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CONFERENCE ABSTRACT

Design of a map of chronicity indicators according Triple Aim

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Introduction: Madrid is undergoing an interesting time of transformation of care model and the engine that promotes this change is the Strategy for the Care of Patients with Chronic Diseases. One of the main projects arising from the Strategy which is the development of a map of indicators for addressing chronic disease in the Madrid Region.

Methods: A working group involving experts on indicators with decision-making capacity was established. A set of indicators from the ones already included in our organization dashboard were identified selected, prioritized and classified within the framework of the Triple Aim: population health, patient experience with care and costs.

Once the matrix was constructed, sources of indicators were identified. A total of 9 different data sources were used: primary care electronic health record (AP Madrid), scorecard for primary care (eSOAP), Hospital Minimum Basic Data Set (CMBD), Information System of Public Health and Food (SISPAL), Cibeles (basic information needed to identify Madrid health organization), System Risk Factor Surveillance for Non Communicable Diseases associated with adult and youngsters (SIVFRENT A and J), Health Education Database (EpSalud), Madrid Satisfaction Survey and drug prescription information (F@rmadrid).

Extraction and presentation of data was normalized and the values achieved for each of the indicators in 2012, 2013 and 2014, depending on the availability of the information obtained.

Results: 118 indicators were identified: 71 about population health, 13 about patient experience with care and 34 related to costs.

After prioritization by relevance, 82 indicators were finally selected: 73 about population health, 5 about patient experience with the care received and 4 with costs related to pharmaceutical expenditure (Table 1). We think it is a quite wide data set to start with.

Besides classifying the indicators according to the Triple Aim, 16 different Classes of indicators were identified as display contents for every block.

Each Class is summarized by a Class Index, a value that represents all of the indicators included within the Class. In five cases the Class Index represents the most relevant indicator of the group: Patients classified in the High Level of Risk, Patients with Cardiovascular Disease and

Care Plans, Hypertensive Patients with Blood Pressure values under control, Global Satisfaction with Care and Pharmaceutical Expenditure on Chronic Medication. In the remaining, the Class Index represents a global indicator comprising the most relevant chronic diseases included in each Class or it is an aggregated indicator that already exists in the organization (such as for disability and mortality in non-communicable diseases).

Different number of indicators based on the feasibility and relevance were included in each of the Classes. The range goes from 1 indicator for Group Health Education (Programs) to 14 indicators within the Class of Chronic Diseases Programs Coverage.

For each Class, the Class Index and indicators were plotted. show the 2013 – 2014 trace.

Finally, using some selected indicators and based on the Classes defined, some processes of selected chronic diseases were designed transversally. This gives us a picture of the process considering the prevalence, the related major risks factors including preventing activities and programs, intermediate health outcomes and admissions.

The first report on indicators in chronicity has just been published, which today is available on the Intranet.

Conclusion: The purpose of this project was not only to create a tool that would allow the organization to address outcomes with a focus on chronic diseases for the Madrid Region, but also to provide to all professionals a set of indicators that can be used to evaluate the results of the different projects that are being locally implemented as part of the cultural change promoted by the Strategy for the Care of Patients with Chronic Diseases.

Although we still have a long way to go, we have taken an important step forward to have a tool that allows us to put the focus on the outcomes of our population.

We are working on developing a tool to advance in the measurement of patient experience with the health professionals and with the health system.

As well, there is a need to introduce the measurement of quality of life as an outcome to monitor the effectiveness of our interventions as well as more indicators related with social care

The map of indicators for addressing chronic disease in the Madrid Region will allow us to periodically evaluate and improve our final outcomes to further advance in the transformation of our Health and Social Systems.

Keywords: triple aim; chronic diseases; indicators; population health; patient experience; cost