





The Excellent Care for All Act (ECFA Act) sets the foundation for improving the quality of care. This is important not just because it means better quality of care, but also better value for the money we spend. In the long run, high-quality care costs the system less.

The ECFA Act also supports the notion that we must use the best available evidence to guide our decisions about what to fund and what not to fund. We will increasingly rely on research and evidence because we simply must put our precious healthcare dollars where they will deliver the most effective care for patients.

As we implement The Action Plan for Healthy Change, we're moving forward on better integration of care, particularly for those patients who have complex health needs. It is just too hard on patients, and too expensive for the system, to have people navigate their way through multiple specialists and other healthcare providers. High-quality care for patients includes the notion that the healthcare system is designed for them and responsive to their needs, that their care is managed by someone who can ensure they are getting the right care, the right tests and the right drugs from the right providers.

We are also committed to accountability and transparency. We have learned that measuring results - and publicly posting

those results - drives positive change. After all, Ontario's healthcare system is there for Ontarians, and paid for by Ontarians. We have a responsibility to show them where their money is going, and what results they're getting!

I am enormously encouraged by the strides that we are already making to improve the quality of care Ontario patients are receiving. While we have much work ahead of us, Ontario's healthcare leaders are moving decisively and confidently in the right direction. As Ontario's minister of health and long-term care, I thank you for leading the way.

Sincerely,

Deb Matthews

Deb Matthews Minister of Health and Long-Term Care

Toward Performance and Quality

1 Letter from the Minister Deb Matthews

TOWARDS PERFORMANCE AND QUALITY

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Adalsteinn Brown, G. Ross Baker, Tom Closson and Terrence Sullivan

Over the past three decades, Ontario has developed a number of strong efforts to promote better quality and cost in healthcare. Starting with the establishment of the CQI Network, Ontario has progressively produced internationally admired efforts in cardiac surgery wait times reporting, hospital performance reporting, cancer system improvement, safety measurement and improvement, access and safety reporting, and now the Excellent Care for All Act (EFCA Act). All these efforts involve similar elements: creating goals for improvement, reporting against progress, and attempting to engage both clinical and managerial elements in the system. In this paper, Brown and colleagues describe the extent to which consistent themes across these improvement efforts have helped build a culture of quality improvement in Ontario and discuss whether the combination of these efforts will build a sustainable platform for quality improvement.

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In this paper, a team from the Ministry of Health and Long-Term Care, the Ontario Hospital Association and Health Quality Ontario describe a collaborative process that helped a number of organizations prepare their quality improvement plans, a key requirement under the Excellent Care for All Act. They report that the majority of hospitals found the resulting guidance helpful and contrast some of the successes and failures from the first year's plans. A key element across this review is the importance of focus, whether through targets or benchmarks, and prioritization across the range of potential improvement projects.

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Carol Sawka, Jillian Ross, John Srigley and Jonathan Irish In this paper, authors from Cancer Care Ontario review the agency's efforts to engage clinicians in leadership on quality improvement across the cancer system. This paper, and subsequent ones on clinician engagement, calls to attention one of the missing elements in the Excellent Care for All Act. which focuses on institutions, not providers. The authors describe a range of models for engagement and some of the positive results associated with engagement.

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G. Ross Baker and Anu MacIntosh-Murray

In this paper, Baker and MacIntosh-Murray describe the results of interviews with leading hospitals in Ontario following implementation of the Excellent Care for All Act. In keeping with an earlier paper describing a positive impact and increased profile for quality improvement across Ontario hospitals, this article describes some of the limitations that a provincial strategy can place on leading organizations that had already adopted many of the practices prescribed in the EFCA Act. The authors point to a fundamental challenge in systemwide improvement efforts: how to improve the mean while supporting the best performers.

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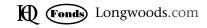
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The Journey toward High Performance and Excellent Quality

Adalsteinn Brown, G. Ross Baker, Tom Closson and Terrence Sullivan

Abstract

Signalling the importance of healthcare quality and quality improvement plans in Ontario, the province's Excellent Care for all act requires all hospitals to publish quality improvement plans, conduct regular patient and staff surveys, and forge a clear link between hospital CEO compensation and quality improvement. The act also clarifies and strengthens links between evidence and quality of care.

The act is an important step toward Ontario's becoming a high-performing healthcare system. Yet as some of the papers in this special issue of Healthcare Quarterly discuss, there remains much to be done. Other papers and interviews draw attention to the importance of strategic and system design levers - particularly setting goals, public reporting of results and clinician engagement - to stimulating improvement. Yet other papers present a diverse range of perspectives and ideas on how to pursue improvement and to bridge the knowing-doing gap in healthcare so that evidence informs better practice. Achieving and sustaining high performance in healthcare will require dedicated effort by everyone in every healthcare organization. With a view to the future, the act allows for the expansion of the quality obligations initially applicable to hospitals to other publicly funded health organizations.

ust over two years ago, the Legislative Assembly of Ontario voted unanimously in favour of the Excellent Care for All Act (Legislative Assembly of Ontario 2010). The act signals the importance of quality and quality improvement across hospitals by requiring quality improvement plans, regular patient and staff surveying, and a clear link between hospital CEO compensation and quality improvement. The act also makes clearer and stronger links between evidence and

quality of care. Perhaps most notably, the act enjoyed wide support across the healthcare system, and its provisions can be extended beyond hospitals through regulation.

... improvement methods have

expanded to include the breakthrough collaborative approach developed by the ... IHI ... as well as the application of Lean and Six Sigma techniques.

The act is not a dramatic departure from previous policies but rather an incremental and inclusive step from earlier efforts to improve quality across Canada. Starting in the early 1980s, a number of academics, policy makers and practitioners worked to advance continuous quality improvement across healthcare organizations. The creation of the 3M Health Care Quality Team Awards, the development of the Ontario Continuous Quality Improver Network (now the Quality Healthcare Network) and the publication of a number of papers, reports and case studies on quality improvement in Canada are some legacies of an era focused on increasing capacity for improvement and the evolution of a quality culture. More recently, improvement methods have expanded to include the breakthrough collaborative approach developed by the Institute for Healthcare Improvement (IHI) in the United States as well as the application of Lean and Six Sigma techniques.

By the 1990s, a growing body of reports from the University of Manitoba Centre for Health Policy, the Institute for Clinical Evaluative Sciences in Ontario, the University of British Columbia Centre for Health Services and Policy Research, and a range of hospital report cards in Ontario and elsewhere shifted attention to accountability for quality and introduced benchmarking, ranking and other types of comparisons to the quality improvement landscape. The emergence of quality councils in a number of provinces (Dobrow et al. 2006), the establishment of the Health Council of Canada, and a greatly expanded range of performance reports from the Canadian Institute for Health Information facilitated the acceptance of performance reporting as an important element of quality improvement efforts in Canada.

By the early 2000s, a number of papers – most notably the Baker–Norton study on adverse events in Canada (Baker et al. 2004) – helped make the case for change and stimulated widespread efforts to improve the quality and safety of healthcare across Canada. These critical efforts, along with an increased recognition of the importance of governance, have added momentum and focused accountability for improvement in quality and safety. Seen against this historical backdrop, the ECFA Act represents a continuation and a synthesis of efforts to improve quality of care.

... a **key first** step is the articulation of expectations.

Although the act represents an important step forward, it is not the final stop on the journey toward a high-quality health system, let alone a high-performing health system. As the papers in this issue illustrate, there remain a number of important steps yet to be taken in Ontario. Studies of high-performing health-care systems, including the Quality by Design study (Baker et al. 2008) and work by American (Lukas et al. 2007) and British (Bate et al. 2008) scholars, have emphasized a number of key factors contributing to improved and sustained performance. Some of these factors find reflection in the papers and interviews that follow. This sort of consistency underlines the critical importance of how healthcare institutions are structured and how they organize and maintain a focus on improvement.

However, the papers and interviews in this issue also draw attention to the importance of some strategic and system design levers to stimulating improvement. Three of these levers – goals, reporting and clinician engagement – deserve some attention. The first lever is some form of publicly communicated commitment to improved quality. This commitment can include benchmarks, targets and other aspirational descriptions of better quality. None of the systems referenced explicitly or implicitly throughout this special issue of *Healthcare Quarterly* have begun the quality journey without some form of commitment. The key element seems to be recognition of the importance of improvement and a clear and compelling vision and goal. At their best, these commitments establish a clear and

explicit strategy, and make strong linkages between quality improvement initiatives and this strategy, establishing clear accountability for strategy execution (Baker et al. 2008). The IHI's 100,000 Lives Campaign provides a very clear example of the successful use of goal statements, coupled with a tactical approach to implementation to improve healthcare (Berwick et al. 2006). Although there is some debate about the magnitude of its final outcome, it is clear that over an 18-month period ending in 2006, the IHI campaign helped disseminate evidence of effective practices, mobilized improvement efforts across the United States and stimulated similar campaigns in Canada, Denmark, the United Kingdom and elsewhere. The more recent Triple Aim campaign can be seen in the same vein, although it has a broader set of aspirations.

... data suggest that public reporting of results can be a powerful tool for motivating change, establishing accountabilities and creating transparency.

In this special issue of Healthcare Quarterly, Cancer Care Ontario and the Cancer Quality Council of Ontario provide examples of the importance of goals. Cancer Care Ontario's first three-year Ontario Cancer Plan established a comprehensive strategy and goals for improvement. These efforts have been followed up with annual updates that publicly report progress toward measurable targets for each stated goal (Duvalko et al. 2009). The importance of a commitment to quality and improvement finds clear reflection in the interviews with Richard Ernst and Joe Mapa about how to make measurable improvements in the patient experience. In her paper on what makes care patient-centred, Barbara Balik (2012) references the Triple Aim goals and makes it clear that a key first step is the articulation of expectations. Speaking to the importance of conversations at all levels of an organization to move toward partnerships with patients, she states: "Facilitated conversations can reveal what all participants expect and what behaviours are needed to transition to partnerships."

The second element is effective performance reporting. Although typically drawn from observational studies, data suggest that public reporting of results can be a powerful tool for motivating change, establishing accountabilities and creating transparency. Done well, public reporting can draw the attention of clinicians to areas of deficiencies and motivate positive change. For example, reporting of cardiac surgery outcomes in New York State and California prompted surgeons to rethink how they care for certain groups of patients, particularly those who are at high risk (Hannan et al. 1994; Harlan 2000). Likewise, British performance results improved only in England, where

results were reported publicly; they did not improve in Scotland, where they were reported privately (i.e., back to each institution individually); or in Wales, where they were not reported at all (Alvarez-Rosete et al. 2005). In Canada, a cardiac report card by the Institute for Clinical Evaluative Sciences for treatment of patients who had suffered a heart attack prompted over half of clinicians surveyed to launch one or more quality initiatives at their hospital (Tu and Cameron 2003). Public reporting has also been shown to motivate healthcare administrators to make necessary changes to improve care. Examples of administrative responses to publicly reported information include improvements in recruitment practices and performance monitoring, and increased investments in quality improvement (Bentley and Nash 1998).

It is often unclear whether the improvements stimulated by public reporting stem from the effect of competition on patient decision making or concerns over reputational damage on staff decision making. A recent study, however, highlights the importance of a simple and much more complementary driver: a staff culture oriented toward improvement. Veillard and colleagues (2012) show that private reporting of results - strongly linked to evidence-based guidelines and a theory of improvement - were also associated with increased quality improvement activity. Thus, it is reporting that captures attention that matters, perhaps because it is public or it is useful to clinicians and managers. This sort of reporting may touch on the intrinsic incentives faced by providers and managers, their desire to do right by their patients and the growing recognition of how evidence, including performance data, shapes providers' and managers' decisions. Once again, each of the systems referenced in this report have some form of public performance reporting. Perhaps, not surprisingly, in their survey of what other jurisdictions have done around quality legislation, Veillard and colleagues (2012) note that performance reporting is a common element of these laws.

The third element contributing to better quality is strong clinician leadership for improvement efforts that are aligned to meet improvement goals.

The third element necessary to better quality is strong clinician leadership for improvement efforts that are aligned to meet improvement goals. Strong clinical governance has been demonstrated as an important ingredient for continuously improving the quality of patient care (Scally and Donaldson 1998). The importance of clinical governance has been highlighted in the United Kingdom's National Health System reform (Scally and Donaldson 1998; Halligan and Donaldson 2001). Plans for improvement must be owned and understood by the chief



decision makers in patient care. This requires creating teams of physicians (and other clinicians) engaged in patient care that can design and champion improvement plans. A number of papers and interviews draw out the importance of clinician engagement at every step of the improvement journey, starting with the articulation of shared goals. In their interviews, both Levinson and Flemons speak to the importance of a genuine supported engagement with physicians and the potential for strong clinical leadership on quality improvement. Papers by Sawka and colleagues (2012) on Cancer Care Ontario and by Cochrane and colleagues on British Columbia point to the necessary, but not sufficient, role of structures for engaging physicians in the quality journey.

Despite these common themes, the papers in this special issue also present a diverse range of perspectives and ideas on how to pursue improvement and to bridge the knowing-doing gap in healthcare so that evidence informs better practice. Waldner's paper (2012) on hospital design is one novel reflection of this trend, but most of the papers and interviews touch one way or another on the importance of increasing the use of evidence. For example, Laupacis and Born (2012) discuss the potential of engagement to shape and monitor improvement goals; the papers on the Ontario quality improvement plans, the BC General Practice Services Committee and the Saskatchewan Health Quality Council talk to the importance of effective co-creation between policy makers and providers of the strategies, tools and tactics to improve quality.

