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Conference Abstract

Impact indicators in chronicity to meet the Triple Aim: a balance scorecard.

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Abstract

Introduction: The strategy of care for patients with chronic diseases in the Community of Madrid is specified in a strategic framework model representing the set of elements that the community will develop in the coming years. In order to implement the strategy, nine execution lines are already working in parallel with their respective projects and milestones. The last but not the least execution line comprises the continuous evaluation of impact indicators related to chronicity.
Madrid's Health Service has already developed and implemented a balance scorecard for primary care professionals that offer homogeneous and agreed indicators which are critical for sharing information among the various levels of decision making in the organization, facilitate coordination and tracking of targets. This dashboard is accessible to all professionals through an application called e-SOAP (Tracking Objectives Primary Care) which is accessed through the organization intranet.

In order to evaluate the overall impact of the strategy there was a need to primary select a set of indicators from the ones already included in our dashboard that could let us monitor the evolution in terms of health impact of the strategy implementation measured through a triple vision: health outcomes, service utilization and satisfaction and quality of life of patients and caregivers.

Short description of practice change implemented: A multidisciplinary team was established to work on the identification and prioritization of the measures that should be closely monitored as well as on the development of a strategic roadmap according to the Institute for Healthcare Improvement (IHI) Triple Aim.

A set of 68 indicators were selected from the 534 indicators already included in the balance scorecard because of their relation to chronicity and because they could perfectly fit in one of the three main dimensions of the IHI Triple Aim: population health (44 measures), experience of care (16 measures) and per capita cost (8 measures).

Aim and theory of change: The aim of the project was to develop a minimum set of indicators for evaluation and tracking the care of patients with chronic diseases, agreed with professionals, using the dimensions of the IHI Triple Aim.

Targeted population and stakeholders: The target population comprises the population attached to the primary care centres, a total of 6,381,027 patients.

All health professionals and managers belonging to the General Directorate of Primary Health Care as well as other departments of the Ministry of Health that generate information to feed the corporate database and / or may require this information for decision making have access to eSOAP. 9,455 professionals are nowadays active users and 7,448 consulted the application during the last year at least once.

Timeline: The duration proposed for this project is three years.

Highlights: Since March 2014, when the Strategy started its dissemination, the number of reports generated by health professionals related to chronicity measures were the greatest among the overall set of reports: 45,865 reports on disease burden and behavioral and physiological factors measurements; 16,845 reports on effectiveness and individualized nurse care plans at the patient level and 10,760 reports on intermediate health results and security of patient as aggregated data. Many of the measures related to chronicity have improved during the past year such as: promotion of healthy habits in childhood, early detection of problems in childhood, influenza vaccination, adult vaccination, promoting healthy lifestyles in adults, attention to adults with obesity, ischemic heart disease, asthma, consumption of cigarettes, alcohol abuse, prevention for the elderly, immobilized patient domiciliary care, palliative care, nurse care plans for patients over 65 years, fragile patients and immobilized patients, nurse care plans for patients with cardiovascular disease, hypertensive and diabetic patient control, hypercholesterolemia in ischemic heart disease patients, antiplatelet therapy and statins in patients with ischemic heart disease and adequacy of treatment in patients with diabetic nephropathy.

Comments on sustainability: There are currently 15 sources or data sources that feed information to the database being the patient electronic medical record one of the main sources.

Comments on transferability: Sharing our experience will contribute to systematizing assessment models and promote the development of accessible dashboards to all professionals to foster the management and improvement of the results of their interventions specially focusing on chronic patients.

Discussions: Analyze and monitor the magnitude and trends of inequalities in health and its social determinants, by adapting information systems available and disaggregating by geographical area in order to plan interventions to reduce them.

Lessons learned: Health innovation includes not only technological innovation but also organizational innovation and innovation in services, and should be understood as a process of continuous improvement of responsiveness to the needs of the public and professionals.

Keywords

chronic disease; comorbidity; scorecard; healthcare quality assessment

PowerPoint presentation

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