Managing Data To Inform Program Development:

Using Data to Highlight Team Capacity and Workload in a Family Health Team

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Historically our Inter-disciplinary Healthcare Providers (IHPs) have struggled with creating meaningful measures that provide insight into programs and inform their practice. As programs creation was influenced by and designed for the MOH Schedule A, the IHPs often didn't understand their own program process and the measures weren't clearly defined. Data was often inconsistent and certain programs frequently required auditing as the numbers seemed meaningless. In 2020 Haldimand FHT began to focus on targeted data collection that would be more meaningful to IHPs and that would inform Schedule A in a way that better reflected the work of the team.

SOLUTION IMPLEMENTATION

The implementation process allowed the team to gain a better understanding of each program and provided clearer guidance for IHP processes and data collection, that would reflect the work being done with appropriate target populations.

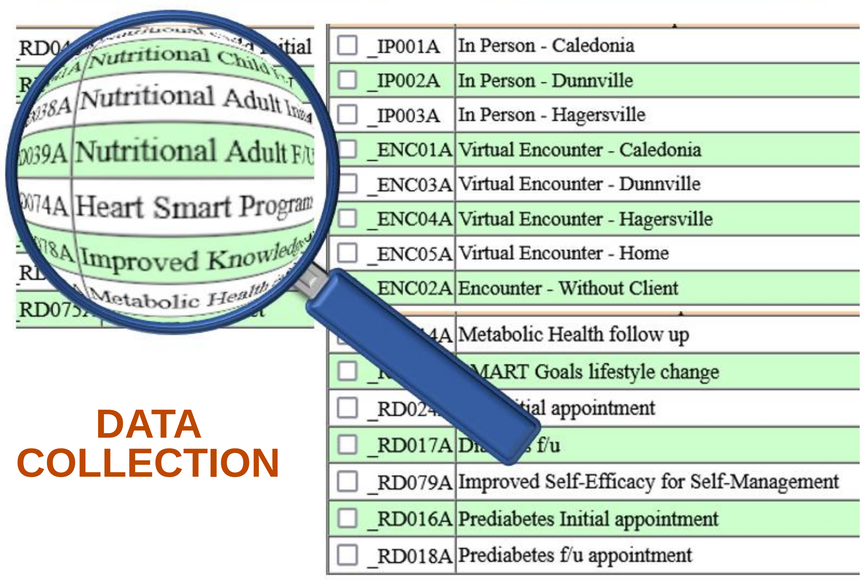
MEETINGS

- One-on-one with each IHP to better understand their typical appointments, roles in programs, and typical populations they serve.
- Reviewed Schedule A reporting requirements and measures and clearly defined target populations, numerators, and denominators for each program.

Example: Defined Numerator/Denominator for Schedule A Data Collection

Measure	Measure
% of PAP tests completed by IHPs	% of patients with improved self-efficacy for self-management
Numerator Number of PAP tests completed by IHPs	**Numerator** Number of patients reporting improved self efficacy
Denominator Number of PAP tests completed in the HFHT	**Denominator** Number of patients answering the survey question

DATA COLLECTION



- Billing code cheat sheets were created for each IHP role, showing the billing code, when to use and what program it was related to.
- The EMR was updated with false billing codes to be used at the end of each appointment as a means of tracking the details of IHP encounters.
- Clear communication on how and when to use specific billing codes and what was being measured.

PROGRESS & SUSTAINABILITY

- Implementation of quarterly meetings with IHPs to review measures, compare current and past performance data and discuss next steps for the direction of the program.
- Compilation of additional data (not required for Schedule A) to help improve team understanding of programs and populations they serve.
- Development of easy-to-read reports for staff and the Board to better illustrate program metrics and performance.
- Engagement of physicians in discussions regarding IHP workload in individual practices.
- Buy-in from IHPs has increased tremendously as they can see accurate data reflecting their clinical activities.

Example: ADHD Program Data Sheet

Type:	Chronic Disease Management
Staff involvement	As per submitted Schedule A: NP 0.3 FTE SW 0.3 FTE RN 0.2 FTE
Program Description	To provide increased access to ADHD assessment, diagnosis, treatment initiation, and follow-up care
Target Population	Any Haldimand Family Health Team patient with a differential diagnosis of potential ADHD or for assistance with management of patients already diagnosed with ADHD.
Target # of patients	130[1]
Goals	To improve quality of life for patients with a diagnosis of ADHD through assessment, medication management and referring to supportive services.
Objectives	1) Timely access to assessment of patients with a differential diagnosis of ADHD 2) To initiate and manage medications that aide in improved symptoms 3) To connect patients with supportive resources within the Haldimand Family Health Team or in the community 4) To improve quality of life in patients with ADHD through treatment and supports provided by the program
Program Activities	1. Initial assessment with NP to review medical history and screening scales 2. Routine follow up every 3-6 months or sooner if warranted. 3. Refer to community resources or other HFHT members 4. Assess quality of life at time of diagnosis and within 6 months of participation in the program. 5. CBT group education for adults with ADHD
Performance Measures	1) # patients referred to the adult ADHD program 2) % of patients who report improvement in quality of life upon completing the ADHD CBT group 3) % of patients who show improvement in their quality of life based on the components of the Sheehan Disability Scale 4) % of patients referred to community resources, specialists or other HFHT members 5) # patients who show improvement in at least 2 ADHD symptoms while participating in the program
Data Collection Method for Performance Measures	1. # of referral 2. # of patients who report improved QoL (ADHD group survey) # of returned surveys 3. AD021AImprovement in QoL AD024A: Baseline QoL done 4. AD022A: Referred to community resource # of patients seen in the quarter 5. AD025A

Targets	**1. 30**	**2. 75%**	**3. 75%**	**4. 10%**	**5. 85%**
Quarter					
Year to Date					

	Patients in quarter	**Appointments in quarter**	**Patients in target population**
Quarter			
Year to Date			

Other statistics	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
Initial appointments	38				
Follow up appointments	142				
Average number of follow ups	1.09				
New diagnosis of ADHD	20				
New medication starts	23				
Existing diagnosis of ADHD	7				
New diagnosis of GAD (Generalized Anxiety Disorder)	1				
Existing diagnosis of GAD	6				
New diagnosis of depression	1				
Existing diagnosis of depression	4				
New diagnosis of ODD	0				
Baseline QOL done	10				
Improvement in QOL	3				
# of Psychometric scales administered	64				
# of times Improvement in 2+ ADHD symptoms was reported	69				
# of Individual patients who reported improvement in 2+ ADHD symptoms	45				
# of patients referred to community resources	29				
# of patients discharged back to MD	13				
# of pediatric patients	13				
# of patients participated in February Group	9				
Average # of sessions attended	10.3				
# of surveys returned	6				
# of participants who reported increased QoL at end of group	6				

"The data provides the Board a clear understanding of the FHT program utilization and how it meet the needs of our client population"
Judy Santone - Board Member

"The introduction of the Program Sheets was such a great way to visualize the effectiveness and capacity of our programs. They provided a well-organized, concise, and easy to read summary of the details of each program and their outcome measures"
Kristina Zubrinic - NP

LESSONS LEARNED

- Understanding individual IHP activities is important in defining performance metrics.
- Training and re-training may be required to ensure consistency in data entry and collection.
- Providing reports in easy-to-understand formats better illustrates program metrics and performance for stakeholders.
- Scheduled data review meetings help identify gaps in care and refine IHP programs.

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