# PCN Community Evaluation Frameworks – Indicator Mapping

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## Frameworks Received and Reviewed

The following communities provided a copy of their evaluation framework, a period report, or both, for use in this analysis.

* KB
* Ridge Meadows
* Comox Valley
* FNW
* Richmond
* Vancouver
* SOS
* Cowichan
* Oceanside
* COK
* North Shore

## List of Consolidated Community Indicators by Prominence

| Indicator Area | # of Communities with at least one indicator | List of Proposed or Actively Collected Community Indicators |
| --- | --- | --- |
| Hiring / Onboarding / Retention | 11 | * # of, FTE, and type of PCN team members (including PCN management) hired and removed from PCN clinics (2)
	+ # of new physicians hired
	+ # of new nurse practitioners hired
	+ # of allied health providers hired
	+ # staff who’ve moved on (turnover)
 |
| Outcomes: Access (Extended /After-Hours) | 11 | * Descriptive: Hours of access of PCN clinics
* #/% of PCN clinics that offer extended hours (from 6pm-8am)
	+ To their patients
	+ To patients in the PCN
* % of patients with access to clinics with extended hours
* # practices currently participating in a network to provide extended service (e.g. call group, phone advice)
 |
| Outcomes: Attachment | 11 | * Total attachment from Health Connect Registry
	+ # of people on Health Connect Registry (HCR)
	+ # of people in HCR waiting list
	+ Minimum Length of time on HCR Waiting list
	+ Maximum length of time on HCR waiting list
	+ Average length of time on HCR waiting list
* Total attachment from $0 Fee Code
	+ Number of Zero attachment codes per reporting period by PCN and PMH within PCN
	+ Number of Zero Attachment codes per eligible physician
* PCN Clinic Panel Data / Clinic Survey Data (requires regular clinic-based panel survey data or access to EMR data)
	+ Net panel size changes by CHSA
	+ % of PCPs who are attaching new patients
	+ # of new patients attached by pre-PCN clinicians (part of clinics before PCN started)
	+ # patients per contracted PCN provider (panel size)
	+ Change in panel size over time
	+ # Attachment requests & denied requests (Ridge Meadows)
	+ # Clinics accepting new patients
	+ # attachment requests
	+ # patients attached to PCN Contracted FP/NP at PCN-level
	+ Panel size of contracted FPs/NPs
	+ # attachment requests declined
	+ # providers accepting new patients in the past 6 months
	+ # of clinics and providers accepting patients in PCN by (Community Health Service Area) CHSA
* MoH attachment Algorithm
	+ % of PCN population who currently have a regular PCP by type of PCP provider (MSP Billing Data)
	+ Type of patients attached (MoH billing data – ICD9)
* Qualitative/Interview data
	+ PCPs reports of their experience of working toward attachment target (successes, challenges)
* UPCC Attachment (if applicable)
	+ Number of UPCC Unattached Clients
	+ Number of new attachments from UPCC referral to primary care (HA data?)
	+ GP Link UPPC Unattached Clients as % of Total UPCC Clients (North shore only)
	+ Total GP Link clients indicating they contacted GP Link through UPCC (North Shore only)
* Patient Survey data (Cowichan, not sure if implemented)
	+ Patients report that the process of attaching to a PCP is easy to navigate
	+ Patients report they are able to become a patient of a PCP in Cowichan if they want one
	+ Patients report that they have a positive relationship with their PCP
	+ Patients report that their primary care needs are being met and appointments are useful
 |
| Outcomes: Access (General) | 10 | * Patient experience with access to care
	+ #/% patients reporting being able to access a provider when they need to
* Time until next booked appointment
	+ # of days to third next available routine appointment for sample weeks
	+ # FPs offering a routine appointment time within:
		- 48 hrs
		- 3-5 business days
		- 6-11 business days
		- >2 weeks
	+ Days to next appointment (waitlist) by PMH/PCN [target within 3-days or other agreed to target by PCN
* # home visits with AHPs and priority response teams
* Wait times to access specialist services
* Total clients served for reporting period
 |
| Outcomes: Access (Urgent/Same-Day) | 9 | * Clinic Phone Survey one same-day visits
	+ # of same day appointments per PCP available in each PCN clinic for sample days (Phone call survey sample)
	+ # of same day appointments that provider had at beginning of day
	+ # of same day appointments that got squeezed in
	+ # of ppl who called for same day apt who couldn’t be scheduled
	+ 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
* # of patients accommodated within 24 hours and # turned away per day for urgent appointments for sample days (Phone call survey sample)
* UPCC hours (if applicable)
* Clinic hours/coverage from all PCN-participating clinics
 |
| Cultural Safety | 9 | * Provider/PCN Team Training & Competence
	+ #/% providers receiving cultural safety training (San'yas)
	+ #/% providers reporting they have the training, tools and ability to practice cultural humility and provide culturally safe and appropriate care
	+ #/% providers offering culturally safe and appropriate care (PMH Ax, self-report)