The paper by Kutty, Ladak, Paul and Orchard (2012) notes that most hospitals found that preparing the quality improvement plans required under the *Excellent Care for All Act* was a positive experience and helpful in terms of promoting quality. But Baker and MacIntosh-Murray (2012) report that some leading institutions found the increased requirements limiting and at times detrimental to their quality improvement efforts. This finding highlights the challenge that any systemic approach faces. New initiatives need to motivate and assist low performers while facilitating continued progress for organizations at more advanced stages of their quality improvement journey.

This last point – that different organizations perform variably and need different tools at various points in moving toward high performance and excellent quality – highlights the importance of capacity building. The Excellent Care for All Act, and many other strategies across Canada, have emphasized stronger accountability and an increased focus on quality. In the novel Shoeless Joe, later adapted into the film Field of Dreams, W.P. Kinsella imagines a fantasy world where building a baseball diamond in an Iowa cornfield is sufficient to lure famous baseball players to emerge. However, securing high performance in healthcare will require dedicated and sustained efforts by every healthcare organization to develop the capacity for improvement, engaging clinicians, managers and leaders across the system. Happily, the ECFA Act allows for the expansion of the quality obligations initially applicable to hospitals to other publicly funded health organizations. HQ

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Patient-and Family-Centredness: Growing a Sustainable Culture

Barbara Balik

Abstract

Elements of a sustainable culture that nourishes patient- and family-centredness (PFC) in healthcare are elegantly simple, but achieving PFC poses profound challenges for healthcare systems and policy. Healthcare organizations and policy makers often identify tactics and tools that they believe enhance PFC, but they fail to involve the very people who use healthcare services: patients, their families and community members. A way of viewing the journey to a sustainable PFC culture is by examining those elements of leadership, partnership and infrastructure that are necessary for its achievement.

he journey toward delivering patient- and familycentredness (PFC) healthcare can be characterized in three stages. In the "doing to" stage, healthcare administrators and clinicians decide what's best for the patient; in "doing for," although patients' needs are prominent in program design, administrators and clinicians consult patients and families late in the process. "Doing with," however, is a collaborative approach where administrators and clinicians work in full partnership with patients and families to design and deliver healthcare that is truly targeted to patients' and their families' needs.

The "Doing To" Model

In Canada, the United States and the United Kingdom, healthcare administrators and clinicians often hold unspoken beliefs about how services should be provided, beliefs that incorporate the organization's or health professional's viewpoint, but seldom the patient's and family's. Examples of how good care is defined when systems "do to" patients and families include determining schedules and diet and limiting

"What patients want is not rocket science, which is really unfortunate because if it were rocket science, we would be doing it. We are great at rocket science. We love rocket science. What we're not good at are the things that are so simple and basic that we overlook them."

> - Laura Gilpin, Griffin Hospital, Planetree Hospital

family access in hospitals; creating systems in clinics that meet clinicians' but not patients' needs; holding conversations about care that exclude the patient and family; sharing incomplete or biased information in a way that patients and their loved ones cannot easily understand and act on; and holding a belief that care is primarily provided in healthcare settings. Terms such as "compliance" are used to describe the patient's ability to follow clinicians' recommendations. This collective mindset limits the potential for transformational change because we ignore a precious asset - the wisdom and experience of patients and

The "Doing For" Model

Gradual progress toward PFC is evident when leaders and clinicians move to "doing for" patients and families. In efforts to develop PFC care, patients are kept in mind during the design of facilities and programs; family presence replaces visiting hours; and clinicians recognize that patients and families are primarily responsible for care. However, it is still a stage of professional or organizational dominance - we design then ask, rather than partner with patients from the outset; we manage expectations about waiting or pain rather than asking what is of value to the patient and partnering to mutually set goals.

High levels of PFC performance lead to the development of true partnerships between patients/families and clinicians ...

The "Doing With" Model

High levels of PFC performance lead to the development of true partnerships between patients/families and clinicians – a "doing with" relationship, where all involved understand that healthcare and health transcend location. The conversation recognizes that most healthcare is actually self-care (Krueger 2011). PFC provides the foundation to achieve the "Triple Aim" - better care, better health and lower costs (Berwick et al. 2008). Krueger (2011) describes this stage as recognition that in patient-centred care, the patient/family elects to determine their location within health and care. It implies that healthcare leaders need to work with patients to develop a system for the patient's needs, not the needs of professionals or organizations. Hallmarks of PFC include mutual decision making, recognizing the assets that each partner - patient/family and clinician - brings to improved health; including patients and families as design and quality improvement partners; conveying understanding through use of health literacy; and viewing all systems through the lens of the patient/family experience.

For healthcare leaders, clinicians and policy makers, the question is, where to go from here to achieve PFC? Lessons from leaders in PFC provide the following guidance to create a fertile ground for the seeds of partnership to take root and flourish.

Leadership, Partnerships and Infrastructure

Leadership, partnerships and infrastructure are essential factors in the transformation from an organizational-centred focus to a patient-and-family-centred one.

To begin, healthcare and policy leaders, clinicians and community members need to assess current systems in light of the Doing To, Doing For and Doing With stages. Facilitated conversations about what currently exists and is accepted or

tolerated set the groundwork for moving to greater partnerships. These conversations can occur throughout the organization or the community - in an improvement team at a clinic, with patients as members; at governing boards with patient and family participation; or in regional policy committees, again with patient and family involvement. Facilitated conversations can reveal what all participants expect and what behaviours are needed to transition to partnerships.

Leadership

In their IHI Innovation Series White Paper, Balik et al. (2011) identified leadership prerequisites for an exceptional patient and family healthcare experience. In this model, governance and executive leaders demonstrate that every part of the organization's culture is focused on patient- and family-centred care, and that PFC is practised throughout. In words and actions, leaders consistently communicate that the patient's safety and well-being are the critical criteria guiding all decision making. Furthermore, patients and families are included as partners in care at every level, from policy decision-making bodies to team members providing individual care.

Balik et al. (2012) found, based on learning from exemplars and others striving for PFC, that the following seven leadership actions can create fertile ground in which to establish the PFC

- Purpose clearly describe the purpose of PFC for everyone in the organization or community.
- It's Everyone senior leaders ensure that all leaders are clear and consistent in words and actions about the purpose of
- Puzzle Maker leaders assemble the puzzle pieces so that others can see how PFC fits in the organization's overall strategy for safety, quality and financial vitality.
- Close to the Work leaders understand firsthand the barriers to achieving PFC in their organization and strive to remove them, in partnership with those who do the work and with patients and families.
- Leadership Development leaders and clinicians develop the skills to engage in successful partnerships with other clinicians, team members, and patients and families.
- Engage the Hearts and Minds of Staff and Providers hire and engage people whose values are consistent with provision of PFC, develop effective systems of care and service that enable partnerships, and ensure resources are available for continual learning and improvement.

Examples of leaders who are Puzzle Makers and Close to the Work are executives found throughout Spectrum Health, Grand Rapid, MI, in the US. Through regular purposeful leadership rounding, they engage staff and providers in conversations about PFC and links to the organization's mission. During rounds they also seek to understand the daily care environment for patients/families and staff and to actively remove barriers to effective PFC.

Partnerships

Partnerships between patients/families and clinicians are an essential component of PFC. To help forge these partnerships, three main requirements must be considered. First, knowledgeable patients and family partners must be involved in care design and improvement. Patient and family commitment to these partnerships can range from short-term participation, such as a review of patient or community education materials, to long-term, such as involvement in designing health services to better meet the needs of those with chronic conditions. If the issue at hand is about patients or healthcare delivery, consumers of healthcare should, without exception, be at the table.

A second requirement for partnerships is health literacy. Clinicians carry the responsibility for health literacy, ensuring that communication – written and verbal – is clear and understandable to patients and their families. In so doing, clinicians can empower patients and families to be more informed and capable in self-management.

A third requirement is family presence, as described fully by the Institute for Patient- and Family-Centered Care (www.ipfcc. org). Family presence ensures that loved ones are not separated during the course of care.

High-impact systems enable clinicians and others in healthcare to develop new skills and tap into the passion that led to their entering the healthcare profession.

Infrastructure

Effective systems and supportive infrastructure are essential for a successful PFC environment. High-impact systems enable clinicians and others in healthcare to develop new skills and tap into the passion that led to their entering the healthcare profession. Developing partnership skills – and these are new for most clinicians, administrators, and patients and families enables the partners to create new systems together to meet the needs of those receiving care. To realize these high-impact systems, organizations need to put structures and processes in place to ensure that patient and family partners are clear about their role, responsibilities and skills.

Achieving PFC requires significant changes in existing healthcare systems, and performance improvement systems can accelerate progress toward PFC. However, performance improvement must become deeply embedded in the infrastructure of the organization; otherwise, old patterns will continue to dominate.

More direct involvement with the patient experience of leaders in the organization also leads to important improvements. Leaders and clinicians who observe and learn from the patient's journey - across sites of care and into the community - will gain new insights that lead to designing high-impact systems.

Role Models for Progressing to PFC

Adopting these elements of leadership, partnership and infrastructure is not an instant solution, but they are important steps on the journey to PFC and true transformation in health and healthcare. The energizing story is that organizations exist that illuminate many of these essential characteristics in action. Spectrum Health, Winchester Hospital, Winchester, MA; St. Mary's Hospital, Rochester, MN; Gundersen Lutheran, LaCrosse, WI; Baylor Medical Center, Dallas, TX; Mary Hitchcock, Dartmouth, NH; and all the Planetree-designated hospitals (http://planetree.org/?page_id=260;) are among those who exemplify the best in what healthcare can become. While the organizations listed here would stress that they have far to go, they offer encouraging role models of leaders who are able to successfully grow a sustainable culture of patient- and familycentredness. HQ

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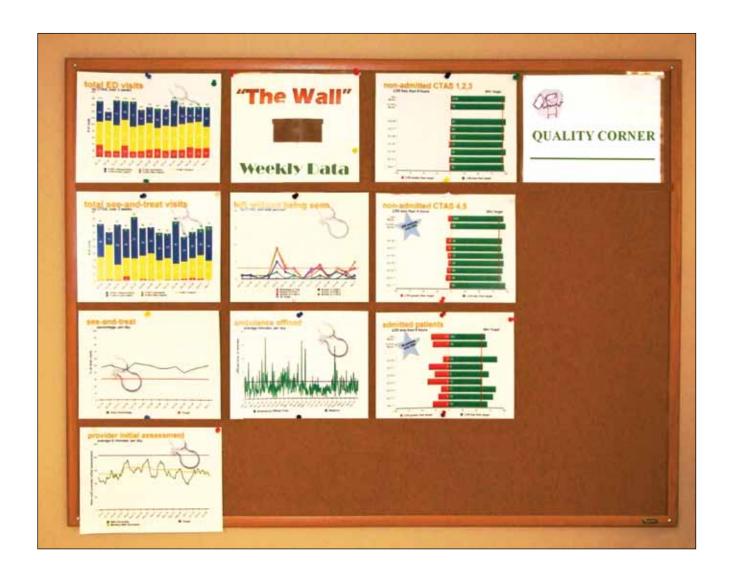
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A Relentless Commitment to Improvement:

The Guelph General Hospital Experience

Esther Green, in conversation with Richard Ernst



atient experience is now accepted as a key element of quality care. In one of two interviews that touch on the patient experience with Esther Green (EG), Richard Ernst (RE) - the CEO of Guelph General Hospital - talks about the full range of efforts that his organization has used to achieve and sustain excellent patient experience ratings. The interview underlies the importance of an organization-wide approach to improvement that touches on processes, human resources, and culture as well as a relentless commitment to improvement that is manifested through regular meetings that track progress.

EG: Guelph General Hospital has seen some positive results with respect to improving the patients' experience. Could you tell me, Richard, what you think are the key factors that have really contributed to the change?

RE: I'll start by mentioning that we've been tracking patient satisfaction indicators on a dashboard since 2007. Prior to that, we were certainly reporting the information that came out of the hospital report on a regular basis. A key factor was not just tracking the outcomes but also focusing on opportunities for improvement that are routinely identified through these reports.

The organization itself has made a commitment to improving our patient experience, and I think one of the best examples is what's transpired in our Emergency Department over the past couple of years. Emergency, as you know, is an entry point to the hospital. Ninety percent of medical patients admitted to our hospital come through our Emergency Department. That's 55,000 ED patients each year, and it's an area of significance to us relative to patient satisfaction.

Starting in about February 2009, Guelph General Hospital became involved in a program of process improvement launched by the Ministry of Health and Long-Term Care. The ministry invested resources in providing consultants to help hospitals in the Waterloo-Wellington LHIN try to move the bar on some of the metrics in the Emergency Departments. In our hospital, we introduced a concept of Lean methodology - value-stream mapping. Using front-line staff, we were able to start to make some changes. For example, when we looked at value-stream mapping, one of the key elements is, you don't do things that don't add value to either care providers or care receivers. If you're not doing things that add no value to patients, you are, by default, improving the patient experience.

Throughout that time, we had great physician leadership, and we had nurses from the Emergency Department shadowing nurses up in the Medical Unit and vice versa, so they could walk a mile in someone else's shoes. This led to an acknowledgement that patients who come to the hospital aren't Emergency Department patients and they're not Medical Unit patients they are our patients. And it wasn't just those two nursing areas either; it was the diagnostic areas, environmental services, and bed allocation. Everybody who's involved in the process that affects patients recognizes we have to look after these people as they come into the organization.

Some outcomes from that realization were really quite remarkable. In the past, patients may have waited a bit longer in the Emergency Department before they got a bed up in the Medical Unit. But recognizing the concept of these being our patients led to the medical floors phoning the Emergency Department to ask, "Have you got any patients we could bring upstairs?"

EG: Wow, that's a difference.

RE: Absolutely. From the old days when the Medical Unit didn't tell Emergency that they had an empty room, it was as if they were pulling patients to the floors. We changed the way we handled some of our lower acuity patients by setting up a "see and treat" model in the Emergency Department. We had patients complaining that they didn't have time to drink their coffee before they were in and out the door.

