Data Liberation Stories

-Primary Health Care-

Acknowledgement of partnerships on Data Sharing Standards in PHC:
Content

➢ Introduction and 9 pillars

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➢ Conclusion: Contact Information
Introduction

• The Data Sharing Standards:
  - A framework for Primary Care Networks and their physicians who wish to access matched data from AH, AHS and the HQCA for secondary use of data purposes (quality improvement, evaluation, business planning, panel management, etc.).
  - It is a collaborative initiative with representation from AHS, HQCA, AH, AMA (PCN PMO, TOP), AIM, PCNs, physician leads and OIPC. Under the guidance of the Data Sharing Standards Advisory Committee, the work is moving forward by the Privacy Officers’ Working Group and the Implementation Group.

• The collaborative multi-organizational “Data Liberation Stories in PHC” presentation: a platform for all partners to share data liberation stories regarding value of data sharing and use in Primary Health Care.
9 Pillars of Data Sharing Framework

1. Leadership – Data Governance
2. Information & Privacy
3. IT Support
4. EMR Support
5. Data Use
6. Data Literacy
7. Communication
8. Paneling
9. Practice Improvement
Community Information Integration (CII)

Understanding the role of CII in advancing data sharing in primary health care

October 24, 2017

Presented by:
Martin Tailleur
- Executive Director, Strategic IMT Services, CII Executive Lead, AH
What is CII?

The Community Information Integration (CII) project:

• Collects clinical patient data from community family physician offices, specialists and other community based clinics

• Displays clinical reports from community providers in Alberta Netcare as part of a comprehensive patient Electronic Health Record (EHR)

• Analyzes patient health data to support quality improvement, population health assessment and health system planning
What is the goal of CII?

- Improve Albertan’s continuity of care across the health system through better access to primary care and community health information
- We will get there by:
  - Collaboration with the Alberta Medical Association (AMA), College of Physicians and Surgeons (CPSA) and Primary Care Networks (PCN)
  - Partnership with Alberta EMR Vendors (Microquest, TELUS and others)
What are the benefits of CII?

**PATIENT**
- Improved continuity of care
- Reduces redundant and unnecessary treatments
- Improved patient safety
- Reduced information repetition

**PROVIDER**
- Access to community clinical reports
- More comprehensive patient longitudinal health record
- Enhanced integration with Alberta Netcare
- Minimal impact to workflow

**HEALTH SYSTEM**
- Better population health management
- More informed care
- Fewer gaps and delays
- Improved support for quality improvement initiatives
What does Phase 1 look like?

Clinic EMRs
Collecting clinical patient data and consult reports from community clinics, including family physician offices and specialists

CII HUB
(Data Extracts and Specialist Consult Reports)

Alberta Netcare Portal
Sharing clinical reports from community providers as part of a comprehensive patient EHR

Healthcare Data Repository
Enabling quality improvement efforts, population health assessment and health system planning
What are the data elements being shared?

<table>
<thead>
<tr>
<th>CLIENT</th>
<th>PROVIDER</th>
<th>SERVICE DELIVERY LOCATION</th>
<th>LAB ORDERS</th>
<th>LAB RESULTS</th>
<th>DI ORDERS</th>
<th>DI RESULTS</th>
<th>ATTACHMENT</th>
<th>REFERRAL REQUEST</th>
<th>REFERRAL RESULT</th>
<th>ENCOUNTER</th>
<th>OBSERVATION</th>
<th>INTERVENTION</th>
<th>MEDICATION PRESCRIBED</th>
<th>MEDICATION DISPENSED</th>
<th>IMMUNIZATION</th>
<th>MASKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name, Identifier (PHN), Birth Date, Gender, Postal Code, Rostering Status</td>
<td>Name, Identifier, Role, Expertise</td>
<td>Name, Identifier, Type of Services, Postal Code</td>
<td>Lab Test Ordered, Date</td>
<td>Lab Test Performed, Result, Date</td>
<td>Diagnostic Imaging Test Ordered, Date</td>
<td>DI Test Performed Date</td>
<td>Roster / Panel Status, Start / End Dates</td>
<td>Service Requested, Date</td>
<td>Service Occurred, Date</td>
<td>Date, Reason for Visit, Mode, Payment Source, Billing / Health Service Code</td>
<td>Health Concern, Allergies, Blood Pressure, Height, Weight, Waist, Clinical Assessment</td>
<td>Intervention / Treatment, Date</td>
<td>Medication Prescribed, Date</td>
<td>Medication dispensed, Date</td>
<td>Vaccine Administered, Date, Lot Number</td>
<td>Patient Confidentiality Flags</td>
</tr>
</tbody>
</table>

* Data not collected as it is already available in Netcare
What are the initial CII Netcare reports?

