

# Quality key performance indicators for primary health care community-based services

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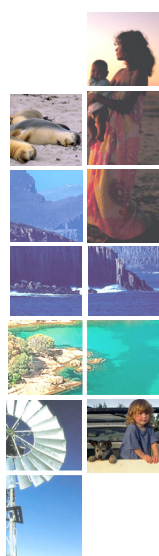
## INTRODUCTION

Community-based services within the Mid Western Area Health Service (MWAHS) Primary Health Care program identified gaps in the ability to measure quality and performance, particularly in relation to performance targets. For community-based services no key performance indicators had been developed for use specifically within a primary care framework. Differing facilities, disciplines and individuals were measuring service delivery in a multitude of ways. This confusion and the lack of data combined with competition from the acute setting for funding and a general inability of primary health care services to adequately define service outcomes often created difficulties for the service leaving primary health very vulnerable, especially at a time when there are significant budgetary constraints. The absence of performance indicators did not allow accurate bench marking against peer groups to occur. This then was the impetus for the community-based service managers to develop a set of quality key performance indicators for use within a primary care service model, which the paper outlines.

In 1996 Rural New South Wales underwent a further restructure of the then District Health Service to the current Area Health Service structure. This was the third restructure in a period of four years and as a result of this, in the Mid Western Area Health Service, community-based services at the local level came under the then new health service management structure. As a result, community-based services [community health centres] and acute care services [hospital inpatients and outpatients] are now managed by a local health service manager (HSM) in an endeavour to provide an integrated service. The larger community-based service teams have a community-based services manager responsible to the HSM whilst the smaller ones have a direct management line to the HSM. There are now seven community-based services managers and two team leaders. At the Area Health Service level, there is a manager of primary health care who is responsible for the strategic directions of the program.

At the time of the last restructure significant changes were happening within the acute care sector in relation to accountability for performance, and for the level and quality of services provided. This included localised budget management and reporting and improved clinical performance. Across NSW episode funding was being implemented with peer hospitals required to meet benchmarks.

“Measurement” took on a new meaning, and the data being collected – such as “available bed days” and “average length of stay” became much more closely scrutinised and other means of measuring performance and accountability were also being established. Data collection for the acute sector was and still is much more sophisticated than for community-based services. More importantly, it has given that



sector of the service a platform from which to enhance the development of quality improvement processes and the development of a sound set of quantitative data to substantiate funding and future enhancements.

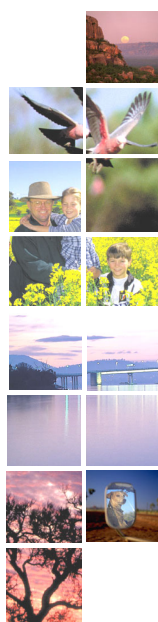
Participation in quality and accreditation processes by community-based services had been relatively high preceding the final restructure. Community health had been evaluated under a system that was geared for community-based services alone, and when closely examined it was felt it was not meeting current or future needs. At one point it was mooted that both the community-based and the acute system of accreditation may have to be utilised. This, was seen by the community health managers as untenable, both, from the staffs' perspective for the time required to participate in two systems, and also from a financial angle. Two systems would also not progress a continuum of care service model. The community health managers lobbied hard, for change and to be included with the acute sector who participate in the Australian Council of Healthcare Standards (ACHS) EQuIP framework. This has now successfully resulted in the inclusion of community-based services in the EQuIP process, which whilst not always applicable to community-based services has provided an opportunity to encourage a more integrated service to clients and patients, and, in actual fact lessen the age old syndrome of the "them and us".

The primary health team over the last year, had conducted a service mapping exercise in an effort to measure and provide equitable primary care services to the rural and regional communities served by the MWAHS.

The subsequent development by New South Wales Health of a "Framework for Managing the Quality of Health Services" which included requirements for accreditation and the formation of an Area Health Service Quality Council were detailed and directions for implementation outlined. The Area Quality Council ... "provides a means by which the quality of clinical care provided to consumers within that Area can be defined, measured, monitored, improved and reported to...." (A Framework for Managing the Quality of Health Services in New South Wales (1999) p33) The Area Health services are required to collect, report and act on specific minimum indicators. These were clearly defined for the acute care service, but not so for community-based services.