EG: As opposed to before?

RE: Yes. Again, the most patient complaints related to emergency services are going to be from low acuity patients who tend to get bumped along the way and wait for long periods. We've been able to cut wait times for those patients by a couple of hours. I think the average wait time for Triage Level Four and Five patients is around 2.2 hours. Under provincial targets, 90% of them would be seen within four hours, and we're well under that.

EG: Amazing.

RE: Yes. We've had about 30 hospitals come to see what we're dong here, so obviously we've been successful in that regard, but it's not just about the Emergency Department.

Every Thursday morning, staff from medicine come down to the Emergency Department and chat. We go over our metrics every single week, and it's an opportunity for front-line staff to interact with the Chief Nursing Executive (CNE) or the Chief of Staff. I attend these meetings – not every week but often – and there's problem-solving right there, on the spot, about things they've learned or things they want to try. We've got structured groups working on these things all the time. Three years ago, we were on the verge of a collapse with regard to morale and the feeling of providing really good care in emergency. I think there's lots of literature to support the concept "happy nurses = happy patients." It's been a real change for us.

The other thing is that as an organization, we're focused on quality and patient safety. It was the first strategic goal approved by our board, and it's been in place for some time. The board also approved a quality framework that makes quality at Guelph General Hospital part of everyday life. And our cultural evolution.

Interview continues on page 86.

Public Engagement in Ontario's Hospitals - Opportunities and Challenges

Karen Born and Andreas Laupacis

Abstract

The Excellent Care for All Act strengthens the accountability of healthcare provider organizations to the public. However, the ways in which healthcare organizations have engaged the public have often been limited. There are a number of organizations and approaches described in this paper that have exceeded existing public governance and input processes by involving, engaging and partnering with the public. Their processes range from engaging with patients to improve the quality, safety and appropriateness of healthcare services to approaches that strengthen organizational decision making and strategic planning.

The Argument for Public Engagement

Hospitals in Ontario are facing difficult choices about setting priorities, allocating resources and providing quality services. One approach that Ontario hospitals could draw on to help improve the quality and legitimacy of their choices is by engaging the public in decision making. While experts and stakeholders within the healthcare system provide crucial technical expertise, citizens provide expertise in "lived experience" that is complementary to the experts' input (Maxwell et al. 2003).

Public engagement is especially warranted within Canada's publicly funded healthcare system for at least four reasons (Bruni et al. 2008). First, as the public are both the main funders and users of the healthcare system, they are the most important stakeholders. Second, the public should be at the table when decisions are made, in keeping with democratic principles (Maioni 2010). Third, it has been argued that public involvement in decision making provides important insights into what members of the public value. These insights should lead to higher-quality decisions, or at least to greater acceptance of decisions made with citizen input. Finally, empowering the public to provide input into the healthcare system helps improve public trust and confidence (Bruni et al. 2008).

Healthcare organizations can engage members of the public through a variety of approaches and for many purposes. Health Canada (2000) adapted a Public Involvement Continuum framework to capture the range of purposes and the depth to which the public can be informed, involved and engaged by healthcare organizations (see Figure 1).

Governments and health regions in Canada have increasingly adopted public engagement processes along this continuum, developing deliberative processes and councils to inform policy questions and commissions (Mitton et al. 2009). For example, the 2002 Romanow Commission included extensive engagement with the public and key healthcare stakeholders. However, it is our observation that hospitals have focused the majority of their engagement efforts on the communications, education and information-gathering end of the spectrum mostly on one-way communication to inform and educate the public and patients. They tend to have few mechanisms for involving the public in decision-making processes.

While hospitals formally engage citizens through public boards of directors, these individuals are generally selected for their stature in the community, their governance expertise and their fundraising abilities (Bruni et al. 2008). Although hospital boards provide an important link to the community, research suggests that the demographic and socioeconomic characteristics found in hospital boards of governors do not mirror those of the general public (Frankish et al. 2002). These individuals may not

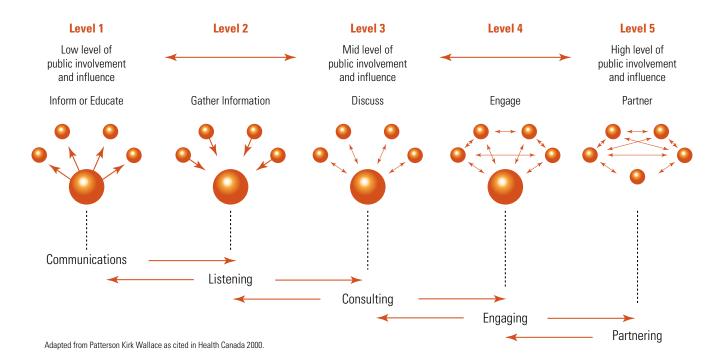


FIGURE 1. Health Canada's public involvement continuum

appreciate the healthcare issues faced by the different sectors of the community that their hospitals serve (Chessie 2009).

... the ECFA Act creates legislative mechanisms that strengthen the role of hospital governors and their ability to improve public responsiveness and accountability.

In addition to having members of the public sit on hospital boards, most Ontario hospitals have at least some mechanisms in place to receive citizen input. At a minimum, they include feedback from regular patient satisfaction surveys and from a hospital ombudsperson who can respond to patient concerns and complaints. However, these approaches are similarly focused on information gathering, listening and communication. Hospitals can strengthen decision-making processes by moving further along the spectrum by consulting, engaging and partnering with patients, communities and the public.

Excellent Care for All and Mechanisms for Public Engagement

More intensive public engagement approaches can improve existing mechanisms for quality improvement and engagement. The Excellent Care for All Act (ECFA Act) (Legislative Assembly of Ontario 2010) introduces a number of these mechanisms. In its preamble, the ECFA Act states that:

The people of Ontario and their government are committed to ensuring that healthcare organizations are responsive and accountable to the public, and focused on creating positive patient experience and delivering high quality healthcare. (Legislative Assembly of Ontario 2010)

Beyond affirming the value of a patient-centred healthcare system, the ECFA Act creates legislative mechanisms that strengthen the role of hospital governors and their ability to improve public responsiveness and accountability.

Citizen engagement processes can help build public trust, improve accountability and provide insights around quality. They can inform complex decision-making processes and help develop programs and services that are responsive to public

needs. But considerations of context are essential. Research suggests that organizations should pay careful attention to the context of the issues they are seeking public engagement and input for (Abelson et al. 2007). Understanding the context informs approaches and helps select individuals well suited to the public engagement processes. The Canadian Institutes of Health Research (2010) framework for citizen engagement includes a typology of citizens to reflect the various publics, such as patients, the general public and organized community

Context determined the approach to addressing a specific question about a single issue at the Northumberland Hills Hospital - how to deal with an impending hospital deficit. Consequently, the hospital convened a Citizen Advisory Panel to conduct a deliberative, time-limited approach with members of the general public. Kingston General Hospital's Patient and Family Advisory Council and the St. Michael's Hospital Community Advisory Panels illustrate a different approach. These advisory bodies include members of the hospitals' patient communities and are integrated into the organizations in a formalized partnership capacity.

In these examples, Ontario organizations have consulted, engaged and partnered with members of the public to strengthen organizational decision making, improve quality and safety and inform strategic planning processes. In the following section, we describe them in more detail.

Public Involvement: Northumberland Hills Hospital Citizens Advisory Panel

After running three successive years of operating deficits, the Northumberland Hills Hospital, located in Cobourg, Ontario, initiated a Community Advisory Panel (CAP) process that engaged a representative sample of 28 members of the public over a three-month period. The process was motivated by the imperative to bring the hospital's deficit under control, which would necessitate difficult decisions about the services the hospital provided. The hospital did not take this decision lightly, knowing that shifting or removing services would impact patients, hospital staff and the wider community.

Members of the public were invited to participate in the CAP through a civic lottery process, where 5,000 random households in the community were mailed an invitation. The 28 community members selected were balanced for gender, age and geography. The CAP was tasked with providing the hospital board with recommendations around which of the 23 core service areas could be cut and shifted to the community, in order to balance the budget. CAP members developed six criteria to help prioritize the hospital's services according to values determined by the group. Along with criteria such as sustainability and accessibility, they included effectiveness, safety and high standards that focused on quality, safety, patient

outcomes and best practices. The recommendations, along with input from hospital staff, physicians and senior leaders, were taken into consideration during the board's decision-making process, and the board's decisions largely aligned with the citizens' recommendations (Northumberland Hills Hospital 2010).

This approach reflects the Health Canada (2000) public involvement continuum of discussion and consulting, as this was a specific issue where the community would be affected by the outcome. As such, a process that facilitated public involvement and discussion, as well as an opportunity to influence the final outcome, was appropriate. The process not only supplied legitimacy to a difficult process, it also helped build public trust in hospital decision makers (The Monieson Centre, Queen's School of Business 2010).

Northumberland Hills Hospital's CAP is the first participatory hospital budgeting exercise in Canada that we are aware of. However, Ontario and the Northumberland Hills Hospital are not alone in facing these challenges. Other jurisdictions are grappling with similar issues - the United Kingdom's National Health Service, for example, is facing political pressure to reconfigure hospital services (Cole 2011). However, the UK-based Kings Fund warns in a 2010 policy briefing against blunt political decisions, suggesting that "ways need to be found to de-politicize the process and to make decisions on the basis of quality, safety and efficiency, while retaining strong citizen engagement in local decision-making" (Imison 2011: 1). The briefing emphasizes that public involvement should occur when there are credible choices and options for the public to review.

... engaging patients directly can provide more in-depth advice, insight and clarity on how to address concerns around the quality of patient care.

Patient and Family Engagement: Kingston General Hospital Patient and Family Advisory Council

In Ontario, some hospitals have developed structures for ongoing engagement of patients and the public within the organization. One such example is the Kingston General Hospital Patient and Family Advisory Council, founded in February 2010 as part of a broader organizational strategy of improving patient and family-centred care (Kingston General Hospital 2010). The Patient and Family Advisory Council is composed of patients, family members and hospital staff, including the vice president of clinical administration, professional practice, and the chief nursing executive. Council members are distributed among hospital core program areas of medicine, emergency, surgery, oncology, mental health and pediatrics. Among the council's

responsibilities are identifying opportunities for improvement around quality of care and patients' experiences.

Ongoing patient and family input into hospital programs goes beyond a time-limited discussion and toward engagement along the Health Canada (2000) public involvement continuum, where there is an opportunity for the public to shape the agenda. The engagement is characterized by an open time frame for deliberation around the issues that are important to patients and their families, and where options generated through engagement will be respected. For example, the Patient and Family Advisory Council recommended increasing the visibility of hand hygiene compliance rates through the organization and requested that handwashing rates be posted at hospital entrances, as well as on individual patient units. (D. Bell, manager of PAC, Kingston General Hospital, personal communication February 27, 2012)

Patient satisfaction surveys can also benefit from engagement with patient, family and community councils. It has been argued that satisfaction surveys are an insufficient basis for identifying areas for improvement (Martin and Ronson 2007). While hospitals are mandated to collect surveys about quality of care and patient experiences, there are well known limitations around the sensitivity, specificity and depth of these surveys. Given these limitations, engaging patients directly can provide more in-depth advice, insight and clarity on how to address concerns around the quality of patient care.

Community Partnership: St. Michael's Hospital **Community Advisory Panels**

St. Michael's Hospital in Toronto has been engaging members of the inner-city community that the hospital serves through specialized Community Advisory Panels (CAPs) for the last 15 years. These CAPs have a mandate to provide advice to the hospital on priority populations, ensure continuous improvements and advocate on behalf of the populations they represent. Members of the community constitute two thirds of the CAPs and hospital staff make up the other third. The CAPs focus on specific priorities: (1) women and children, (2) the homeless and under-housed and (3) mental health. Chairs of each CAP report directly to the hospital board of directors, and there is a CAP committee of the board that includes members of hospital leadership. The Centre for Research on Inner City Health's evaluation of the CAP program suggested that these partnerships have "been instrumental in generating a broad array of high-visibility, high-impact and patient responsive initiatives for inner city populations" (Centre for Research on Inner City Health, St. Michael's Hospital 2006:1).

The CAPs are an example of a long-standing partnership with the community, which is appropriate in the context of inner-city health, where citizens and interest groups have been enabled by organizations to develop solutions for themselves. The Health Canada (2010) public involvement continuum notes partnering as the highest level of public involvement and influence, where organizations assume an enabling role and agree to implement solutions generated by the public. One example of such an initiative has been the development of patient-responsive facilities, including the Rotary Transition Centre in the Emergency Department. Homeless and under-housed patients can be discharged from the Emergency Department to the centre, a safe, clean and supportive environment in which to recover while transition to the community is arranged (Centre for Research on Inner City Health, St. Michael's Hospital 2006).

Making the Case for Public Engagement in Ontario's Healthcare Organizations

Longer term, more resource intensive processes of involvement, engagement and partnership may not be an option for all organizations because of cost and human resources constraints. While current research mostly focuses on use of the Web for communication and dissemination to the public, there is a growing interest in using it to facilitate more meaningful, inexpensive and real-time two-way communication (Martin and Ronson 2007). Using the Web can also mitigate some identified barriers to reaching a representative sample of the population through public engagement processes. Personal commitments such as childcare, or professional commitments such as shift work, can preclude much of the population's participation in community engagement (Shields et al. 2010).