	+ # PCN clinicians with language skills other than English
	+ # activities that address cultural competency
* Indigenous participation in PCN structures and teams:
	+ # of Indigenous people on PCN Steering Committee
	+ # of Indigenous and Indigenous-focused staff hired
		- (e.g. Traditional knowledge keeper, XX)
* Experience of cultural safety: Patients
	+ Patients report feeling safe *and* respected when accessing care (Patient survey)
	+ #/% patients report being respected (Patient Experience Tool)
	+ Patients report feeling like they are a partner in deciding what services to receive
	+ % of patients reported culturally centred care (including engaging with Aboriginal Healers, and Elders and accessing Aboriginal healing practices)
* Experience of cultural safety: providers
	+ PCPs & AHPs report feeling safe
	+ PCPs & AHPs report that PCN resources have had a positive impact on cultural safety and humility knowledge and practice
* Unique:
	+ Cowichan Indigenous Community of Practice # of meetings
	+ # Indigenous Health Coordinators hired
	+ # unique patients served by IHC
 |
| Outcomes: Coordination of Care / Care Integration | 9 | * Patient Surveys (most common)
	+ #/% of patients who report their care is coordinated
	+ #/% reporting satisfaction with coordination of care
	+ Patients report that their needs have been met via referrals
* Provider/Allied Health Surveys
	+ Wait times to access specialist services
	+ % providers satisfied with ease of coordinating care (PMH Assessment)
	+ % of providers reporting improved coordination of care
	+ Existing PCPs report increased coordination as a result of SW/BHC/MH Counsellors
* Service Type provided by PCN Team
	+ Types of patients supported (by AH, RN) –i.e., % MHSU, high complexity, frail (IMIT/HA Data, Encounter Code Data)
	+ Number of Pharmacist’s Consultations with PMH MRP and Team
* Referral Tracker
	+ # of MOAs/FPs trained to use Referral Tracker
	+ % of GPs who made referrals divided by total GPs/MOAs trained to use Referral Tracker
* # Referrals per PCN member by reason (EMR data?)
	+ # new patient referrals by AHP discipline at PCN-level
	+ # patient encounters by AHP discipline at PCN-level
	+ Encounter codes, by type of AHP discipline
	+ # cross-discipline (PCN internal) referrals
	+ # FP/NPs referring by AHP discipline at PCN-level
	+ # corridor consults/team huddles
* Referral wait time to see specialists / PCN allied health (HA data? Pathways? CareConnect?)
* SCSP/Community Service Integration
	+ Number of referrals to community programs by program (Home & Community Care, Mental Health & Addictions, Primary Care, Public Health - HA Data, VCH decision support)
	+ # health authority programs integrated
	+ # referrals to community-based services
		- e.g. SHARE in FNW
	+ # referrals to HA-led care programs
	+ Enhanced integration of services/clinicians within PCN; improved relationship between PMHs and Island Health services
	+ # FP/NP/PCN providers that report
		- patient information to other health services
		- receiving patient information from other health services
		- FP/NP maintains the role of MRC
		- 1 professional within each SCSP as they key contact as patients transition between service streams
		- coordination/integration with other health services has been enhanced
 |
| TBC / Team Functioning / Provider Experience | 8 | * Provider Data (Clinic/Provider Surveys)
	+ Average score on Mini-Z burnout survey burnout question and happiness question for PCPs across PCN clinics
	+ Team Climate Inventory-19
	+ % of providers reporting increased collaboration with other providers and other clinics
	+ % FP, NP, PCN clinicians reporting that they are working to the full scope of practice, by discipline
	+ % FP, NP, PCN clinicians satisfied with the use of their skills, by discipline
	+ % FP, NP, PCN clinicians reporting an intention to remain within the network
	+ % FP, NP, PCN clinicians that report that their team exhibits characteristics of a highly effective multidisciplinary team
	+ % FP, NP, PCN clinicians that report modifying their practice as a result of PCN participation
	+ % of FPs reporting increased support for patients with complex and/or chronic health conditions
	+ FP, NP, PCN clinician experience
		- Description of activities/processes used to support team development and role definition; core components of team’s successes
	+ # of practices offering primary care teams (i.e. with team members beyond FP, NP and/or MOA) vs. baseline
	+ Increased collegiality and trust among health care providers
	+ # corridor consults/team huddles
	+ PCN Team Assessment scores across PCN clinics
* Interview data:
	+ Provider experiences of communication, shared leadership, and scope of practice/time commitments in teams
	+ Most Significant Change - Provider TBC experience
* #/description of team manuals (roles, responsibilities, policies and procedures) created for PCN staff
 |
| Outcomes: Access (Virtual Care) | 7 | * Patient Access to Virtual Visits/Advice
	+ % clinics offering virtual care
	+ % visits to AHP virtually (HA/IMIT Data)
	+ Averaged proportion of Face-to-Face access versus Virtual access
