# 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 |