In an attempt to overcome vast distances and access difficultto-reach populations, the North West Local Health Integration Network (LHIN) developed a web-based application to lead citizens in the region through a series of exercises to identify priorities for the LHIN Integrated Health Services Plan for 2010-2013. The "Share Your Story, Shape Your Care" exercise first provided the public with an overview of health system issues in the region, reviewed priorities from previous integrated health services plans and requested comments on future priorities (Gallant et al. 2011). Over 800 community members participated. They ranked priority areas for the LHIN, described experiences of coordinated (and uncoordinated) care, provided suggestions for improvement and highlighted priorities that addressed local needs and challenges, many of which were reflected in the Integrated Health Services Plan (Shields et al. 2010).

While many theorists argue for the intrinsic value of public engagement, we are aware that in the current fiscal climate, Ontario's hospitals are motivated to demonstrate return on investments. There are also limitations to public engagement. Formal evaluations of engagement processes are rare, and little high-quality evidence exists to support public engagement in healthcare decision making. This is in part due to the complexities of decision-making processes, which make evidence of the direct impact of public engagement difficult to

produce (Bruni et al. 2008). In addition, public engagement processes demand significant attention and time from senior leadership and staff; they can be resource intensive.

... public engagement processes demand significant attention and time from senior leadership and staff; they can be resource intensive.

However, as Ontario attempts to move toward a patientcentred healthcare system, hospitals will no doubt be faced with challenges in ensuring the legitimacy, transparency and validity of important decisions. There are opportunities to leverage the experiences and learn from Ontario hospitals that have engaged their communities in shared decision-making processes.

Experience in Ontario suggests that developing appropriate public engagement approaches can lead to improved quality of healthcare services as well as strengthened relationships with patients, communities and the public - Ontario's most important health system stakeholders. HQ

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We need to work to link all the health care providers in a given geographic area who are providing care to individuals in the top 1% or top 5%. So that primary care docs know when their patients are getting care elsewhere – in the hospital, from the specialist, from home care. So that all the providers have the same information about a patient: what medication they are on, what tests they have had and what those results are...

Then we need that network of linked health care providers to work as a team to collectively manage the needs of those patients with the greatest needs, in partnership with family and community, so they move smoothly through the system, always confident that they're being looked after. That they don't fall through the "gaps" in the system. They will work to ensure that there is one "most responsible provider" for each patient. Someone responsible for making sure that that patient is getting the right care, at the right time, in the right place. That the patient is getting pro-active care. To keep people out of hospital, out of long-term care. ">>

> The Honourable Deb Matthews Minister of Health and Long-Term Care for Ontario November 7, 2012

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he Excellent Care for All Act requires assessment and improvement of patient experience as a key element of hospitals' commitment to quality. In one of two interviews that speak to improvement efforts focused on the patient experience, Esther Green (EG) talks with Joe Mapa (JM) – the CEO of Mount Sinai Hospital – about the importance of organizational culture and managerial discipline to quality improvement. Culture in this interview includes all members of the team so that everyone is focused on improvement in some way. Discipline speaks to the importance of making expectations for improvement clear in every decision and communication.

EG: Mount Sinai Hospital has seen improved results in the patient experience. What do you think are the key contributing factors?

JM: There are two major factors: culture and discipline. Culture of course engenders a shared vision of performance, where the organization is driven to not merely comply with but to exceed standards. The other part is the discipline to ensure that culture is operationalized. You need to embed the direction through clear accountabilities, systems, reporting, communication and, ultimately, evidence, to discern whether or not this culture is translating into benefits for patients.

EG: When you talk about the follow-through on accountability or reporting, how does your organization communicate with your senior team and the broader organization in terms of how the standards are being met?

JM: It goes back to the discipline around the culture: everyone in our organization is accountable for quality or the patient experience in some way. When we define expectations about our performance goals, we want to make sure they are well understood, meaningful, achievable and measurable. We communicate the results, teams analyze and challenge themselves, and we drive toward improvement. In our leadership structure, all of our clinical activities and service lines are organized under Centres of Excellence. The centres structure is the vehicle for dialogue on quality and improvement and brings this conversation back to our senior leadership team. There are checks and balances all the way up to our Board of Directors, who ultimately provide their insight and guidance on our performance.

EG: Excellent. I'm going on to the next question. You talked about clinician engagement, which is obviously very, very important. I'm wondering if you could talk a bit more about how the clinician champions and senior leaders have made

JM: Clinical champions are indispensible in achieving our goals. While these champions can sometimes be informal leadership roles, we also take steps to embed them formally

into our organizational design. In our leadership structure, our Centres of Excellence all come together under one individual, the chief clinical officer. This important leadership position can champion cross-enterprise goals, such as patient safety, quality and clinical outcomes, as a key part of its mandate. The Centres of Excellence nursing and physician co-leaders also act as champions at the program level, as they lead their teams to execute our goals and strategy. The chief clinical officer works with them regularly to coach each centre to ensure continuous improvement.

EG: Can you describe how the rest of the senior leadership team have a quality and patient experience mandate?

JM: Our organizational chart has two complementary components: corporate services and clinical services. No matter what the portfolio, it's essential that patient safety, quality and the patient experience be top of mind. So while individual departments and units may focus on their local experience, we find a lot of strength in our Centres of Excellence structure, which enables us to look at the patient's journey through the organization from a multidisciplinary perspective. We have an Office of the Patient Experience and Outcomes that can partner with care teams as a resource for improving the patient journey within our organization.

EG: There's been a lot recorded in the literature around engagement of patient/family advisors or advisory councils. What is your experience? What is the Mount Sinai experience about patient/family advisors? How might they have influenced change?

JM: Mount Sinai has a significant history in patient-centred care. We engage patients in the improvement of our organization – whether it's long-term planning, experience-based design of our facilities or making changes to the clinical service delivery model. I believe it's essential to set clear corporate expectations and structures to engage patients in all of the key organizational decisions. My leaders and managers have to think about what is the most applicable vehicle for this participation - whether it's patient advisory councils, patient opinion surveys, patient panels and focus groups, or learning about day-to-day interactions from patients. As a health sector, our challenge is holding ourselves accountable to improve and evolve our organization based on that feedback. We take it seriously and learn from it. For Mount Sinai, it's a living agenda and we want to continuously raise the bar. We are a learning organization, and we are always scanning the environment to see how both private and public sector organizations incorporate customer feedback.

Interview continues on page 90.

A Ten-Year History: The Cancer **Quality Council of Ontario**

Rebecca Anas, Robert Bell, Adalsteinn Brown, William Evans and Carol Sawka

Abstract

One of the longest-established quality oversight organizations in Canadian healthcare, the Cancer Quality Council of Ontario (CQCO) is an advisory group formed in 2002 by the Ministry of Health and Long-Term Care. Although quasi-independent from Cancer Care Ontario (CCO), the council was established to provide advice to CCO and the ministry in their efforts to improve the quality of cancer care in the province. The council is composed of a multidisciplinary group of healthcare providers, cancer survivors and experts in the areas of oncology, health system policy and administration, governance, performance measurement and health services research. Its mandate is to monitor and report publicly on the performance of the Ontario cancer system and to motivate improvement through national and international benchmarking. Since its formation, the council has played an evolving role in improving the quality of care received by Ontario cancer patients. This article will briefly describe the origins and founding principles of the CQCO, its changing role in monitoring quality and its relationship with CCO.

The Origins of Cancer Services Organization in Ontario

Before 2001, Ontario had no integrated provincial system for delivering cancer care, and patients were treated at Cancer Care Ontario (CCO) centres, at Princess Margaret Hospital (PMH), and at other hospitals across the province.

CCO had evolved from the Ontario Cancer Treatment Research Foundation, which had been established in 1943; its name changed officially to Cancer Care Ontario in 1997. Until the late 1990s, CCO managed its delivery of cancer services at regional cancer centres that provided much of the radiotherapy in the province. CCO centres also administered a significant component of systemic treatments (chemotherapy). However, CCO was responsible for none of the cancer surgery that is a crucial part of cancer treatment and had no jurisdiction over pathology, medical imaging or palliative care. As a consequence, CCO coordinated only a relatively small part of the cancer care in the province.

PMH, which had opened its doors in 1958, was the other provider of radiation services in Ontario. PMH also delivered chemotherapy, cancer surgery, pathology, medical imaging and palliative care, as did many other hospitals across the province.

This state of affairs changed in 2001 when the Ontario cancer system was restructured, following a review of cancer services undertaken by a group of CCO and non-CCO cancer experts supported by a CCO secretariat. The report of this Cancer System Implementation Committee led to the devolution of management of the cancer centres from CCO to the host hospitals via a formal Cancer Program Integration Agreement (Ministry of Health and Long-Term Care [MOHLTC] 2001). CCO retained the annual operational funding and established contracts with the host hospitals for their delivery of services on an annual basis. This allowed CCO to attach expectations to the funding for volumes of activity, including data provision and quality improvement initiatives. In return for receiving the capital assets and operational funding for the cancer centres, the host hospitals agreed to maintain their cancer treatment activity at the same quality and volumes of care provided before the asset transfer. CCO developed a new role as an independent, incorporated Schedule A agency of the ministry. With a board appointed by provincial cabinet Orders-in-Council, CCO became responsible for advising the ministry on the provision of an integrated cancer system.

In taking responsibility for advising the ministry, CCO undertook a review of the existing state of the province's cancer

services, engaging outside experts as well as its own. CCO also provided a secretariat function to provide data to inform the analysis. This secretariat extended the usual sources of cancer information available through the Ontario Cancer Registry to include the Discharge Abstract Database (DAD) from the Canadian Institute of Health Informatics. The DAD provided a wealth of new information about the extent of cancer surgery across Ontario as well data describing inpatient chemotherapy provision.

The Cancer System Implementation Committee also signalled a need for an external oversight body to ensure continuous monitoring of quality (MOHLTC 2001). The oversight body was the foundation of one of Canada's first health quality councils, the Cancer Quality Council of Ontario (CQCO). Officially established in 2002 by an announcement by Health Minister Tony Clement, the council was positioned at arm's length from CCO and challenged the provincial agency to improve the documentation of the quality of care in cancer services. The council's mandate was to monitor and publicly report on the quality of Ontario's cancer system.

First, the council focused on the quality issues of existing cancer services in Ontario. It published its findings in a book, Strengthening the Quality of Cancer Services in Ontario, in 2003 (Sullivan et al. 2003). The council's first product, the book describes the challenges inherent in creating an integrated provincial cancer system. Michael Decter, a former Ontario deputy minister of health, was recruited to chair the council and provided the book's executive editorial leadership.

The council's governance is a self-renewing body, with members meeting as a whole to nominate new members, achieving a skill mix matrix. CQCO members recognized that expertise was required from clinical experts in and out of the CCO system, as well as from members of the public knowledgeable about healthcare and cancer services, cancer patients and their families, and health service experts. Throughout its ten-year lifespan, the Council has recruited members who fit this skill and experience matrix. It has also retained a secretariat administered by CCO and has an agreement that data sources available to CCO should be provided to the council. This "inside-outside" relationship provides the council with sophisticated expertise and access to extensive data holdings, while maintaining an independent oversight role with respect to CCO performance.

The council's initial work emphasized just how little was known about the quality of cancer treatment, especially outside the treatment centres previously managed by CCO and PMH. Indeed, the CQCO recognized that complete information about the extent of cancer care was available only for radiation therapy. Cancer surgery was essentially a black box, with treatment provided at virtually every hospital in Ontario, and with little information about quality of service. Similarly, infor-

mation about chemotherapy provided outside previous CCO centres, as well as pathology, imaging and palliative care services, was not available.

In its early days, the CQCO held CCO accountable to develop a cancer control strategy for Ontario. The groundwork began in 2003, with CCO working with system stakeholders to redefine its vision, mission and guiding principles and to lead the development of a three-year provincial cancer plan encompassing a full range of cancer services. Subsequently, CCO published its first Ontario Cancer Action Plan, for the years 2005-2008 (Cancer Care Ontario 2005). The CQCO challenged CCO to develop an outcomes-based strategy and emphasized the use of verifiable quality metrics. This approach culminated in the council's most important product, a North American first in 2005 - the Cancer System Quality Index (CSQI) (CQCO 2012a).

The CSQI is a web-based, interactive public reporting tool that presents comprehensive information on key indicators of cancer system performance. including data on mortality and survival.

CQCO's Cancer System Quality Index

The CSQI is a web-based, interactive public reporting tool that presents comprehensive information on key indicators of cancer system performance, including data on mortality and survival. The CSQI is structured as a matrix reflecting the seven dimensions of quality as well as the patient's cancer journey from prevention and screening to active treatment, survivorship and end-of-life care. A valuable system-wide monitor that tracks the quality and consistency of key cancer services delivered across Ontario's cancer system, the CSQI is one of the most comprehensive reports of its kind in its breadth of measurement, jurisdictional comparisons and international benchmarks.

As such, the CSQI is an important tool for health professionals and cancer organizations, planners and policy makers in identifying cancer trends and in planning and making improvements in all areas of cancer control. Indicators within CSQI are a specific measure of progress against one of the seven quality dimensions:

- Safe (avoiding, preventing and ameliorating adverse outcomes or injuries caused by healthcare management)
- Effective (providing services based on scientific knowledge to all who could benefit)
- Accessible (making health services available in the most suitable setting in a reasonable time and distance)
- Responsive/patient-centred (providing care that is respectful

of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions)

- Equitable (providing care and ensuring health status does not vary in quality because of personal characteristics (gender, ethnicity, geographic location, socioeconomic status, age)
- Integrated (coordinating health services across the various functions, activities and operating units of a system)
- Efficient (optimally using resources to achieve desired outcomes)

The CSQI has evolved since its inception and most recently reflects CCO's vision of "creating the best cancer system in the world" (Cancer Care Ontario 2011: 16). International comparisons of quality in cancer care are achieved by comparing cancer survival and patient experience across developed countries that maintain well-documented cancer registries. In 2011, an international comparison of cancer outcomes in several developed countries was published in *The Lancet*; it reported that Ontario's cancer survival was among the best in the world (Coleman et al. 2011).