	+ Virtual access (phone, text, email, and videoconference)
	+ % of patients with access to e-booking
	+ % of patients with access to virtual or telephone visits
	+ # FP visits provided virtually (by phone, v-conf) vs. similar time last year
	+ # NP visits provided virtually (by phone, v-conf)
	+ # PCN clinician visits provided virtually (by phone, v-conf)
	+ # patients reporting access to virtual advice
* Use of Virtual Care Tools
	+ # of practices using patient portals
	+ # patients using patient portals
	+ # virtual tools/applications being adopted
	+ # team huddles/care conferences done virtually
	+ % of FP/NP/PCN clinicians reporting an intention to continue utilizing virtual tools/applications
	+ # patients being telemonitored
* FP/NP and PCN clinician experience with tools
	+ training
	+ comfort with virtual tools/applications being used
 |
| Governance / Enabling Structures | 6 | * Existence of structures/ processes/documentation in place to support initiative implementation
	+ Membership of structures (PCS SC, working groups, etc.)
		- Roles of committee & working group members
	+ Meeting Count
* PCN Communities of Practice (unique to Cowichan, similar to KB LL?)
	+ # meetings of CoPs
	+ # of CoPs
* # and type of engagement activities (e.g. working group meetings, focus groups, etc.)
* Team climate assessment
	+ Perception of stakeholders (survey/interview) of:
		- Effectiveness of engagement
		- Satisfaction with level of engagement
		- Cultural appropriateness and meaningfulness of engagement
		- Barriers to engagement
		- Satisfaction with partnerships formed
		- Appropriate representation from all stakeholder groups
 |
| System Utilization | 6 | * Hospital / Emergency Department Utilization + Acuity
	+ Number of patients and visits to Emergency Department CTAS Level – Target is reduction of CTAS 4 and 5 of visits and repeat visits within a 30-day period.
	+ Number of patients and visits admitted to acute care within audit period
	+ Number of patients re-admitted to acute care for same condition at prior visit with a 10 day and 30-day period after discharge
	+ #/rate of CTAS 4 and 5 visits by attached and unattached patients to EDs (by PCN clinic and region-wide)
	+ Hospitalization rates including rate per 1000 population, ALOS, total inpatient cases, total inpatient days, ALC days
	+ ER use by attached patients
* PCP visits: # of visits by GP/NP (HA- employed and private practice - HA data + MoH MSP billing data)
* # of patient encounters (visits) by allied health, nurses and health coordinators in PCN by provider type, and total, by day (average) and by quarter (encounter data only available - MOH wants Visit data, which will be fewer)
* RN in practice Absence rate in PMHs vs. HA settings (monthly)
* MHSU client days by PCN (HA data)
 |
| Outcomes: Relational Continuity | 5 | * The percentage of encounters of panel patients with their own MRP (EMR Data)
* PCPs report strengthened relationship with patients
* #/% reporting continuity of care
* The number of patients’ visits to primary care physician divided by the total number of all family physician visits.
* Average physician continuity-the sum of all individual patients’ physician continuity divided by the total number of patients in the physician panel.
* Number of family physician visits to a primary care facility divided by the total number of all facility visits.
* % of providers reporting improved continuity of care
 |
| PCN Participation | 4 | * # of clinics within PCN geography
* # of clinics participating in PCN
* # of clinics not participating in PCN
* # of physicians in the community
* # of physicians participating in PCN
* # of PCN clinics offering primary care teams
 |
| Health outcomes / Preventative Care / Proactive Care\* (\*not yet implemented in any community) | 4 | * Quality of Clinical care: Screening/Disease Management (HDC – MSPQ3)
	+ Diabetes and BP Within 140/90 in Past Year
	+ Diabetes and HbA1c in Past Six Months
	+ Diabetes and LDL in Past 5 Years
	+ Diabetics with Last HbA1c < 7.1%
	+ Diabetics with Last HbA1c > 9.0%
	+ Diabetics with Last HbA1c 7.1- 8.0%
	+ Diabetics with Last HbA1c 8.1- 9.0%
	+ Heart Failure and at Least 1 Active ACE Inhibitor or ARB Long Term Medication
	+ Heart Failure and Two Weight Measurements in Past 6 Months
	+ Heart Failure and Use of Beta Blocker Medication
	+ Heart Failure and Weight Measured in Past Year
	+ Heart Failure with Ejection Fraction Recorded
	+ Hypertension and Blood Pressure Documented
	+ Hypertension and Last Blood Pressure Less than 140/90 in Past Year.
	+ Impaired Renal Function and BP Measurement within 6 Months
* Quality of Clinical care: Polypharmacy
	+ 65 and Older on 10 or More Long Term Medications
	+ 65 and Older on 5 or More Long Term Medications
* MoH Patient Health Outcome Data (not implemented)
	+ %/# perinatal services
	+ %/# Childhood immunizations
	+ CVD screening rates
* MSC/Success stories (Qualitative)
* Patient self-report outcomes on standardized assessments e.g. SF-36, GAD-7, PHQ-9
* % 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
* Average time to receive discharge report from hospital after patient has been discharged
 |