendix A. For example, it is not expected that PCN implementation would affect mortality rates or birth weights. Those sub-domains are just provided in the table above as examples of what types of indicators each domain comprises.

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### Appendix C: KB PCN Logic Model



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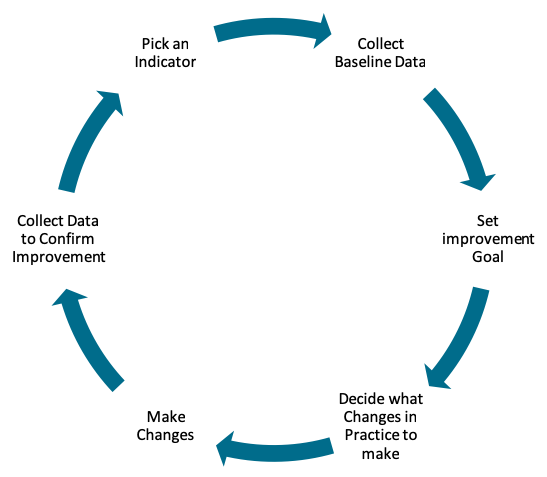
### Appendix D: Future Phase Indicators

This appendix contains indicators that may be considered in future phases of the KB PCN. These indicators may be utilized if for example a virtual care strategy is implemented in Kootenay Boundary PCNs and if methodologies become available to assess the indicator (in the case of total costs of care indicators).

As of May 2021, additional indicators are also under development for the KB PCN virtual unattached patient clinic, and for Division-run PCN clinics. These clinics are expected to primarily utilize the main set of indicators as outlined above, but with a few additional governance and patient population indicators.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Domain** | **Indicator** | **Approach** | **Frequency** | **Clinic Workload** |
| **1. Primary Care Inputs and Supports** | # of mild to moderate mental health encounters by GP/NP | EMR data query - note there is currently no workable methodology for this as PCPs do not code or bill for these encounters in a consistent way | Annually | Clinic PCN QI lead 2 hrs 1x/year |
| **3. Access** | # of emails, phone calls and texts from providers to patients in virtual care provider to patient communication program | No method; May be possible depending on platform chosen | No schedule | Will depend on platform |
| % of clinics offering ability to:  · Request appointments or referrals online  · Send medical question or concern via email  · Request prescription refills online | Collected by PCN team members/panel managers within clinics | Biannually | Clinic PCN QI lead 0.25 hrs 2x/year |
| # and % of patients utilizing virtual care provider to patient communication program | No method; May be possible depending on platform chosen | No schedule | Will depend on platform |
| Patient experience with virtual care | Kootenay Boundary patient survey | Annually for first 2 years then every 2 years | Limited; Have patient survey avail in clinic |
| Patient experience with regard to routine access | PCN patient survey; administered and compiled by PCN QI Coordinators | Annually for first 2 years then every 2 years | Limited; Have patient survey avail in clinic |
| Patient experience with getting after hours care | PCN patient survey; administered and compiled by PCN QI Coordinators | Annually for first 2 years then every 2 years | Limited; Have patient survey avail in clinic |
| **5. Quality of Care** | Average time to receive discharge report from hospital after patient has been discharged | Sample chart review | Annually | Unclear |
| % of patients who receive follow-up office visit from PCP within 7 days of discharge or ED visit for:  · Mental health  · COPD  · Diabetes  · Unstable angina | Sample chart review | Annually | Unclear |
| **6. System Utilization** | # of ED visits for:  · asthma  · congestive heart failure  (specific conditions or presenting complaints to be selected) | Administrative data from Interior Health | Biannually | None |
| MHSU client days by PCN | Administrative data from Interior Health | Annually | None |
| **7. Total Costs of care[[5]](#footnote-5)** | Total adjusted costs of care in KB region | MoH and Interior Health Administrative data | No schedule | None |
| Average adjusted cost per patient in PCN clinics and non-PCN clinics per year | MoH and Interior Health Administrative data | No schedule | None |

### Appendix E: Clinic QI Cycles

A key part of QI is the **clinic QI cycle** whereby a clinic reflects on the data it collects or receives, and uses that data to change workflows or processes, as illustrated in the diagram below. Based on the preferences of the PCN clinic, Clinic QI cycles can be very formal and follow the diagram precisely, or they can be more informal where clinics reflect on some of the data and incorporate changes in a more ad hoc manner. The area of focus for clinic QI cycles can be on preventative care delivery or clinic workflows or team interactions – whatever the clinic team wants to work on.

*Example QI Cycle*

Potential Indicator: Colorectal cancer FOBT screening in past two years for asymptomatic patients between ages of 50 and 74.

Baseline Data: Baseline data from EMR shows that only 45% of clinic patients between ages of 50 and 74 have had FOBT screening in past 2 years.

Improvement Goal: >60% of clinic patients between ages of 50 and 74 have had FOBT screening in past two years.

Changes in Practice: Have physicians discuss and offer FOBT screening with patients between 50 and 74 during regular checkups. Have nurses call all patients 50 to 74 who have not had screening and recommend that they come in to get the requisition.

Follow Up Data in Four Months: Follow up data from EMR shows that 60% of clinic patients between ages of 50 and 74 have had FOBT screening in past 2 years. Clinic agrees to move on to new indicator.

1. See Appendix A for a full description of PCN Core Attributes [↑](#footnote-ref-1)
2. Reporting will be based on fiscal years. Quarterly reporting will be based on April-June, July-Sept, Oct-Dec, Jan-March. **The Ministry of Health has not yet specified when the PCN annual report is due.** [↑](#footnote-ref-2)
3. Current data methods allow for pulling encounter data only, not visit data. Note that Ministry wants visit data. Currently working on a methodology for this. Encounters include anything that provider charts for including indirect services on behalf of patient. Visit includes actually seeing/talking to patient. Thus encounters will be >visits. [↑](#footnote-ref-3)
4. All starred Ministry required clinician experience/satisfaction measures will be measured using the PMH assessment tool. [↑](#footnote-ref-4)
5. Although total costs of care cannot currently be measured, these indicators are here as a placeholder to signal the importance of total costs of care as an indicator in a robust PCN QI and Evaluation Framework. To some extent system utilization can be utilized as a proxy for cost savings, and some costs can be calculated from utilization rates. [↑](#footnote-ref-5)