The progressive measurement of cancer quality metrics generated by the CSQI has resulted in many improvements and has been incorporated within CCO's performance improvement cycle and clinical governance structures (Duvalko et al. 2009). Improvements include decreased surgical 30-day mortality related to consolidation of complex care in Ontario founded on evidence-based standards (i.e., thoracic surgery for lung and esophageal cancer as well as hepato–pancreatic–bilary surgery for pancreatic and liver cancer). Survival compares favourably with that of other jurisdictions; this is attributed to many factors, including oversight, accountability and the use of evidence to drive practice (e.g., pathology reporting being submitted in a standardized synoptic electronic format with discrete data fields that improve quality and readability).

In addition to ensuring accurate measurements of wait times for cancer treatment, CCO now reports wait times for more than 190 procedures and diagnostic exams for cancer and other conditions. Public reporting of these wait times has shown where bottlenecks are in the system and where quality improvement initiatives are needed.

The CSQI has also documented improvement in both modifiable cancer risk factors and improved uptake of cancer screening. Non-clinician members of the council have focused on ensuring there are indicators that measure the patient experience in the journey across the cancer. Indicators related to system integration and customer service are difficult to develop and measure, but doing so remains a goal of the Council.

The annual CSQI serves as an important benchmarking exercise that holds CCO accountable for progress in the quality of cancer services across Ontario. The CSQI also tracks Ontario's

progress toward better outcomes in cancer care and highlights where cancer service providers can advance the quality and performance of care.

CQCO Products: Signature Events, Programmatic Reviews and Quality and Innovation Awards

The council not only measures CCO's progress, using the CSQI, it also suggests which elements of the cancer system require CCO's focused attention. The vehicle for council's annual focus on strategic priorities became known as the Signature Event. These one-day events are action-oriented and bring national and international expertise to the province, providing practical solutions and identifying areas of opportunity to improve the quality of health service delivery within the Ontario context. Annually since 2003, the Signature Event series has brought together practice leaders, policy makers, providers and patient representatives to solve pressing quality challenges in Ontario's cancer system. Subsequently, these events have been used as a catalyst to shape strategic directions and models to implement globally recognized best practices, helping CCO realize its vision of being the "best cancer system in the world" (Cancer Care Ontario 2011: 16).

Signature Events have explored topics such as cancer wait times and access to cancer services, palliative cancer care and colorectal cancer screening. They have explored using technology to improve the patient experience in cancer care, innovative models of care, the patient experience and, most recently, a system approach to preventing chronic disease (a collaborative engaging the Council, CCO and Public Health Ontario) (CQCO 2012b). These Signature Events are particularly important to quality improvement, since CCO's clinical council chair reports back to the CQCO on changes in program provision and initiatives undertaken by CCO as a result of the event recommendations.

A more recent CQCO product is the Programmatic Review, undertaken at the request of the clinical programs that are represented in the CCO Clinical Council. The first was a formative review focused on disease pathway management, in 2010. For these reviews, the CQCO invites international experts to Ontario to review progress, analyze the effectiveness of CCO programs and provide the programs with international expert advice on best practices. The result of the Programmatic Review is a set of recommendations on the strategic directions and improvements that the CCO program should undertake.

Finally, the CQCO sponsors annual Quality and Innovation Awards, which are provided to recipients at an event following the annual Signature Event. Since their inception in 2006, the Quality and Innovation Awards have recognized significant contributions to quality or innovation in the delivery of cancer care within Ontario. The 2011 awards expanded to include

contributions to cancer prevention, and the 2012 awards will include primary care integration with cancer. The awards are hosted and co-sponsored by the Council, CCO and the Canadian Cancer Society – Ontario Division.

These awards serve to recognize and promote front-line quality improvement. They complete the CQCO's quality improvement strategy, which includes measurement of cancer system performance (CSQI), identification of areas of opportunity (Signature Events) and analysis of program progress (Programmatic Reviews). The work of the CQCO is fundamental to CCO's quality agenda and will remain a central aspect of that agenda for the foreseeable future.

Conclusion

Over the last decade the CQCO has consistently improved its role in monitoring and reporting on quality, as well as providing tools to improve system performance and the quality of care that Ontario cancer patients received. The CQCO's next chapter is to ensure that the quality of the patient's experience is given equal weight in the quality agenda as clinical outcomes.

The source of the CQCO's success is directly linked to the commitment of its volunteer members, as well as to its productive working relationships with CCO, the regional cancer programs and other measurement/performance organizations locally, nationally and internationally. The shared beliefs in transparency, dedication to quality improvement and the perspective of the patient have been the critical success factors that will continue to serve the CQCO in its future work. HQ

About the Authors

Rebecca Anas, BSc, MBA, is the director of the Cancer Quality Council of Ontario (CQCO) Secretariat. In her current role, she leads a team to support the work of the CQCO, a quality oversight council that provides advice to Cancer Care Ontario and the Ministry of Health and Long-Term care in their efforts to improve the quality of cancer care in the province.

Robert Bell, MDCM, MSc, FACS, FRCSC, is president and CEO of the University Health Network (UHN) in Toronto, ON and is chair of the CQCO. From 2000 to 2005, he served as chief operating officer of UHN's Princess Margaret Hospital where he was responsible for leading Canada's largest comprehensive cancer centre. From 2003 to 2005, he served as regional vice president and chair of the Clinical Council of Cancer Care Ontario.

Adalsteinn Brown, DPhil, is the director of the Institute for Health Policy, Management and Evaluation at the University of Toronto. He is also leads the Division of Public Health Policy at the Dalla Lana School of Public Health and is a scientist at the Keenan Research Centre in the Li Ka Shing Knowledge Institute at St. Michael's Hospital. Dr. Brown is a member of the CQCO.

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Carol Sawka, MD, FRCPC, is vice president, clinical programs & quality initiatives and co-chair, clinical council, Cancer Care Ontario. In that role, she works with clinical leaders across the province to improve the quality and coordination of the full spectrum of cancer care and is an ex-officio member of the CQCO. Dr. Sawka is a medical oncologist with a special interest in the management of breast cancer.

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SUCCESSFUL QUALITY COUNCILS

Aligning and Pursuing Quality Goals:

The Role of Health Quality Ontario

Anthony Dale, in conversation with Ben Chan



The Excellent Care for All Act expanded the mandate of Health Quality Ontario so that it would measure performance, support quality improvement and make recommendations on best practices and the funding of care to support these best practices. In an interview with Anthony Dale (AD), Ben Chan (BC) - the former CEO of Health Quality Ontario (HQO) - talks about the challenges that lie ahead for the organization as it works to implement this much broader and more powerful mandate to support quality improvement. Throughout the interview Dr. Chan speaks to the importance of focus and alignment in pursuing quality goals so that the power of evidence can reach into every aspect of decision-making.

AD: Let's just dive in with some of our questions here. Transforming Health Quality Ontario from a very small organization with a mandate to examine and report annually on health system performance into a much larger organization with a more complex mandate, more employees, and so on, is a major undertaking. It goes without saying, and you know better than anybody, it's also central to the success of the government's plan to transform healthcare. The stakes are quite high. I'm not telling you anything you don't already know. Some consultations taking place are about creating a strategic plan for the new HQO, which of course has been transformed from the Ontario Health Quality Council.

Can you tell us about your strategic plan and how you will move forward with implementation?

BC: Our strategic plan sets forth a bold vision for what transformation of the entire healthcare system in Ontario is going to look like. I think that's the key difference between the old OHQC and the new Health Quality Ontario. It's not just about doing some public reporting and quality improvement; it's about broad system transformation. There are three key components to that transformation. One is a rapid, accelerated uptake of the best clinical evidence. We've heard for years now from the Institute of Medicine in the US that it takes 15 to 20 years for best practices to be adopted. We cannot tolerate that time lag any more. Let's cut it by half or more as we get better and better at accelerating evidence.

The second piece of the transformation relates to the creation of a true culture of quality that encompasses a number of different elements. One is that everybody is thinking and measuring, and looking at quality in ways and with an intensity that we've never seen before. It means that people are being held accountable and holding themselves accountable for delivering on hard improvements in quality. It means that our system is infused with quality improvement capacity, with staff at all levels who understand how to redesign their care processes, how to understand the causes of problems in the system and how to mobilize change.

The third component is partnerships and integration across the healthcare system. Our system is, to be frank, hopelessly disintegrated. Anybody who has watched a sick relative move out of hospital and back into the community has experienced it first-hand. Communication gets lost, providers don't talk to each other and the patient often feels left out of the process.

We have to fix this integration at an individual patient level but also at a system level. Healthcare leaders tell me over and over again that they feel pulled in too many directions from different initiatives that are all great, in and of themselves. But these initiatives either overlap in ways that are not productive or lead to a dilution of priorities. The activities that drive quality all need to be closely integrated to eliminate this sense of people being pulled in too many directions.

AD: Just a sidebar: you mentioned talking to a lot of different health system leaders, and it sounds like they fed into your strategic planning exercise, which helped take you toward this conclusion. Can you elaborate further on what the leaders in the system suggested?

BC: Yes, the leaders are giving us a number of messages. One is that we need to aim for a broad transformation, as I mentioned. Another of the most important messages was that the system needs to sharpen its focus on what it is trying to improve. Again, we can't be working on too many different priorities at once. This was particularly strong advice to HQO, that it has a very important role in creating and supporting the system to make sure it stays focused on a limited set of priorities. Very importantly, we can't be changing that priority as if it were the flavour of the month. Pick a big topic and follow it through over a long time period. The transformation doesn't happen overnight. We need to pick a big problem and work it through over the next several years.

What's emerged also from our conversations really addresses the second question. One of the areas that we're going to be very interested in for the next three years or beyond is individuals with multiple chronic conditions, individuals who are often cared for by many different parts of the healthcare system, individuals who often move in and out of hospital. These people also account for a large share of healthcare expenditures. There's an enormous amount of work we can do to improve evidence-based care, improve care transitions and these patients' experience of care, and keep them from winding up in hospital unnecessarily.

Interview continues on page 91.

It's about the Relationships: Reflections from a Provincial Quality Council on Building a Better Healthcare System

Bonnie Brossart

Abstract

The mandate of Saskatchewan's Health Quality Council (HQC) is to play a hands-on role in health system transformation by working collaboratively with government, regional health authorities, health professions and citizens. Instead of the traditional, representative model, HQC is governed by an "expert board." Because board members do not represent their own organization or profession, they have stayed focused on the "system" nature of HQC's mandate, working with individuals and organizations committed to improving quality at a system level.

In recent years, HQC has achieved a significant shift in attitude toward quality improvement throughout Saskatchewan's healthcare system, realized partly through building strong, effective relationships with those managing and delivering care. Hundreds of front-line providers, managers and leaders are now learning and applying quality improvement methods to improve healthcare quality. Since its inception, HQC has moved to a higher level of interdependence with other healthcare system stakeholders, helping advance the quality agenda so that everyone has a greater understanding about mutual responsibilities.

t is hard to believe that a decade has passed since Commissioner Ken Fyke's visionary recommendation. While several provinces have since established their own quality councils, the mandate of Saskatchewan's Health Quality Council (HQC) – to play a hands-on role in health system transformation by working collaboratively with government, regional health authorities, health professions and citizens – makes it unique. Although it may be premature to describe

The Commission also recommends
the creation of a Quality Council with a
mandate to improve the quality of health
services in the province. The Council should
be an evidence-based organization, arm's
length from government and reporting
to the Legislative Assembly. In so doing,
Saskatchewan will lead the country in the
pursuit of a quality culture that will be the
next great revolution in health care.
(Government of Saskatchewan 2001)

the changes over the past ten years as a revolution, there has been a tangible shift in our provincial health system's aspirations, vocabulary and behaviour. Today, there is a widespread, unwavering focus on and commitment to improving healthcare quality here and across the country (Sullivan et al. 2011). We are regularly asked how we came to play such a collaborative and influential role within this province's health system. This essay describes factors behind our achievements to date and some of our disappointments and ongoing challenges.

The passing of The Health Quality Council Act in November 2002 laid the foundation for HQC to succeed (Government of Saskatchewan 2002). As this piece of legislation was the first of its kind in Canada, the Ministry of Health sought fairly broad input from health system leaders. The result

was legislation that was broad and ambitious, and based on an understanding that HQC was to actively work to advance the quality agenda. Government took a calculated risk in creating an agency whose mandate included publicly reporting - warts and all - on a health system funded by, and perceived to be run by, government. The legislative mandate gave force and clarity to both the HQC's mandate and degree of independence. Of those provinces that have created their own quality organizations, Alberta and Ontario have similarly enacted legislation (Government of Alberta 2011; Government of Ontario 2010).

So many of the improvement ideas and approaches that are being applied in Saskatchewan have been stolen shamelessly from elsewhere and carefully adapted to the local environment.

The policy makers behind our legislation departed from the norm by recommending that HQC's board of directors be an "expert board" rather than the traditional, representative model. The minister of mealth submits a list of potential candidates for selection by Cabinet. Saskatchewan's lieutenant governor in council appoints HQC board members for a three-year term and reappoints existing directors for subsequent terms. From the outset, we have been governed by a board of 12 provincial, national and international leaders from healthcare and other fields with expertise in clinical care, system administration and management, health system research, health policy and quality improvement. This diverse makeup has yielded several benefits. Because board members do not come to the table representing their own organization or profession, the group has always stayed focused on the "system" nature of our mandate - and on working with individuals and organizations who share this commitment to improving quality at a system level. The involvement of board members from outside the province demonstrated government's commitment to learning from elsewhere and ensured that crucial deliberations were grounded in both local context and learning and innovation from other health systems. So many of the improvement ideas and approaches that are being applied in Saskatchewan have been stolen shamelessly from elsewhere and carefully adapted to the local environment. A tangible benefit of having an expert board is the strategic relationships they have helped us build with leaders from other high-performing health systems from across the globe.