Community-based service managers and the management of primary health services within Mid Western Area Health Service [MWAHS] acknowledged there was a need for an integrated whole of service approach across the Area to ensure community-based services:

- has performance indicators developed by the Primary Care service managers and providers for use within primary care setting
- were in a position to effectively argue and challenge the need to continue current funding levels with a view to augmentation where necessary
- to ensure services were maintained at a level of service delivery that met the identified needs of the communities
- ensure services were delivered within an environment that supported best practice standards and outcomes



- are measured within a quality framework that gives a true reflection of the areas requiring improvement in community-based settings.

Combined with the changes a Strategic Planning process for the MWAHS Primary Health Care Program commenced in February 2000, where a joint Vision Statement was developed, with values to underpin the philosophy of a Mission Statement.

#### **Mission Statement**

To work in partnership, to promote, maintain and improve the health and well-being of the community.

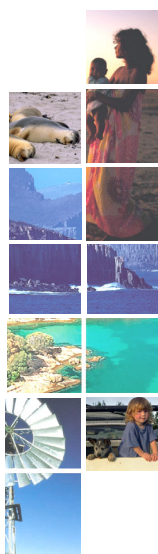
#### **Values**

- Accountability
- Commitment
- Collaboration
- Social Justice
- Empowerment
- Respect
- Excellence
- Justice
- Integrity

The strategic planning process identified areas that primary health care services needed to develop, enhance and establish clear directions for the future. This process resulted in the development of the MWAHS Framework for Primary Health Care 2002–2005. During this process it was determined that with some urgency some measurable key performance indicators (KPIs) must be developed by primary health care managers and service providers. If this did not occur it was becoming apparent that inappropriate indicators could be “inflicted” on Primary Care. This could have been either the imposition of inappropriate, acute service indicators or the development of indicators not in line with the current primary health thinking and philosophy and the Framework document.

## **PROCESS**

A working party drawn from the community health managers was formed and a search for a clear meaning of the term “performance indicator” commenced. It was soon realised this was ill defined, particularly for primary health care and that the task would not be easy, but would be a challenge to understand and to develop workable indicators. It was a concept with which none of the working party was very familiar. Community-based services had primarily focused on measuring (which really only meant evaluating) for example, the success of a health promotion program, or a community development project. This had allowed us to comfortably sit back and not get too impassioned about measuring the long-term affects of such initiatives, as they were “long-term” and years before the real effect may be seen.



The agreed interpretation utilised is:

Performance indicators are statistics or other units of information which reflects, directly or indirectly, the extent to which an anticipated outcome is achieved, or the quality of processes leading to that outcome. (Health Outcome Performance Indicators (HOPIs): Monitoring Health Improvement. NSW Health Department 1998, p3.)

It became apparent that identification of statistical data would allow an improvement in current quality processes, measure real outcomes *today* thus allowing the community-based services to effectively argue the need for sustaining, and where appropriate enhancing services.

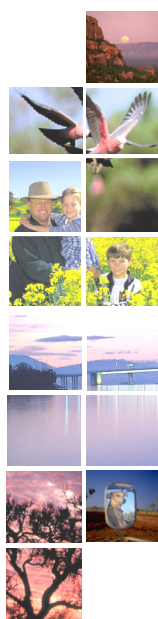
In commencing to develop a tool it was evident that a framework was required within which to build indicators. Firstly, Community health practice, as a component of primary health care, is underpinned and informed by the values and principles espoused in the Alma Ata Declaration on Primary Health Care (WHO, 1978), and the Ottawa Charter for Health Promotion (WHO, 1986). In summary these are:

- recognition of the broad social, economic and environmental determinants of health and illness
- the importance of health promotion and disease prevention
- the importance of community participation in decision making
- the importance of working with a variety of sectors outside of health
- seeing equity as an important outcome of health service intervention.

The indicator framework also needed to reflect those primary care principles, in addition to the existing quality and accreditation processes and meet the Area Health Service reporting requirements whilst initially not being too daunting or onerous for community-based staff. It was important to the community-based managers that primary care principles be maintained particularly within the new management structure and that the culture and philosophy of primary health care be embedded within that new structure. It also was essential that these community health indicators fitted into a framework which reflected all aspects of integrated health care. The framework needed to foster enhancement of current practice, it needed to be flexible to support continual development and change in practice, and it needed to promote partnership elements of service delivery with other key internal and external service providers.