**Specialist Consult Report**
- Provides a copy of the patient consult report to Netcare in PDF format

**Community Encounter Digest (CED) Report**
- Reasons for Visits
- Clinical Assessments
- Health Concerns
- Referral Requests
- Possible Allergies
- Observations
- Provides a snapshot of all encounters a patient has had with community physicians over the past year
What are the CII selection criteria?

- **Clinic Eligibility**
  - ANP user
  - Family Physician, Specialist, Nurse Practitioner
  - Custodian consensus and use of conformed EMR

- **Willingness**
  - Assign site liaison
  - LPR agreement letter
  - Latest Version of EMR

- **Readiness Assessment**
  - EMR PIA and EMR IMA
  - CII PIA endorsement letter
  - pORA
What is the LPR timeline?

- **June 2017**: Approved Microquest (MQ) sites
- **November 2017**: Approved TELUS Med Access (MA) sites
- **December 2017**: Approved TELUS Wolf and PS Suite sites
- **January 2018**: General Release
What is the long term vision for CII?

- **Alberta Netcare Portal (ANP)**
  - Sharing of additional clinical reports and information, such as care plans and patient summaries

- **EMR Integration**
  - Bi-directional information flow allowing the import of high value clinical and practice management reports into the EMR, and export of other information like PCN metrics

- **Central Patient Attachment Registry (CPAR)**
  - Tracking patient attachment and paneling across all clinics in Alberta

- **Personal Health Portal (PHP)**
  - Sharing of additional clinical reports and information, such as care plans and patient summaries

- **Healthcare Analytics**
  - Improved reporting to clinics and PCNs, enabling quality improvement across the Alberta health system

- **Canadian Primary Care Sentinel Surveillance Network (CPCSSN)**
  - Support for a multi-disease electronic medical record surveillance system
What do patients think?

“What Connecting Patients for Better Health Survey, 2016”, Canada Health Infoway:

- Access – 86% of patients believe that digital health ensures that clinicians have easy access to a comprehensive health history
- Sharing – 96% of patients think it is important that health records are kept electronically for easy transfer within the health system
- Positive Impact – 74% of patients believe that digital health is having a positive impact on the health system
- Despite the above, 70% of patients say they are not confident their health care providers are currently sharing information for a holistic view of their health

“albertapatients Community Information Integration (CII) Survey, 2017”, Alberta Medical Association

- Interesting and relevant results that could be offered in a future presentation to this audience
Questions?

Contact:
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Martin.tailleur@gov.ab.ca or (780) 415-1427

Contact:
**Michael McDermott**, CII Project Manager
Michael.Mcdermott@gov.ab.ca or (780) 937-5208
Health Analytics Portal (HAP)

What is HAP?

The Health Analytics Portal gives healthcare stakeholders a secure entry point for accessing data and reports that have been generated by Alberta Health Services. The portal supports the Alberta government's commitment to leverage research and innovation to improve healthcare.

https://extranet.ahsnet.ca/hap/Pages/default.aspx

Presented by:
Heather EN Cooper
- Director, Data & Data Governance Services, Data & Repository Services, Analytics (DIMR)
Sharon Exham
- Senior Data Sharing, Access & Auditing Advisor, Data & Repository Services, Analytics (DIMR)
Health Analytics Portal (HAP)

Focus today is on:

#2 Describe your data partnership – with whom you shared data.

