WHAT'S NEW IN D2D 5.0?
CHANGES COMING IN FALL 2017

We're adding **new Core and Expanded indicators** to D2D and making **changes to the composite score indicators**.

We're also adding a **module to collect demographic and contextual data**. This data will help teams understand the context and characteristics that contribute to high performance, making it easier to take local action to improve. In the past, AFHTO attempted to collect this information via surveys released during the D2D data submission period. Response rates were persistently low; no more than 25% of teams responded, and very few of those provided their team codes to link their identity with their D2D data. Adding these contextual indicators to the D2D data submission process is our attempt to assemble more of this data without asking members to do another survey.

Another important change coming to the D2D platform is the opportunity for teams to **unmask themselves so their results will be available for other teams to see**. This will allow teams to reach out to one another to learn about their performance.

Changes to Core and Expanded Indicators

- **New** core indicator: *Follow-up after Hospitalization* (previously an exploratory indicator)
- **New** expanded indicator: *Bone Mineral Density Test*
- **Refined** expanded indicator: *Medication Reconciliation*

Changes to the EMR Data Quality score

- Three **new** sub-indicators:
  - *% of patients with chronic heart failure who have a coded diagnosis*
  - *% of patients with chronic obstructive pulmonary disease who have a coded diagnosis*
  - *% of patients with depression who have a coded diagnosis*

New Exploratory Indicator

- **New** diabetes care sub-indicator: *Individualized HbA1C Target Recorded in the EMR*. This is the first step towards being able to measure whether these targets are being met. Including it in D2D:
  - Allows us to estimate how many teams are already recording individualized HbA1C targets in the EMR.
  - May encourage teams who are not already recording individualized HbA1C targets in standard way in their EMRs to start doing so.
  - Is the first step towards including this measure and other patient-centred measures in the diabetes care composite indicator.

New Contextual Data: Demographic and Team Profile Indicators

These indicators provide contextual information about your team. The information can help members understand what characterizes high- performing teams. As with the rest of D2D, **completing these indicators is optional.** Please answer as many as you can. We may be able to further reduce the work of answering these questions by linking to the information in the AFHTO membership database. If this becomes possible, members will be invited to give permission for that to reduce their data entry efforts. In any event, these questions will only be asked periodically – not with every iteration of D2D – as the answers tend not to change over time.

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Part 1: Patient Demographic Data (from Primary Care Practice Report)

The following **patient demographic data** will come from your team's HQO Primary Care Practice Report (PCPR):

- Recent OHIP registration (%) (this measure is meant to be a proxy for tracking recent immigrants, as new immigrants would be required to sign up for OHIP)
- Age group 65+ years (%)
- Patient Rurality Index of Ontario (RIO) scores (%)
  - Rural: 40+
  - Other: 0-39
- Low Income (1st & 2nd) Quintiles (%)

Work is underway to add these data to the PCPR AFHTO appendix to reduce the data-entry effort associated with this.

Part 2: Organization Profile Data (self-reported)

The following **organizational profile data** will be asked of members. Some of this is already captured at AFHTO membership renewal. Teams may be asked if they would like AFHTO to populate selected data items from the membership database, to reduce data-entry effort for these items.

- Does your team have a clinician champion for quality improvement?
- Does your team have regular conversations with NPs/physicians on the team about performance?
- How is your FHT involved in a QIDS Specialist Partnership (as a host, a partner, or not at all)? (n/a for NPLCs)
- Does your FHT have access to the results from the OMD EMR Progress Assessment for the team's physicians? (n/a for NPLCs)
- What wave was your FHT announced in? (n/a for NPLCs)
- What is the team's governance structure (i.e., community, physician led, mixed, or other)?
- How many sites does your team have, and how far apart are they (maximum distance)?
- When did the team become operational?
- Breakdown of the type of staff by profession, their numbers and FTE for the following professions
  - Family physician
  - Registered nurse
  - Registered practical nurse
  - Nurse practitioners
  - Psychiatric nurse
  - Community/home care nurse
  - Other specialized nurse
  - Receptionist/med. secretary
  - Social work
  - Nutritionist/Dietician
  - Occupational therapist
  - Physical therapist
  - Manager of the centre or practice (not a physician)
  - Physiotherapist
  - Dentist
  - Pharmacist
  - Psychologist/Psychiatrist
  - Speech and language pathologist
  - Respiratory therapist
  - Case manager/care coordinator/care navigator
  - Other clinical staff
  - Other non-clinical staff

In addition to the above, we are asking **six new questions about team traits**. Numerous research studies have identified traits that are precursors to successful improvement in primary care. Answers to these questions will allow AFHTO members to better identify traits of successful teams and offer a road map for teams to follow towards their own successes. We provide them in their entirety, below, to help members prepare for the workload of data entry at submission.