While establishing and nurturing relationships with global colleagues has been key in informing our approach to health system transformation in Saskatchewan, the quality of our relationship with our health system partners in this province is even more critical to our work. Our Saskatchewan board members - and indeed everyone who works at HQC - are actively involved in maintaining these all-important connections. The board chair, vice-chair and CEO work as ambassadors, building bridges with health regions, health professions and government. Recognizing that engaging physicians would be critical to the success of HQC, government made the conscious decision to appoint a physician as the first chair. Naming a nursing leader as vice-chair was also a strategic move, given the environment at that time. Having the CEO of a Regional Health Authority as chair for a period enabled the agency to strengthen engagement and relationships with this key constituency. HQC board members have participated at all significant provincial meetings as official representatives of the agency or when called upon to bring this perspective.

Strong, constructive relationships between an agency like a quality council and other organizations in the health system are critical to advancing improvement ambitions; transforming healthcare challenges us to rethink how we have always done things. Not surprisingly, these relationships have been tested over the years. There have been instances where stakeholders, such as the Ministry of Health, objected to content and key messages in HQC's public reports. Similarly, HQC has at times been frustrated when policy makers have not addressed gaps in policy or incentives we identified as having the potential to improve quality. Appealing to people's altruism and in some cases underwriting some or all of their expenses for participating in quality improvement programs, we learned, was an insufficient catalyst for transformational change.

... hundreds of front-line providers, managers and leaders are now learning and applying quality improvement methods to improve healthcare quality throughout Saskatchewan's healthcare system.

For many years, one of the biggest challenges the HQC faced was complacency among some health system leaders; people were hesitant to set bold targets and invest resources accordingly to address poor quality. There may have been a perception that quality improvement was someone else's job, possibly HQC's - this despite the fact that our \$5.5 million operating grant represented just 0.1% of the overall healthcare budget. There has been a significant shift in attitudes in recent years, spurred in part by our efforts to regularly challenge the status quo, but we achieved the shift through strong, effective relationships with those managing and delivering care. As a result, hundreds of front-line providers, managers and leaders are now learning and applying quality improvement methods to improve healthcare

quality throughout Saskatchewan's healthcare system. There is growing appreciation for and use of publicly available performance data as a foundation for ongoing improvement (Health Quality Council 2012a). As well, more people living with chronic diseases are receiving evidence-based care, and more patients in hospitals are benefitting from improved processes, thanks to the lean-based improvement strategy Releasing Time to CareTM (Health Quality Council 2010; Health Quality Council 2012b).

HQC's role in the health system has evolved from one of more implied independence to becoming a better partner.

Both the board and staff at HQC have had many philosophical and practical discussions over the years about our theory of change. By default, we have followed an eclectic approach, which, in many ways, reflects the importance of our relationships and collaboration with our partners (especially, working with them wherever they are at, in terms of readiness for change) and a continuous quality improvement approach to our own methodologies and theories.

HQC's role in the health system has evolved from one of more implied independence to becoming a better partner. This has involved some organizational learning about how to work more skilfully and collaboratively with our many partners, to foster a culture where all are learning and focusing on our respective roles. We have moved to a higher level of interdependence, where we still see ourselves playing a role in advancing the agenda so that everyone has a greater understanding about our mutual responsibilities. Some may argue the shift from independence to partnership requires trade-offs; we feel it is more constructive to determine which approach is most effective (and when) to accomplish the collective goals HQC shares with its health system colleagues. Just as partnering and leveraging our respective talents to meet these ambitions will be critical, there will also be times when, given our provincial perspective and role, an independent voice or perspective is what's required to make further progress.

There are challenges ahead, ones that will demand even greater risk-taking and courage on the part of all stakeholders governments, health regions and agencies such as quality councils. What is known, however, is that we will be unsuccessful in reaching our ambitions without an unwavering focus on patient-centred care, publicly available information on health system quality, a commitment to build and support those doing the work, the skills and capacity to continuously improve, and a collective, system-wide focus on health system improvement. These elements, critical to system transformation, will remain grounded in solid, respectful relationships. HQ

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The Excellent Care for All Act's Quality Improvement Plans: Reflections on the First Year

Sudha Kutty, Nizar Ladak, Cyrelle Muskat, Jillian Paul and Margo Orchard

Abstract

In 2010, Ontario passed the Excellent Care for All Act (the EFCA Act). Although the purpose of the Act was clear, the legislation itself was relatively non-prescriptive in relation to the mandatory quality improvement plans (QIPs), and hospitals needed direction on how to proceed. A task group was established to develop a common provincial QIP template, along with guidance, support and educational materials. The template was field tested across the province and, subsequently, all hospitals developed their QIPs, posted them publicly, and submitted them to Health Quality Ontario (HQO).

Despite challenges including short time frames, limitations in data availability and a variance of skills in performance measurement, the implementation of QIPs in hospitals was a success. Success is part could be attributed to a strong tripartite partnership and good communication channels with hospitals. Hospitals with the most effective QIPs were those whose leaders used the opportunity of a provincially mandated QIP as a lever to drive and legitimize the need to have conversations regarding quality from the boardroom down to the front line. As organizations continue to develop and implement their QIPs, we will see this tremendous quality improvement effort sustained. The QIPs will remain a significant transformational lever to engage the system in improving performance and achieving excellent care for all.

ntario recently passed the Excellent Care for All Act, 2010 (ECFA Act), legislation and associated policy aimed at improving quality and value in the healthcare system (Legislative Assembly of Ontario 2010). One of the cornerstones of this legislation was a

requirement for hospitals to develop annual quality improvement plans (QIPs). The first year of implementation of these plans was a success, despite short time frames, limitations in data availability and a variance of skills in performance measurement. The new legislation, combined with a strong tripartite partnership and communication channels to a receptive environment, has allowed hospitals to accelerate Ontario's quality improvement journey and sets the stage for improving the culture of quality across the healthcare system. Through a review of the QIP development process during the first year, this article provides a summary of key success factors, critical achievements and opportunities for improvement in future QIP planning.

Key Success Factors

Several factors led to the success of year one of the QIPs.

1. Legislative Levers: The Excellent Care for All Act, 2010

One key success factor was the legislative force behind the ECFA Act, passed by all parties in June 2010. The act was established with the patient in mind and with the intent that by improving the health of patients and their caregivers, quality and value in Ontario's healthcare system would be improved and sustained. The legislation recognizes the value of transparency in the healthcare system and focuses on embedding quality oversight and improvement at the senior and board levels within healthcare organizations. It also focuses on encouraging a culture of quality to permeate to all levels of the organization. The passage of the act provided the foundation for quality improvement by making quality a responsibility of everyone delivering care in Ontario, and making the executive team and board accountable for quality improvement.

As part of the ECFA Act, hospitals are required to establish a quality committee responsible for overseeing the development of an annual QIP and to make this plan available to the public. QIPs need to include performance improvement targets, and compensation of senior executives at the organization must be tied to performance on these targets, thereby setting clear expectations and accountabilities for performance on quality indicators. As part of the legislation, board quality committees are also required to review, assess and attest to the completion of the QIPs, thus engaging hospital governance.

Many hospitals in Ontario already had quality plans that were embedded in hospital culture and integrated with internal strategic and/or patient safety plans. The introduction of the QIP under the ECFA Act, however, provided for a common playing field and a standard template to permit province-wide comparison of and reporting on a minimum set of quality indicators. The intention of the QIP template and supporting materials was to complement and augment, rather than replace, existing quality work and planning materials.

... the legislation was relatively non-prescriptive, and hospitals needed direction on how to proceed.

2. A Tripartite Partnership: The QIP Task Group

Although the purpose of the ECFA Act was clear, the legislation was relatively non-prescriptive, and hospitals needed direction on how to proceed. Through the direction of the Minister of Health and Long-Term Care, an implementation working group (IWG; see http://www.health.gov.on.ca/en/ms/ecfa/pro/ ecfa_act.aspx for more information about the ECFA Act IWG) was convened to provide that direction. The IWG consisted of members from the Ministry, the Ontario Hospital Association (OHA), Health Quality Ontario (HQO), Local Health Integration Networks (LHINs) and senior hospital leaders. This group developed a phased approach, using a set of basic principles to guide implementation, with the first year focusing on implementation and compliance and getting everyone to the same level, or "floor." The following years would focus on driving standardization and improved performance and raising the "ceiling." The IWG provided hospitals with a single point of contact and communication for all things related to the Act. This included providing guidance on the role and responsibilities of quality committees, recommendations on conducting patient surveys and the development of a patient declaration of values. These tools and supports were provided to hospitals through existing communication methods to help hospitals implement all of components of the act.

While the IWG provided guidance on the components,

the QIP required more targeted and detailed attention. A task group was established to provide this additional assistance and guidance. The goal of this the QIP task group was to develop a common provincial QIP template and guidance materials (see http://www.health.gov.on.ca/en/ms/ecfa/pro/updates/quality-improve/update.aspx for more information) for hospitals to enable QIP submission. This group consisted of representatives from the ministry, the Ontario Hospital Association and Health Quality Ontario, and reported directly to the IWG. The following principles guided the work of the QIP task group in developing a provincial template:

- Support hospitals in being compliant with the legislation and related regulations
- Be easy to interpret, and provide a snapshot view of quality;
- Be generalizable to all hospitals, regardless of size or type
- Create a QIP that is standardized and comparable across the province, with a core set of indicators that are relevant to all hospitals
- Create a QIP that is unique enough to each hospital to allow room for indicators that were especially relevant to a particular region or centre
- Streamline the reporting requirements of hospitals, rather than adding a new layer of reporting to duplicate regional efforts

The QIP template itself was based on the Institute for Healthcare Improvement's Model for Improvement framework (Langley et al. 2009) and required hospitals in a clear and logical way to outline the Aim, Measure and Change for each of their quality initiatives across four dimensions: safe, effective, accessible and patient-centred.²

... the QIP template was field tested across the province to ensure that it could be used consistently by all hospitals, independent of geography, size and type.

Keeping all this in mind, the QIP template was field tested across the province to ensure that it could be used consistently by all hospitals, independent of geography, size and type. The educational and support materials were developed through expert consultation, and by all groups involved, ensuring alignment of key messages. The template (an excel file and an accompanying narrative) and accompanying support materials were then shared with hospital CEOs and senior management through existing communication channels (webcast, Internet and e-mail).³ All hospitals subsequently developed their QIPs, posted them publicly, and submitted them to HQO.

The guidance and support materials provided by the QIP task group were important to build on the momentum created by the passing of the ECFA Act. This group optimized the strengths of each organization in the design and dissemination of the QIP support materials. For example, the OHA used its strong and well-organized educational services department to provide webcasts, conferences and educational workshops to support the pre-testing and communication strategy for the QIPs. The task group benefited from HQO's methodological foundation, gained through its experience in developing products such as the annual quality report for the Province. The ministry, by virtue of its role as funder and policy steward for the health system, could ensure that political support and leadership interests were aligned and thereby ensure alignment on the aims of quality improvement. Indeed, the very nature of the multi-party task group provided the necessary levers to achieve a higher probability of success.

3. Communication Channels to a Receptive Audience

Although the role of the tripartite task group was an important factor in ensuring that all hospitals submitted a QIP in accordance with the legislation, the communication of this information and receptivity of Ontario hospitals to the QIP guidance was perhaps the most important success factor in the first year of the ECFA Act. Hospitals were at varying levels in their quality improvement journey, but all embraced the components of the Act and posted QIPs in accordance with the legislation. This was a tremendous success, given the short time frames provided and lack of consistency in quality improvement capacity across hospitals prior to the act's passage.

... hospitals were working under very tight time frames to develop a QIP, introduce the concept of performancebased compensation and get board sign-off.

QIP Challenges

A number of challenges emerged during QIP implementation, including tight time lines, data quality issues and shortages in hospital capacity for performance improvement. The ECFA Act was passed in June 2010, and hospitals had ten months to put most of the components of the legislation in place. The QIP materials themselves were released at the end of January 2011. As a result, hospitals were working under very tight time frames to develop a QIP, introduce the concept of performancebased compensation and get board sign-off. This challenge was compounded by the intersection between the requirement for performance-based compensation and the public sector salary

freeze for non-union employees enacted by the Broader Public Sector Accountability Act, 2010 (see http://health.gov.on.ca/en/ legislation/bpsa/).

There were additional challenges with the quality of Ontario health information. These data challenges have been well documented (Health Results Team for Information Management 2006), and the QIP task group continued to struggle with these limitations when selecting core indicators. Timeliness was also an issue, with long lag times between realtime and available data. It is anticipated that as the ECFA Act and the QIP gain momentum, timeliness and data quality will improve.

... a Web-based product with enhanced functionality could significantly reduce data quality concerns ...

Hospitals also faced challenges in performance measurement capacity, as shown in the marked variation in the complexity of QIPs submitted. It was clear that a number of hospitals did not have previous expertise in performance measurement and struggled with the requirements of the QIP. For example, some hospitals (from large teaching centres to small rural hospitals) set weak targets (that is, targets that required only minimal improvement), whereas others set ineffectual targets. A number of factors could have contributed to this, ranging from social to economic. For many hospitals, target-setting was a new exercise and a work in progress. This is an area for continued improvement, and HQO's work in establishing benchmarks and targets will support a more consistent approach across the province. Similarly, although some hospitals developed very sophisticated change ideas to address quality challenges in their QIPs (Health Quality Ontario 2011), others struggled with developing these change ideas. The divide in capacity for performance measurement was also clear during educational sessions led by the QIP task group. These challenges indicate that quality improvement and performance measurement capacity of the system requires further strengthening through education, regional decision support networks and mentorship to balance out the disparity of skills across the province. Table 1 provides a summary of the analysis of the QIPs in year one that was developed by HQO (Health Quality Ontario 2011).