#3 Describe the key processes involved in your example e.g. confirming the relationship; extracting / reporting the confirmation date.
Health Analytics Portal (HAP)

#2 Our HAP partners

In discussions with the following organizations:

- Health Quality Council of Alberta (HQCA)
- Mosaic Primary Care Network
- Airdrie & Area Health Benefits Cooperative
- Opioid Activity Dashboards with AHS Public Health partnering with various organizations
- Long-term / Senior Activity Dashboards with AHS Integrated Supportive & Facility Living - Calgary Zone partnering with various organizations
#3 Our HAP process

- On-boarding process includes the organization signing a participation agreement; followed by designating a HAP Authorized Approver (HAP AA) to support registration; registering users
- Organization Participation Agreement includes – confirming the relationship to AHS; confirming the legal authorities to access the requested data; implementing data sharing agreements; etc.
- HAP AA includes – HAP end-user training; privacy & security training; HAP AA agreement
- Registered Users – privacy & security training; HAP orientation; Registered User agreement
Access Framework

Health Analytics Portal (HAP) User Registration Management

Steering Committee

User Management

HAP Administrator

HAP Security

Access Management

HAP Partipation Agreement

Org A Participating Organization

HAP Authorized Approver

Org A HAP

User Access must align with HAP Participation agreement

Org A HAP User 1

HAP User-Level 3 access to ED

Org A HAP User 2

HAP User-Level 2 access to ED

Org A HAP User 3

HAP User-Level 2 access to DAD/NACRS and Lab

Org A HAP User 4

All User Agreements signed off by Org A HAP AA

Org B Participating Organization

HAP Authorized Approver

Org B HAP

User Access must align with HAP Participation agreement

Org B HAP User 1

HAP User-Level 3 access to ED

Org B HAP User 2

HAP User-Level 2 access to ED

Org B HAP User 3

HAP User-Level 2 access to DAD/NACRS and Lab

Org B HAP User 4

All User Agreements signed off by Org B HAP AA

HAP Partipation Agreement

HAP User Agreement, HAP AA Orientation and Training

HAP User Agreement, HAP AA Orientation and Training

All User Agreements signed off by Org A HAP AA

Org B HAP User 1

HAP User-Level 3 access to ED

Org B HAP User 2

HAP User-Level 2 access to ED

Org B HAP User 3

HAP User-Level 2 access to DAD/NACRS and Lab

Org B HAP User 4

All User Agreements signed off by Org B HAP AA

HAP Partipation Agreement

HAP User Agreement, HAP AA Orientation and Training

HAP User Agreement, HAP AA Orientation and Training

All User Agreements signed off by Org A HAP AA

Org B HAP User 1

HAP User-Level 3 access to ED

Org B HAP User 2

HAP User-Level 2 access to ED

Org B HAP User 3

HAP User-Level 2 access to DAD/NACRS and Lab

Org B HAP User 4

All User Agreements signed off by Org B HAP AA
Health Analytics Portal (HAP)

#3 Our HAP process (cont’d)

- HAP Admin Team – coordinates the build of the data products; metadata; discussion boards to support.
## HAP Access Levels and Participant types

<table>
<thead>
<tr>
<th>Level</th>
<th>Definition and provisions restricting the use of non-identifiable information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td><strong>Aggregate</strong> - This is the default access level and available to the public. Registration is not required for Level 1 - Aggregate. HIA definition-aggregate health information means non-identifying health information about groups of individuals. Means non-identifying health information about groups of individual with common characteristics. This is often referred to as statistical information and often is the kind of information from which it is virtually impossible to identify a single individual unless the cell or sample size is very small (less than 10).</td>
</tr>
<tr>
<td>Level 2</td>
<td><strong>De-identified</strong>: e.g. Patient scrambled PHN, age in years or age groups, geo code not postal code, data shifting where date of service and date of supply are randomly perturbed to ±14 days of the true date. Means that the identity of the individual who is the subject of the information cannot be readily ascertained from the information. The Health Information Act regulates information that identifies individuals. The Health Information Act contains a few basic provisions restricting the use of non-identifiable information.</td>
</tr>
<tr>
<td>Level 3</td>
<td><strong>Partially identifiable</strong>: e.g. Patient PHN, DOB, gender, postal code Means that the identity of the individual who is the subject of the information can be ascertained from the information with minimal effort.</td>
</tr>
<tr>
<td>Level 4</td>
<td><strong>Fully identifiable</strong>: e.g. Patient names, address, contact information Means that the identity of the individual who is the subject of the information can be readily ascertained from the information. (Source, HIA) This may require additional security requirements and possible second authentication.</td>
</tr>
</tbody>
</table>

### Types
1. AHS as Custodian - custodian
2. AHS as Custodian - affiliate
3. AHS as Custodian - non-custodian (e.g. other GOA ministries – e.g. human services, others)
4. Researchers will require AHS Research Agreement** work in process
Health Analytics Portal (HAP)

Resources - HAP FAQ and Onboarding Process

(To open the document, please click on the pin below or attachment section of the presentation.)