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These six questions are also part of a broader research study being conducted by the University of Toronto on how integrated care is delivered for individuals with multi-morbidity. During D2D data submission, teams will be asked for consent to participate in this study. Those who consent can use their D2D data entry to answer these questions, rather than answer them again for the study. They will also be contacted by the researchers to answer additional follow-up questions specifically related to the study. More information will be available on the actual data submission and research consent forms.

1. **Which of the following quality improvement initiatives are used by your FHT or NPLC? (choose all that apply)**
   a. An individual or group of individuals is responsible for leading quality improvement efforts in your team
   b. Regular feedback provided on individual or team performance (e.g. D2D, Schedule A, QIP)
   c. Formal training is provided on quality improvement methods/strategies
   d. There is a structured/formal process to obtain feedback from colleagues
   e. Information pertaining to patient satisfaction or patient experience is shared with providers and staff
   f. There is formal process for self-assessment (e.g. Physician Assessment Review)
   g. Regular feedback provided on the extent of collaboration/teamwork within your practice team
   h. There are incentives to improve quality of care (i.e., financial or non-financial incentives)
   i. Other (please specify) _____

2. **Does your FHT or NPLC use an Information Technology platform that offers the following? (choose all that apply)**
   a. Sharing of patient information between providers in the practice
   b. Scheduling appointments
   c. Electronic medical records (EMR) (i.e., electronic charts)
   d. EMR that is accessible to all providers in the team
   e. EMR that allows external data (e.g. hospital or specialist) to be viewed
   f. Electronic/computerized tools to support medical decision-making tools (e.g. decision trees, alerts & recalls, integration of clinical practice guidelines, etc.)
   g. Patient registries to enable targeted programming (i.e., screening and follow-up)
   h. Electronic reminder system for recommended patient care (e.g., screening)
   i. Electronic interface to access laboratory services (including imaging)
   j. Electronic interface to share prescriptions with pharmacies
   k. Other (please specify) _____

3. **Does your FHT or NPLC have a centralized process for the following? (choose all that apply)**
   a. Registering/enrolling patients
   b. Organizing team meetings for case conferences/discussion
   c. Sharing patient information between providers within your team
   d. Sharing patient information with providers outside your team (i.e., other organizations in the community, specialists etc.)
   e. Referring patients to other providers/services within the tam
   f. Referring patients to services to other organizations (in the community)
   g. Other (please specify) _____

4. **What types of resources are shared among providers in your FHT or NPLC? (choose all that apply)**
   a. Shared spaces (e.g., offices, examination rooms, waiting rooms)
   b. Educational or medical decision-making resources
   c. Operating costs for the practice
   d. Administrative Support staff (secretary and receptionist)
   e. Nursing staff
   f. Appointment management system
   g. EMR/Medical records system
   h. Access to diagnostic services (e.g. radiology, laboratory)
   i. Other (please specify) _____

5. **What types of information are shared among providers in your FHT or NPLC? (choose all that apply)**
   a. Information around patient needs assessment/management
   b. Patient and caregiver goals/preferences
   c. Changes in patient health status/condition (i.e., hospitalization, exacerbation of symptoms, etc.)
   d. Information around referrals made to providers/services within the team
   e. Information about referrals made to providers/organizations outside of the team
   f. Other (please specify) _____

6. **How is information shared among providers within your FHT or NPLC? (choose all that apply)**
   a. Informal or ad hoc exchanges between providers in your team (i.e., face to face chat, phone calls etc.)
   b. Electronic communication through EMRs
   c. Computerized messaging systems
   d. Regular team meetings or case conferences/discussions
   e. Pre-established care protocols for specific conditions/client groups that guide information exchange between providers
   f. Written communication shared via electronic means or hard copy (i.e., care/treatment plans, communication logs/progress notes, sticky notes etc.)
   g. Other (please specify) _____