In light of the above, the authors suggest that the QIP support strategy for subsequent years be enhanced. For instance, individual feedback to hospitals to create the opportunity for shared understanding through dialogue, though a resource intensive activity, would be well received and help address the issues listed in Table 1.

Another suggestion from the authors is the need for an online

TABLE 1. **Health Quality Ontario's Analysis for Learning**

| Themes | What went well | What could be better |
|--------------------|---|---|
| Priority - setting | Some hospitals chose a limited set of priorities, averaging 4.5 high-priority topics | HQO to examine literature on relationship of goal achievement and number of priorities selected |
| Target - setting | Aim for the theoretical best Aim for the 90th percentile among peers Aim to cut defect or waste in half in current cycle Aim to match rate of improvement met by others | Stretch targets were not the norm Sometimes targets were below current performance Sometimes targets represented insignificant or minimal improvement Some QIPs did not include targets or baseline measures |
| Change ideas | Measure and provide feedback to providers Redesign or standardize processes Provide clinical decision supports and reminders Develop and verify staff skills Ensure infrastructure, capacity properly configured Engage patients Create appropriate accountability mechanisms | Unspecified or limited number of change ideas Root cause analysis instead of change strategy No process indicator or target for change ideas |

HQO = Health Quality Ontario; QIP = quality improvement plan.

tool with automated validation rules, pre-populated data fields and reminders. While an electronic Excel and Word template was used, a Web-based product with enhanced functionality could significantly reduce data quality concerns found in the first year's submission and also include helpful reminders that reinforce tactics to address issues found.

In spite of these challenges, many hospitals were able to develop strong, robust QIPs. Hospitals with the most effective QIPs were those whose leaders used the opportunity of a provincially mandated QIP as a lever to drive and legitimize the need to have conversations regarding quality from the boardroom down to the front line. These leaders embedded their OIP into their broader strategic plan and saw one as a subset of the other. Additional detail regarding the analysis of year one QIPs is documented in HQO's report 2011 Quality Improvement Plans: An Analysis for Learning (Health Quality Ontario 2011).

Reflections and Next Steps

In an informal survey of hospitals conducted by the Ministry of Health and Long-Term Care in the spring of 2011, nearly one quarter of respondents felt that the QIP focused their organization's quality goals and encouraged the board to talk about quality and quality improvement. Furthermore, 60% of respondents reported that the QIP had a moderate or significant impact on their quality improvement activities. These are great wins in the spirit of moving the quality improvement bar within the province. In addition, the QIP task group received the Ontario Public Service's ACE Award for Partner Relations from the Ministry of Health and Long-Term Care in recognition of the vision of the collective. This award was a reflection of the success of the combination of strong legislation, the tripartite partnership and effective communication to a receptive audience during the implementation of the QIP.

As we move into the third year of the QIP, the QIP task group continues with the quality

journey, and, as with all quality initiatives, lessons learned will be applied to improvements each year. Table 1 presented some of the areas where we hope to see improvements in future years including the need for more aggressive targets and more sophisticated change ideas. Over and above these, we hope to see greater alignment with existing quality improvement processes and better communication of the QIP to the public.

QIP year one represented a starting point, a stake in the ground. As the QIP journey continues, there will be further refinements. The current focus is implementing the ECFA Act in hospitals, which have a long history of quality improvement, patient safety and governance. As the act matures, the development of QIPs should become more explicitly owned and driven by the organization's board of directors.

Specific examples could include routine reporting on the progress achieved on the QIP at board meetings and dashboards

to profile the progress made and progress to be achieved on the QIP. LHINs should be engaged in open conversations that highlight challenges being experienced and how they can support the achievement of quality aims.

Achieving high-quality care is a journey. As the ECFA Act expands to be a requirement of other sectors such as home care, long-term care and primary care, the focus on quality across all levels of the organization will be strengthened. It is expected that this will be accompanied by supports in benchmarking, regional data and more integrated care across the healthcare continuum, allowing for accountability for patient care to be shared across institutional walls. Our ultimate vision: the entire system focused on improving healthcare quality, resulting in excellent care for all.

Conclusion

The drive toward quality improvement is reflective across Ontario's healthcare organizations, and the QIP is one critical vehicle by which organizations are demonstrating their commitment to improving quality. The ECFA Act provides organizations with the opportunity to demonstrate their ongoing commitment to quality improvement efforts. The partnership between Health Quality Ontario, the Ontario Hospital Association and the Ministry of Health and Long-Term Care provided the necessary leadership and guidance to initiate implementation of the act. Strong communication channels to a receptive and captive audience were equally important, and, as organizations continue to develop and implement their QIPs, we will see this tremendous quality improvement effort sustained.

As Ontario healthcare organizations elevate these quality improvement efforts, the QIPs will remain a significant transformational lever to engage the system in improving performance and achieving excellent care for all. By leveraging the momentum of the QIPs across the hospital sector, we can continue to build on this strong foundation of quality improvement and engagement of all sectors in the province's quality improvement agenda. HQ

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Notes

- ¹ The legislation requires the QIPs to be submitted to HQO in a format that permits province-wide comparison. This was interpreted as requiring a standard provincial template for all to use.
- ² HQO's nine attributes of a high-performing health system were condensed into the four dimensions of the QIP.
- ³ See http://www.health.gov.on.ca/en/ms/ecfa/pro/updates/ qualityimprove/update.aspx for the most recent version of the QIP template.

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The Crucial Role of Clinician Engagement in System-Wide Quality Improvement: The Cancer Care Ontario Experience

Carol Sawka, Jillian Ross, John Srigley and Jonathan Irish

Abstract

In 2004, Cancer Care Ontario's (CCO) role changed from providing direct cancer service to oversight, with a mission to improve the performance of the cancer system by driving quality, accountability and innovation in all cancer-related services. Since then, CCO has built a model for provincewide quality improvement and oversight - the Performance Improvement Cycle - that exemplifies the key elements of the Excellent Care for All Act, 2010. While ensuring that quality of the cancer system is by necessity a continuous process, the approach taken thus far has achieved measurable results and will continue to form the basis of CCO's future work.

Clinician engagement has been critical to the success of CCO's approach to quality oversight and improvement. CCO uses a variety of formal and informal clinical engagement structures at each step of the Performance Improvement Cycle, and has developed operational processes to support quality improvement, and educational and mentorship programs to build clinician leadership capacity in that area. An example of sustained quality improvement in system performance is illustrated in a case study of the surgical treatment of prostate cancer. The improvement was achieved with strong collaboration across CCO's surgery and pathology clinical programs, with support from informatics staff.

n 2004, Cancer Care Ontario (CCO), the provincial agency responsible for cancer services in Ontario, changed its role from that of direct cancer service provision to one of oversight. Its mission became to improve the performance of the cancer system by driving quality, accountability and innovation in all cancer-related services. The obvious challenge was the method by which this mandate could be accomplished in the absence of direct operational authority. Since then, CCO has built a model for province-wide quality improvement and oversight that exemplifies the key elements of the Excellent Care for All Act, 2010 (ECFA Act) (Duvalko et al. 2009). The CCO Performance Improvement Cycle (Figure 1) is based on routine monitoring and public reporting of performance data, developing and disseminating evidence-based best practice guidance, setting annual quality improvement targets, purchasing cancer services (from hospitals organized into regional cancer programs with dedicated cancer leadership) that enable the achievement of quality as well as volume targets, and making provider teams accountable for achievement of these targets. The annual performance of regional cancer leaders is judged on the degree to which agreed-upon volume and quality targets have been met.

The Performance Improvement Cycle has been successful in addressing some of the pressing issues in cancer quality that existed in 2004. For example, access to radiation treatment and cancer surgery has improved considerably, multidisciplinary case conferences occur regularly, high-complexity cancer services have been consolidated in accordance with evidencebased organizational standards, and patients have the ability to report their symptoms in a standardized manner at each clinical intervention, promoting earlier recognition and intervention (Cancer Quality Council of Ontario [CQCO] 2011). While ensuring that quality of the cancer system is by necessity a continuous process, the approach taken thus far has achieved measurable results and will continue to form the basis of CCO's

Clinician engagement has been critical in the success of CCO's approach to quality oversight and improvement (Dobrow et al. 2008). This paper will describe the deliberate manner in which CCO engages and empowers clinicians in this shared quality improvement agenda, provide a case study of a successful engagement strategy, and provide policy recommendations to bridge the traditional gap between administrative and clinical leadership.

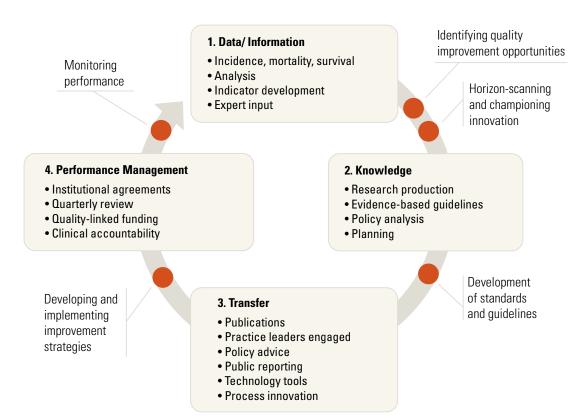


FIGURE 1. Clinicians are engaged in all components of the CCO Performance Improvement Cycle

Clinician Engagement throughout the Performance Improvement Cycle

CCO uses a variety of formal and informal clinical engagement structures at each step of its Performance Improvement Cycle. Communities of Practice (CoPs) are informal groups of clinician providers that identify quality gaps and have a common goal of solving quality problems. Expert panels are formed on a timelimited basis to address specific topics (such as development of quality indicators), incorporating best evidence supplemented by consensus. In collaboration with the Program in Evidence-Based Care, multidisciplinary teams develop evidence-based best practice guidance documents, including clinical practice guidelines and organizational standards. Feedback from a larger group of practitioners is incorporated into final documents. The formal clinical engagement structure is centred around clinical leadership for each of the CCO's programmatic areas of focus. Provincial and regional clinical leads form provincial clinical program committees that set the quality agenda. Regional clinical leads are accountable for bringing local perspective to inform the quality agenda and for serving as explicit champions for regional implementation. Regional clinical and administra-

tive leads are jointly accountable, through their regional vice presidents, for regional performance and participate in quarterly performance reviews with CCO. Provincial clinical leads are responsible for provincial program oversight and for knowledge exchange with regional leads to ensure that they are positioned to succeed in their regional commitments.

Operational Processes

CCO has developed a Clinical Accountability Framework that explicitly defines the roles and responsibilities of the provincial and regional clinical leads. It stipulates clear lines of accountability and specifically the relationship between the clinical and administrative leads that generates a model of integrated clinical accountability. The framework has been the foundation for the development of role statements, recruitment processes, annual setting of objectives and performance review. We also developed remuneration guidelines sufficient to free up time from clinical practice. We provide infrastructure support to ensure that clinical leads, a relatively costly resource, are utilized only for appropriate functions. As a direct result of implementing the framework, the quality agenda is formed, executed and evalu-

ated by clinical leaders with clear accountabilities that include formal engagement of a representative group of clinicians from across the province.

Building Leadership Capacity in Quality Improvement

Since clinicians are not routinely trained in quality improvement methodology or in leadership techniques, we recognized our responsibility to build leadership capacity in quality improvement. We hold an annual educational event that has used a graduated curriculum to build leadership skills and incorporate regional successes as an explicit way to exchange best practice in implementation. For instance, one such event introduced the Institute for Healthcare Improvement's clinician engagement framework, provided a workshop format to allow application of the framework to actual local examples and included presentation of "what worked, what did not" from some of the more experienced clinical leaders. Provincial leads incorporate practical advice designed to enhance leadership capacity of regional leads in their regular program meetings. In addition, provincial leads conduct regular site visits and coach and mentor regional leads. Importantly, leadership development is aligned with regional and provincial improvement goals.

Engaging Front-Line Providers in a Quality Improvement Agenda

The success of any quality improvement initiative requires not only front-line clinicians' acknowledgement of a quality gap but also their involvement in specific quality improvement efforts. We have relied heavily on regular provision of performance data both internally and publicly to drive quality improvement. We contrast current performance with evidence-based best practice and where possible give data on top performance within Ontario and beyond to illustrate the improvement potential.

While these data are most commonly provided in aggregate at the hospital or regional level, we are increasingly providing clinicians with their individual performance data. Clinicians are strongly motivated by a desire to provide best care, and they respond well to this technique. On occasion we have used academic detailing. We also host educational events to highlight best practice and, in a limited way to date, have made individual practice audits a prerequisite for registration in these events.

For complex quality gaps that involve clinicians, hospital operations and information technology solutions, provision of current performance data and best practice guidance, while necessary, is insufficient for change. We have therefore developed capacity to help regions implement best practice using a variety of techniques ranging from coaching to active implementation teams. Synoptic pathology reporting is one example. Pathologists identified that standardized reporting checklists would ensure that pathology reports included all important

information, and that this would improve the efficiency of clinicians in their assignment of prognosis and treatment decisions. They further identified that an electronic tool would facilitate uptake. The province-wide implementation of electronic pathology reports in a standardized format (synoptic reports with evidence-based content and data standards) required a complex partnership of clinicians, information technology and administrative professionals.

We also link best practice advice to funding recommendations and delivery models where appropriate. These recommendations are made by clinician experts, based on best evidence. For example, cancer drugs, PET/CT scans, and thoracic and hepatobiliary surgery are all reimbursed only when done according to eligibility criteria or in accordance with organizational standards.