HAP – contact us at the HAP @ ServiceDesk.HealthAnalyticsPortal@albertahealthservices.ca
Chinook PCN’s PAIR Website

- Paneling
- Data Use
- Information & Privacy
Data Sources and Data Flow

- A joint venture agreement allows the CPCN to access AHS administrative data and other facilities
- The Chinook PCN has remote access to member clinic’s EMRs
- Data requests to AH provide us with biannual billing data from all of our clinics
- Through the input of data from multiple sources and data matching we are able to provide comprehensive reports back to our clinics
Patient Attachment

- Categories: 1, 2, 3A, 3B, and 4
- Data from Alberta Health billing and Clinic EMRs
- Developed multiple patient categories that separate patients by degree of attachment
- Last category focuses on patients that are attached to multiple physicians
Panel Data

Colorectal Cancer Screening

Click the columns to view Physician Breakdowns for that year.

2016 CPCN Wide Network Percentage: 66.45%

Description
Number of patients (50-74 years of age) who have had a fecal immunochemical test (<24 months), sigmoidoscopy (<60 months) or colonoscopy (<120 months)

2016 CPCN Network Wide Percentage
66.45%
Emergency Room Visits

Click the columns to view Monthly Breakdowns for that year.

REPORT OVERVIEW

Emergency Room Visits
for Peter McKernan
Generated on: Aug 29, 2017 :: 10:12am
Description:
Number of Emergency Department Visits by paneled patients
Value Add and Patient Care

• Reduction in cross paneled patients increases continuity of care and potentially opens up a panel spot for other members of the community
• List of recently hospitalized and deceased patients keeps physicians up to date on patient activity when an inpatient notification or deceased notification is misplaced
• The tools on the website allow providers to review preventative screening on which patients are overdue
• Utilization data of the emergency department will allow providers to determine whether patients are using the ED for conditions best managed at primary care and prevent future visits or readmissions
Privacy and Agreements

- Information Manager and Data Matching Agreement between AHS and CPCN participating physicians
- Information Sharing Agreement between Lead Custodian and CPCN participating physicians
- Information Manager agreement between the CPCN and Internet Solutions Group
- Collection Notice
- Data Matching PIA
- PAIR Website PIA
- AHS Policies and Procedures
- Security Audits
Questions?

Contact:
Jeffrey Decker
- Information Management Lead, Chinook PCN
Jeffrey.Decker@albertahealthservices.ca
Central Patient Attachment Registry (CPAR):
Key Technical Enabler for Continuity of Care for Albertans

Data Liberation Stories – Primary Health Care
October 24, 2017

Presented by:
Barbra McCaffrey
- EMR Lead, Toward Optimized Practice, AMA
Arvelle M Balon-Lyon
- Program Director, Toward Optimized Practice, AMA
9 Pillars of Data Sharing Framework

1. Leadership – Data Governance
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6. Data Literacy
7. Communication
8. Paneling
9. Practice Improvement
Why Focus on Continuity?

- Better coordination between providers of care
- Better patient-reported outcomes
- Increased patient and provider satisfaction

- Better health outcomes
- Decreased mortality
- Better quality of care
- Better coordination of care
- Reduced overall health cost to the system
- Increased patient and provider satisfaction
- Improved access
- Fewer ER visits & preventable hospital admissions
- Enabler for new physician compensation models

- Better handoffs between providers
- Better communication
- Less duplication
- Increased patient and provider satisfaction
- Facilitates a patient-centred approach to care
What is the Central Patient Attachment Registry?

- 2016 Amending Agreement between AMA and AH
- Common provincial repository
- Registry of primary providers and their confirmed panels
- Technical enabler for improved continuity of care in Alberta
- Desire to have primary provider information appear in Netcare
- AMA Section of General Practice is working on this joint initiative with AH and AHS
Panel Identification: Clinics Have 4 Key Behaviors in Place

1. At every interaction ask who the patient identifies as their primary provider
2. Record it in the EMR & Date Stamp It
3. Maintain & Review the panel List
4. Utilize the panel list to plan care delivery starting with ASaP
What is Different with CPAR?
Panel Maintenance with CPAR

1. At every interaction ask who the patient identifies as their primary provider
2. Record it in the EMR & Date Stamp It
3. Maintain & Review the panel List
4. Utilize the panel list to plan care delivery
5. Submit the Panel List to CPAR
Who Should Upload Panels?