The framework outlined in the NSW Department of Health document "A Framework for Managing the Quality of Health Services in NSW" (1999) was utilised. This framework used six dimensions of Quality, which are:

- Effectiveness
- Appropriateness
- Safety
- Consumer Participation
- Access
- Efficiency.



Key performance indicators were developed utilising the dimensions of quality, which in turn became a quality activity. Planning and consultation processes were major elements, which enabled individual clinicians, groups of service providers, as well as management and the Area Executive to have input into the development of the indicators.

## DEVELOPMENT OF THE KEY PERFORMANCE INDICATORS

Information was gathered from various sources to determine what was already available in the guise of community-based service performance indicators. There was very little information available, and like the MWAHS many other Area Health Services were at a similar developmental stage. Particular acknowledgment is given to S. Torr, Associate Director – Community Development, South East Health, who provided us with information from the unpublished document “Recommended Phase 1, Quality Indicators – Community Health, September 2001 *draft*”

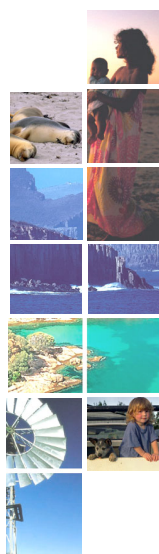
The framework identifies the development of quality health care indicators as a three-phase process to develop and refine measures of the quality of care in New South Wales. Phase 1 deals with indicators developed from data that currently exists in New South Wales’s databases. Phase 2 involves refining information that is available in the New South Wales databases but is not yet in a form suitable as a quality of health care indicator. Phase 3 will involve developing new indicators and Data Collections.

This same quality framework document also identifies there five cross-dimensional issues related to the quality of health care:

- competence of providers, multi-disciplinary teams and health care organisations
- continuity of care
- information management to support effective decision making
- education and training for quality
- accreditation of health services.

With the “three phase process” and the above cross-dimensional issues in mind, the MWAHS Primary Care Services have progressed to develop the following initial performance indicators. This will enable an Area wide planned approach to the collection of data and quality improvement thus facilitating reporting mechanisms and the ability to examine, utilise and benchmark against peer health services.

Some examples of the indicators developed are as follows.



## 1 APPROPRIATENESS

### 1.1 Clinical pathways or flow paths in use

#### *Objective*

To determine the percentage of clients that have an established/accepted clinical pathway being used in clinical practice.

#### *Rationale*

Clinical pathways are developed using the best available evidence and therefore should result in better outcomes for the clients.

#### *Numerator*

Number of clinical pathways being used in clinical practice within community-based services during the period of study.

#### *Denominator*

Total number of clinical pathways available in the Area during the period of study.

### 1.2 Clinical pathways in place for all identified Department of Veterans' Affairs clients

#### *Objective*

To determine the percentage of Department of Veteran Affairs clients that have an established/accepted clinical pathway being used in clinical practice.

#### *Rationale*

Clinical pathways are developed using the best available evidence and therefore should result in better outcomes for the clients.

#### *Numerator*

Number of clinical pathways being used for all identified DVA clients in clinical practice within community-based services during the period of study.

#### *Denominator*

Total number of clinical pathways available to DVA clients during the period of study.

### 2.1 Achievement of desired/agreed outcome at discharge

#### *Objective*

To determine the percentage of discharged clients with an achieved plan, desired outcome or agreed finishing point.

#### *Rationale*

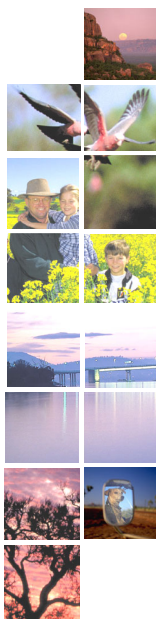
Achieving an identified plan of care is a measure of service provider efficiency and effectiveness.

#### *Numerator*

Number of clients discharged by a service that had an achieved plan that reached the desired outcome or agreed finishing point.

