IND-007 SELECTING PRIMARY CARE PERFORMANCE INDICATORS: DATA QUALITY AND PERFORMANCE MEASUREMENT

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Objective:
The main study objective was to identify valid, concise, and feasible indicators that can be used to assess clinical and management performance in family practices with different organizational, geographic, and funding characteristics.

Methods:
In 2000 – 2001, a comprehensive literature review, and communication with international experts in primary care performance measurement, resulted in a list of 131 structure- and process-based performance indicators as well as evidence of the association between each indicator and patient outcomes. In a two-round Delphi consensus process, 12 clinicians rated each indicator according to its importance as a measure of performance in family practice. Consensus was reached on 84 indicators considered very important in performance assessment. Forty-eight indicators were selected for a pilot test in Ontario family practices which occurred in 2001 – 2003.

A convenience sample of ten family practices participated in the study and included group and solo practices; urban, suburban, rural, and northern settings; fee-for-service, capitation-based, and salaried practices; academic and community-based practices, and practices with paper-based and electronic medical records. Clinical performance data were collected through chart audit. Management performance data were collected through direct observation of the practices and a key informant questionnaire. Following data collection and analysis, workshops were held with each practice to report results and to discuss the use of performance indicators as quality improvement tools.

Results:
Indicators were identified for which data were completely and consistently recorded in most practices and which, therefore, could be used to measure performance. Legibility was poor in 15% of patient records. Documentation was a concern in 20% to 40% of patient records for indicators related to tobacco use, clinical breast examination, neonatal breast feeding, and antibiotic prescribing for sore throats, and in 50% of records for tobacco cessation advice and asthma education. The practice workshops helped to determine whether these indicators were poorly designed, or reflected poor performance in charting or office management, and highlighted areas for improvement. Workshop participants noted indicators for which there is an absence of evidence-based guidelines or existing guidelines conflict.

Conclusions:
This study focussed on the quality of office-based patient record data and the accurate measurement of performance using data collection instruments designed for the study. The results identified indicators that can be used with confidence to assess clinical and management performance in family practices, indicators that must be revised and re-tested before they can be used to assess performance, indicators that cannot be used because information is poorly documented in the patient record, and indicators that require further clarification regarding best practice. Participants responded very positively to the information provided in the workshops and discussed actions they could take to improve practice.

Indicator assessment and workshops provide an approach that can be applied within individual practices or across practices as part of ongoing monitoring and improvement activities. For some aspects of care, it is difficult for practices to determine acceptable performance in the absence of clearly stated evidence-based guidelines.

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