Providers with Panel
• Provide comprehensive longitudinal primary care
• Include long-term care patients in panel (may be separate panel)

Caseload/Episodic Care
• Specialty services
  • Vasectomies
  • Maternity Care
  • Sports Med
  • Pap clinic
  • Aesthetic services
• Patients seen for episodic care (not on panel)
How Will CPAR Work for Panel?

Clinic team acts on panel conflicts and mismatch notifications. CPAR verifies panel.

Clinics confirm panel at practice.

Produce confirmed panel list at practice for each primary provider.

Provider receives list of panel conflicts and mismatch notifications.

Registry receives the list and looks for duplicates and mismatches to PCR.

Save list as csv file and submit to registry via secure portal.

Repeat Quarterly.

Clinics receive list of panel conflicts and mismatch notifications.

CPAR Registration for Panel Access Administrator, Panel Administrator & Provider Panels.

Clinics are already doing this:
- Name
- PHN/ULI
- DOB
- Gender
- Date of last visit
- Date last confirmed
New Tools

Conflict Report

• Lists patients on the providers panel that have been paneled to other participating providers at other practices in Alberta

Mismatch Notifications

• Lists patients where the demographic information does not match the Patient Client Registry at Alberta Health
• Deceased patients
Key Benefits of CPAR

Panel Based Care

• PCNs and clinics have invested significantly in panel management
• Registry reports will allow clinics to address panel conflicts to ensure that panel management is delivered to a providers VERIFIED panel patients

Foundation for Informational Continuity

• When the registry shows that a patient is paneled to one primary provider, the patient’s Netcare record identifies the provider
• This sets the foundation so that in the future primary providers will be aware of their patients having important touch points in the Alberta health care system.
Future Discussions of Pillars

• Leadership – Data Governance

• Information and Privacy
  - PIA in progress
Thank You!

Questions?

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arvelle.balon-lyon@topalbertadoctors.org
Strategy to Reduce COPD Exacerbations

Presented by:
Dr. Karen Seigel
- Physician Lead, Crowfoot Village Family Practice

Lesa Zimmerman
- Clinic and Privacy Manager, Crowfoot Village Family Practice
Reducing COPD Exacerbations

Pillar: Practice Improvement

Why?

• Severity of COPD and history of exacerbations predict future exacerbations
• Clinic data (EMR) best for identifying COPD patients and disease severity
• Administrative data best for identifying exacerbations
Data Sharing Process

- CVFP patients are formally rostered by written agreement, and submitted to AH
- Possible COPD patients were identified through EMR
- Lists were validated by responsible MD
- PIA submitted by AHS and IMA signed between AHS and Master Custodian at CVFP
- Confirmed patient lists were sent by sFTP to AHS
- Matched health care utilization data sent back to our clinic
Value Add

• Great example of the value of merging EMR and AHS administrative data (data matching project – AHS Data Repository for Reporting)
• Clinic EMR: to identify COPD patients and severity
• AHS Administrative data: to identify exacerbations
Value Add

- Proactive approach to COPD care, rather than reactive
- Registry of COPD patients
- Subset of COPD patients most at-risk for exacerbation
- Regular review of at-risk by MDT with review/creation of action plan, consideration for flare-up prescription, and regular recall
- Flu vaccines for all, offer others
- Goal: to reduce exacerbations (using evidence-based approach)
Privacy Work

- PIAs (Privacy Impact Assessment)
- Endorsement Letter for data matching to OIPC
- Clinic ISA (Information Sharing Agreement)
- AHS-Clinic IMA (Information Management Agreement)
- Continuous Privacy Training (led by our clinic manager/privacy officers)
- Notice of Collection
Privacy Work (PIA)

**PIA** is a legal requirement under HIA s.70(2) for data matching projects

a) **External PIA: AHS-PCN/clinic**

b) **Internal PIA: clinic PIA**

c) **Endorsement Letter** for data matching project to OIPC (listed both PIAs #) - accepted

- The data matching project was covered by AHS-PCN/clinic PIA for quality improvement purposes to protect privacy, security and confidentiality of shared individually identifying health information.
- It was important to identify our clinic data sharing model, new data flow, uses and processes.