#### *Denominator*

Number of clients discharged by a service in a defined period of time.



### 3. ACCESS

#### 3.1 Maintaining equitable, population-based resource distribution across all service-mapping levels

##### *Objective*

To ensure all MWAHS communities (regardless of size) have equitable resource distribution and access to primary care and clinical support services.

##### *Rationale*

By utilising a weighted, population-based resource formula; communities/individuals have fairer access to primary care and clinical support services.

##### *Numerator 3.1*

The number of positions filled as per the agreed to population: service provider ratios for each mapping level during the defined period.

##### *Denominator 3.1*

Actual/current population: service provider ratios as identified by the MWAHS “Equity of Access for Rural Health Services – Community-Based Service Mapping” document. (2001)

#### 3.2 Timely filling of vacancies

##### *Objective:*

To ensure all MWAHS communities (regardless of size) have equitable resource distribution and access to primary care and clinical support services.

##### *Rationale*

By utilising a weighted, population-based resource formula; communities/individuals have fairer access to primary care and clinical support services.

##### *Numerator 3.2*

Number of vacancies filled and recruitments completed within 2 months of incumbent vacating position.

##### *Denominator 3.2*

Total number of recruitments within a defined period of time.

#### 3.3 Referral response timeliness for clients with urgent needs

##### *Objective*

To determine the percentage of referred clients contacted/appointment made or assessed by a community health professional following referral, within 24 hours if triaged as “urgent”.

##### *Rationale*

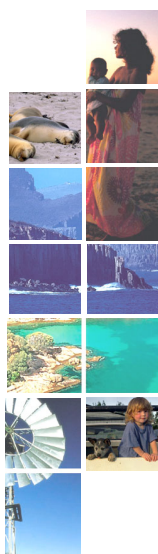
Response times/waiting times are important indicators of timely access to services.

##### *Numerator*

The number of referred clients that have an identified urgent need and have been contacted for an appointment or referral within 24 hours of referral during a defined period of time.

##### *Denominator*

Total number of referred clients that have an identified urgent need during a defined period of time.



## 4. EFFICIENCY

### 4.1 Monitoring of clients who fail to attend

### 4.2 Monitoring of clients who fail to attend with reason for non-attendance

#### *Objectives*

- To reduce the number of clients who fail to attend.
- Monitor why clients have failed to attend.
- To ensure timely ongoing care and support is offered to clients who fail to attend (if required).
- To bring an “episode of care” to a close for clients who do not require further ongoing care.

#### *Rationale*

- Reducing the number of clients who “fail to attend” makes it easier for clinicians to plan their schedules and manage their caseloads.
- Reducing the number of clients who fail to attend increases the time available for other clients/activities.
- Timely discharge/case closure for clients who have no intention of/need for further care, assists case load management.
- Knowing why clients fail to attend may provide opportunities to change the way business is done for certain target groups who find it difficult to access health care (for what ever reason).
- Re-engaging clients/families by diligent follow up may enable needed care to be offered and client outcomes to be improved.

#### *Numerator 4.1*

Number of clients for each service who “fail to attend” over a defined reporting period.

#### *Denominator 4.1*

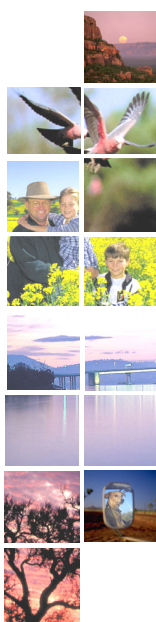
Total number of clients who have appointments for each service in a defined reporting period.

#### *Numerator 4.2*

Number of clients who fail to attend who contact clinician with reason for non-attendance.

#### *Denominator 4.2*

Total number of clients who fail to attend in the defined reporting period.



## 6. CONSUMER PARTICIPATION

### 6.1 Consumer/community participation on local health service committees—relevant to community-based services

#### *Objective*

To ensure consumers and communities participate on committees where it is desirable to gain consumer/community input in the planning, implementation and evaluation of service development.

#### *Rationale*

The World Health Organisation [WHO, Ottawa Charter 1998] recognises the involvement of communities in determining health priorities as an essential ingredient to improving the health of people.