**Lesson learned:** dedicate enough time and involve all required experts to review current PIAs and conduct amendments if required.
Agreements - partnership building tools that outline data sharing processes.

- **Clinic ISA**
  - Developed to define our clinic data sharing model as we a large clinic with 17 physicians

- **AHS-Clinic IMA** (under HIA s.60(2) and stipulated by AHS-PCN/clinic PIA)
  - The new IMA was developed to accommodate our clinic data sharing model: based on our clinic ISA, we identified our Medical Director as a Clinic Master Custodian (Authorized Representative on behalf of all CVFP physicians) who signed the IMA.
  
  - All agreements helped us identify how information will be collected, used and disclosed and all authorized users who will access it.
  - All agreements have been developed in compliance with PIAs and the HIA.
Key Messages

• Early in our process.
• Pioneer data sharing solutions for secondary use to enable evidence-based decision-making.
• Value of merging EMR and AHS administrative data where both carry piece of vital information (primary + acute health care levels of data).
• Potential for big impact on clinical outcomes and health care expenditures with structured approach.
Questions?

Contact:

Dr. Karen Seigel
- Physician Lead, Crowfoot Village Family Practice

Lesa Zimmerman
- Clinic and Privacy Manager, Crowfoot Village Family Practice
Mosaic PCN

Data Sharing Standards Group

Why PCNs Need Data

Collaboration...Sharing Success

Working with AHS, ARES and Supporting Future Collaborations

Presented by:
Peter Rymkiewicz
- Director Measurement & Evaluation, Mosaic PCN
Strategic Partnerships
Working together!

MPCN Physician Members
MPCN & MPL Boards

Calgary Laboratory Services
UNIVERSITY OF CALGARY

Screening For Life.ca

Physician Learning Program

Alberta Health Services

Health Research Ethics Board of Alberta
Community Health Committee

Health Quality Council of Alberta

Office of the Information and Privacy Commissioner of Alberta

CPCSSN

RCSSSP

Toward Optimized Practice

Alberta Screening and Prevention

Data Sharing Standards in PHC
Measurement & Evaluation Strategy

Strategic Vision (Infrastructure, information, process standards)

Privacy / Governance and Trust
- MPCN PIA
- Data Sharing Agreements (DSAs)
- Information Management Agreements (IMAs)
- Patient Health Information Posters

Data Capture / Analysis
- EMR data extraction (multi step process)
- Primary Data Collection
- Access to Quality Data & Information Standards

Secure Information Infrastructure
- Secure Authentication (MS SQL server)
- Thin client computing & two factor authentication

Feedback and Communication
- Organizational Reporting (Operations, Manager, Physicians)
Why Do PCNs Need Data?
Measurement & Evaluation Strategy

1. Organizational decision support & evidence based program evaluation and promoting transparency

2. What improvements in the quality of patient care & health outcomes result from PCN programs and services?

3. How do we share, support and engage our Physicians. How do we support practice improvement as part of the clinic team.
How Can PCNs Use Data

Program Design
• Identified population need(s)
• Understanding of gaps in current service delivery

Understanding Service Delivery (Resource accountability)
• Coaching / Learning
• Planning and Supporting Service Delivery changes
• Provider efficiency

Support Evidence Based Service Delivery
• Are there quality outcomes supporting program delivery

Audit and Feedback, Communication
• Organizational Reporting (Operations, Manager, Physicians)
• Providing Information to physician
  • Co-located MDT referrals
  • Patients referred and seen centrally
MPCN is a Quadruple AIM Organization...

**Clinic Measures**
- BP, A1c, Height & Weight, HDL / LDL

**Acute Care Outcome Measures may include:**
- ED / UCC visits per 1000
- IP admission per 1000 / IP bed days
- 7 or 30 day readmission
- ACSC admission per 1000
- GPSC ED/ UCC Visit per 1000

**Patient Reported Outcome Measures (PROMs)**
- EQ5D-5L
- Patient Activation Measure (PAM)

**Patient Experience**
**Provider Satisfaction**

**Process Measures**
- Visits volumes
- Visits per Adjusted clinical Day (VPCD)
- Reduction in cost per visit

**53**
On-going for all programs
~50-100
MPCN Measurable Progress
Physician Trust and Leadership Supporting the Medical Home