#### *Numerator*

The number of local health service committees relevant to community-based services that have a consumer/community representative as a committee member in a defined period.

#### *Denominator*

The number of local health service committees identified as requiring/benefiting a consumer/community representative on the committee in a defined period.

### 6.2 Partnerships exist to facilitate community participation and enhance capacity—building

#### *Objective*

To ensure all community health services and the MWAHS Primary Care program identify opportunities to create partnerships, at a local, Area and/or State level. This will enable supportive frameworks to be established to provide communities with a platform on which to embark upon community participation and capacity-building endeavours.

#### *Rationale*

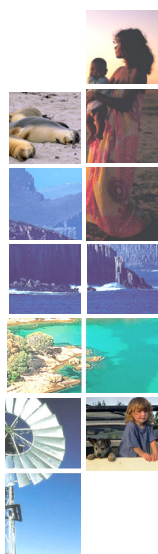
The development of partnerships is an identified means of intersectional collaboration, which through its existence may facilitate the improvement of individual and community health.

#### *Numerator*

Number of partnerships existing to facilitate implementation of Annual Plan strategies and achievement of goals.

#### *Denominator*

Number of partnerships identified as required to facilitate achievement of the Annual Plan in a defined period of time.



## IMPLEMENTATION AND EVALUATION

The implementation process has been staged to increase the probability of success in establishing competent, user-friendly data collection systems. One to two indicators from each dimension were initially selected for all community health facilities to commence collecting and reporting data. Most large facilities began collecting in July 2002, with some of the smaller sites commencing Jan 2003. As sites came on board with collecting the data, they began reporting data in a format that was developed for the implementation of the indicators. This report goes to the MWAHS Quality Council on a monthly basis and is collated as part of the report to the MWAHS Board. A full evaluation of the process will be conducted prior to the implementation of collecting data for more indicators. Evaluation will need to include:

- *Examination of all data collection systems in place.* For example are they working, are staff complying, do staff have a full understanding of the correct methods of collecting etc? This will give an insight into what needs to be improved prior to utilising the data for benchmarking purposes.
- *Review what has been done with the data recorded/reported on.* For example, have quality improvement process been put into action to improve services, service delivery, client outcomes, etc.

Evaluation of this aspect will indicate if staff are collecting data for collection purposes only, which may reveal the indicator is not as reflective of current practice as initially believed. It is important to ensure staff will utilise the indicators to benefit daily practice, and at the same time the indicators augment requirements for accreditation and funding purposes.

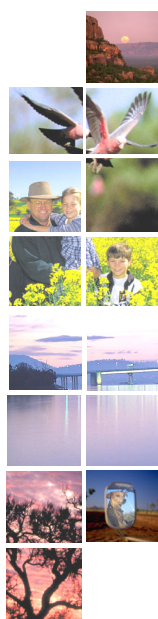
## THE FUTURE

This is but the beginning and is very much a work in progress. There is no doubt that performance indicators such as these will be the foundation for appropriate indicators that will measure the **quality** and **success** of service delivery. Since the development of the KPIs, and an Equity of Access project (Service Mapping for MWAHS), a Service Agreement for visiting services has been developed and implemented and a number of areas for policy development have been identified.

Mid Western Area Health Service is committed to implementing “evidenced-based practice” and “continuous quality improvement” and now will have appropriate information to inform and more accurately be able to analyse and to evaluate service delivery.

It is often not acknowledged that an episode of care within a community health setting may be very different to one in an acute care facility. However, in time it is anticipated that primary health care occasions service will be measured just as effectively as are the acute services.

Recognition of similarities and differences for service provision and the need for community-based services to come in line with the acute setting in the development of appropriate, practical performance indicators has been an achievement for the Primary



Health Program. The ability to develop indicators in consultation with service providers gives a level of ownership and commitment to participation in the process.

It is inevitable that we will need to find the happy medium between meeting the needs of clients by providing services that are continually improved through quality processes and at the same time be adequately positioned to competently argue our case for equitable funding distribution.

## REFERENCES

A Framework for managing the quality of Health Services, NSW Department of Health (2002)

Equity of Access, Service Mapping Document, Mid Western Area Health Service, (2002)