- **16.5%**
  - 2016-17: 126,424
  - 2015-16: 108,512
  - Increase in 1on1 and group Patient Encounters

- **20%**
  - 2016-17: 15%
  - 2015-16: 11%
  - Reduction of No-Show Appointments

- **5.49 → 6.97**
  - MDT Patient Visits Per Day

- **~60%**
  - 24% Increase Patient Access
  - Physician signed DSAs
  - 40% increase

- **94.9%**
  - Member Physicians Satisfied with MPCN
  - 3.9% increase

- **340,580**
  - Patient Screening Offers
Process and Patient Level Outcomes

- Evaluation Objective: Evaluating Offers of screen and screen completion (intervention vs. non-intervention)
- Intervention: 1) PCC Offers of Screen
  2) Multidisciplinary Team Patient visit
- Outcome of interest: Diabetes Screen(A1c/FG), Lipids, PAP, Colorectal

- Evaluation Objective: Active Adult Program
- Intervention: 1) Active Adults Program
- Duration: per 7 month period in the program
- Outcome: sBP - 9.6, dBP - 3.6
  \( p < 0.0000 \)
Save the Date!

Mosaic Half Day CME

From Data to Decisions
Navigating the numbers to enhance clinical care

Wed. Mar 8 – 8AM-noon (breakfast included)
OR
Fri. Mar 17 – noon-4PM (lunch included)
Location: Executive Royal Hotel Calgary

Agenda:

- Alberta Cancer Screening Programs (Dr. Huiming Yang) National and Provincial cancer screening trends and recognize Mosaic family physician members and MPON programs as an integral part of supporting patient care delivery.
- Health Quality Council of Alberta (Markus Lahtinen, Dr. Oliver David) Physician level reports and how physicians can use these reports to improve patient safety and health service quality.
- Physician Learning Program (PLP) (Dr. Tina Nicholson, Dr. Anne Darragh, Dr. Sanjay Waghera) AMA-sponsored, co-facilitated learning session using HQCA provider reports to support clinical questions. PLP will help to facilitate reflection on practice data & supports knowledge translation to improve patient outcomes specific to cancer care.
- MPON OPENING, NEXT STEPS IN EVALUATION, CLOSING REMARKS (Peter Rymkiewicz, Dr. Elizabeth MacKay) Mosaic PCN will present on the importance of health partnerships and evaluation outcomes related to physician adoption of MPON programs to deliver quality patient care.
- Physicians will be reimbursed at the sessional rate (up to 3.5 hours)

Up to 11 Mainpro+ group learning credits available

WATCH FOR YOUR INVITE

For more info: Sandy Oman at cme@mosaicpcn.ca

CME (Audit and Feedback)

• A total of 80 physicians completed the CME Feedback survey.
• 91.5%, indicating a high level of overall satisfaction with this CME event.
• 97.5% (78 out of 80) respondents rated their ability to interpret and use the HQCA provider report at 3 or more out of 5.
• The average mean score before the presentation was 1.9 and after the presentation was 3.8. The average score increased by 100%. This increase is statistically significant (p<0.000)
• 97.5% of respondents found the discussion of cervical screening guidelines and related supports and barriers helpful.
• 94.9% of respondents felt that the HQCA presentation and PLP learning session will support them to set and evaluate personal goals related to individual practice.
• 88.8% of respondents indicated that following this event, they are ready to access and use available data to drive decision-making and improvements in their practice.
• 100% of respondents indicated that the CME increased their understanding of measurement and evaluation.
• 92.4% of respondents indicated they are more likely to use MPCN services.
• 29 respondents indicated they would like more information about the Primary Care Coordinator Program.
Partnering to see how we are Doing (FYE 2015-16)

- 44.6% of our population is in the Least Privileged Deprivation Quintile
- 47% of the Population have a single or multiple comorbidity
  - 17% Higher Disease Burden than the Zone
  - 14% Higher than Alberta
- Influenza vaccination rates at 30% compared to 26% as a Zone
- GPSC ED Visit Rates are 25% low for the Mosaic PCN panel
- ED Visits for MPCN are slightly lower but comparable to the zone (0.27 visits per person per year compared to 0.28 visits per year)
Thank You

Questions?

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- If you would like to share your story in the next presentation or
- If you have any questions about Data Sharing Standards or
- If you have any suggestions or ideas with regards to this work