Case Study: Quality of Prostatectomy Surgery

A tangible example of sustained quality improvement in system performance has been realized in the surgical treatment of prostate cancer. This required a strong collaboration across CCO's surgery and pathology clinical programs, with support from informatics staff.

First, we formed a multidisciplinary Urology Community of Practice. While many issues regarding multidisciplinary care were raised at the initial meeting, one area of concern was the high rate of positive margins after prostatectomy surgery. During such surgery, the surgeon's goal is to remove all of the cancer, along with the rim of normal tissue around it (the "surgical margin"). The pathologist examines the removed tissue and analyzes the surgical margin to be sure it is clear of any cancer cells. Positive surgical margins are associated with higher rates of cancer recurrence and with an increased need for other treatments (e.g., radiation therapy), which results in increased side effects to the patient and increased resource utilization for the cancer system. A manual audit of radical prostatectomy pathology reports from 2005/06 confirmed positive margin rates of 31% and 61% for pathological stage T2(pT2) and T3 prostate cancers, respectively. The rates seemed inordinately high, especially the pT2 rates, and there was significant inter-hospital variability. The CoP identified several potential contributing factors: (1) variable patient selection for radical prostatectomy; (2) pathologists' variable interpretation of a "positive margin"; and (3) variability among surgeons with respect to specific technical aspects of the surgery.

The CoP believed that optimization of pathology and surgical techniques could improve the positive margin rate. The critical success factors in the improvement strategy included (1) The CoP, since it possessed the clinical expertise, developed the engagement strategy. CCO's role was to provide support. (2) An evidence-based clinical practice guideline, Guideline for Optimization of Surgical and Pathological Quality Performance

in Radical Prostatectomy in Prostate Cancer Management (available at https://www.cancercare.on.ca) was developed. (3) The CoP recommended a best practice target of <25% margin positivity for pT2 prostate cancer. The CoP agreed that achieving a 0% positive margin rate was not attainable nor, in fact, desirable, based on the fact that quality-of-life issues (impotence, incontinence) could be unnecessarily sacrificed in the name of optimizing margin performance but with potentially no change in survival outcomes. (4) Performance data were shared anonymously in a non-punitive environment with the philosophy of performance improvement and were included at an aggregate level in the publicly available quality report for cancer, the Cancer System Quality Index. (5) Prostate cancer "champions" consisting of local and regional pathology, surgery and radiation oncology leaders became the disciples for practice change locally.

Local events aimed at quality improvement were able to provide effective knowledge transfer. These events were facilitated by low cost support from CCO, supported by provincial clinical leads (surgery and pathology) and led locally by regional heads of cancer surgery and pathology with local prostate cancer champions. Using recognized provincial leaders, best practices on pathology specimen handling and interpretation, and surgical technique were shared with the philosophy that "quality improvement occurs locally." This approach has resulted in a measureable drop in the provincial pT2 margin positivity rate to 21%, with some regions and individual hospitals showing rates of less than 20%. There is still, however, some significant variation. Further performance improvement will be based on ongoing non-punitive sharing of performance data at the provider level to leverage clinicians' desire to deliver high-quality care and their anticipated efforts to improve performance where they are below the performance of their peers. In addition to individual accountability for quality improvement, regional clinical leads continue to be accountable for regional performance and report on progress in quarterly reviews with their administrative leaders and CCO leadership.

This general approach is used to drive quality improvements in all the quality indicators described in the Cancer System Quality Index. Each indicator has a "business owner," usually a provincial clinical program, charged with working with clinicians and relevant stakeholders to identify the source of the quality gap, then develop and implement a program of work with progressive improvement targets attached. Expectations are embedded in annual contacts with hospitals and regions, and progress is tracked in quarterly reviews.

Policy Recommendations

Successful ECFA Act implementation will require significant clinician engagement. Our policy recommendations are based

on CCO's experience to date and our desired directions to deepen clinician engagement.

- Clinicians should be provided with their own performance data for quality improvement.
- Formal networks of clinicians with defined roles and responsibilities will facilitate greater accountability for performance improvement and quality.
- Clinician remuneration should be linked to quality expectations in a transparent system developed jointly by clinicians and payers.
- Clinicians should be formally affiliated with care systems (hospitals, community care, etc.) to facilitate integrated accountability and to foster the development of novel accountability structures where all parties bear risk and share rewards. HQ

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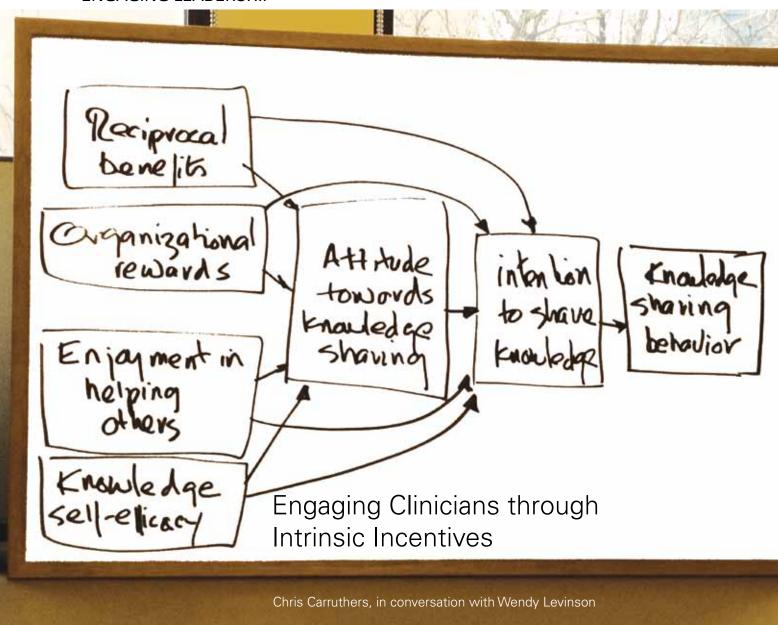
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n one of two interviews that touch on the importance of clinician leadership, Wendy Levinson (WL) - the chair of medicine at the University of Toronto and a quality and patient safety champion - shares with Chris Carruthers (CC) the importance of building a cadre of physician leaders who are passionate about quality and prepared to lead improvement efforts. She speaks to the importance of recognizing and rewarding quality through a much broader range of incentives that play to the intrinsic incentives motivating physicians than can be achieved with simple pay for performance schemes. In a wide-ranging interview, Dr. Levinson also touches on the importance of strong quality leadership to the professionalism and self-regulation of

medicine and how health systems must engage a broad range of clinicians to build and maintain momentum in quality improvement.

CC: Tell us about your role in quality improvement at the University of Toronto Department of Medicine and how you've been engaging physicians in quality improvement.

WL: I'm the chair of medicine at the University of Toronto. I moved back to Canada ten years ago, after practising and living in the US most of my career. The reason I think that's relevant is, I have continued to play a major leadership role in the US and especially in the issues around quality improvement and how to engage physicians.

When I moved back here, I thought we were quite far behind in some of the things that have already happened and are being learned in the US, so I did a strategic plan in our Department of Medicine. I found that everything had trickled up except for the plank on quality improvement, which was not really on people's radar screen at that time. So I've been very committed to engaging physicians in quality improvement.

In the US they've tried many models, including different formulas to pay for performance. But research in the area shows that the most effective and enduring way to engage physicians in quality improvement is to encourage them to make it part of their professional identity - their sense of professionalism - and part of what they do. Paying doctors for performance works while the incentives are in place, but after you take them away the behaviours often disappear. When I moved back here, I felt that the most important way to get the ball rolling was to develop a cadre of physicians who were really starting to be excited by and invested in quality improvement.

I don't run a hospital. My role is as an academic lead, so I'm not in the operational arm of a hospital but I'm very much in the position of helping to influence, support and encourage the faculty who in turn can lead. To do this, about ten years ago I developed something called the Quality Stars Program. It takes individuals, often young but mid-career people, trains them in the methods of quality improvement and helps empower them, giving them resources to go back to their clinical environment and work on issues that they are passionate about and do quality improvement.

The Quality Stars Program started small. Then I recruited a leader in quality improvement who is an academic - Kaveh Shojania, who was General Internist at the University of California at San Francisco, then went to Ottawa and then came here to Toronto. With Kaveh's help, the University developed the Centre for Patient Safety. He took on the course and has turned it into a certificate program that engages these physicians in learning about quality improvement. That's one stream we've used to engage physicians by giving them information about quality improvement and then helping support them in developing projects they are passionate about in the clinical environment.

CC: How do you identify these individuals? Do they come to you, or do you go to them?

WL: Well, in the beginning, it was a bit of both. When we started this it was novel, so people didn't know what it was. We had to look around to see who might be interested and who was already doing a little bit of it, but without much background in how to do quality improvement. Now, after ten years, it's got a life of its own. There are people beating down the door for that course. Initially, we had about 15 people in it. Now there are regularly 40 people or more wanting to take it every year.

The second thing is recognizing and, especially, rewarding people. I don't live in the hospital and pay people to do clinical quality improvement, but I can reward them in several ways. We have a major award every year for research, one for education and now one for quality. The award gives quality improvement stature and showcases the heavy hitters in the field. We nominated people for awards who are doing clinical quality improvement whenever we could. I recently learned that there's an award for innovative curriculum. We nominated the certificate course I just told you about, and it just won the University Award for innovative curriculum.

Another way we can reward people is to promote them for doing those activities. We've been doing that informally, but now we have job descriptions that will be well known to you, Chris - clinician scientist, clinician investigator, clinician educator and clinician teacher. Kaveh and I wrote an article in the Annals of Internal Medicine in JAMA a while ago about promoting people who do quality improvement. As a play on words, we called them CQIs - Clinical Quality Improvers. We're developing a new job description for people who do this as their meat and potatoes, and criteria on how we would judge them at three-year review – we do a three-year review of all new faculty members – and on how we can promote them.

CC: This would be another class in the buffet of potential promotions that you could move forward.

WL: Yes. In reality we already have a set of criteria, something we call Creative Professional Activity. We're modifying it for the CQI criteria as they're quite similar.

CC: Just to clarify, somebody who takes a strong lead in quality improvement could be equally matched against somebody who's a strong researcher in the promotion line.

WL: Yes. I did some survey research with my colleagues, the chairs of medicine across North America, and found that many of them are struggling with what to do to get these people promoted. quality improvement is a local endeavour, for instance - getting your hospital to do hand hygiene. If you just got your hospital to do hand hygiene, it would be hard to get promoted because promotion at U of T requires innovation and evidence of impact outside your institution. To get promoted here, people will have to be more creative than just taking what's already known about hand hygiene, for example, and getting it to work on the Burn Unit.

Interview continues on page 94.

Governance for Quality and Patient Safety: The Impact of the Ontario Excellent Care for All Act, 2010

G. Ross Baker and Anu MacIntosh-Murray

Abstract

The passage of the Excellent Care for All Act, 2010 (ECFA Act) in Ontario has confirmed the responsibilities of hospital boards for quality of care and reinforced expectations that they will monitor performance and establish strategic aims in this area. Quality of care and patient safety have created a new agenda for many healthcare boards that had only a limited focus on these issues. Here, we report on interviews with five Ontario healthcare organizations identified by experts as having high-performing boards. Our question was, how has the ECFA Act influenced Ontario healthcare organizations' governance practices relating to quality and safety?

While the act has raised the profile of these issues, in the short-term it may have blunted the effectiveness of some boards that had already developed a clear strategic focus on quality and patient safety. Executive compensation was the most contentious issue; the introduction of pay for performance was considered poor timing, given the Ontario government's pay freeze. Overall, the act is an important step in increasing responsible governance and has helped align governance activities with the core work of hospitals - delivering high-quality care. However, effective policy must create an environment where all organizations focus on improvement, but where regulation does not limit the capabilities of leading organizations to achieve even higher performance.

The growing awareness of quality and patient safety problems in healthcare has helped to elevate these issues from internal operational matters to strategic concerns (Flemons et al. 2005; Leape and Berwick 2005). Governments and regulators (both in Canada and elsewhere) see boards as key mechanisms for accountability not only on financial performance but also, increasingly, on the quality of patient care (Joshi 2006; Health Quality Ontario 2011). As a result of both these trends, there is greater attention to the role of governing boards in reviewing quality and patient safety performance and in stimulating better outcomes in these areas. Recent research in the United States indicates that board attention to quality of care is associated with better performance (Jha and Epstein 2010; Jiang et al. 2008, 2009). This evidence, coupled with growing demands to improve performance, has created new pressures on healthcare trustees to focus on quality of care and patient safety.

Quality of care and patient safety create a new agenda for many healthcare boards that had only a limited focus on these issues. Enhancing knowledge and attending to specific governance practices can heighten board effectiveness in these efforts. Baker et al. identified five critical levers for creating more effective governance for quality and safety (Baker et al. 2010). They include:

- Better information for the board on quality and patient safety
- Improved trustee education and skills

- Changes to governance roles and processes
- Improved efforts to create and monitor a quality and safety plan, and
- More effective relationships between the board, medical staff and senior leadership

The passage of the Excellent Care for All Act, 2010 (ECFA Act) in Ontario has confirmed the responsibilities of hospital boards for quality of care and reinforced expectations that they will monitor performance and establish strategic aims in this area (Legislative Assembly of Ontario 2010). Although the intent of the legislation was to create minimum standards (Ontario Hospital Association 2010), there have been concerns that using a legislative approach could be overly prescriptive and not sufficiently responsive to local conditions and needs. So how has the ECFA Act influenced Ontario healthcare organizations' governance practices relating to quality and safety?

To explore this question we conducted interviews with five Ontario healthcare organizations nominated by several key informants knowledgeable about the status of healthcare governance in the province. The organizations were recommended because they were seen as leaders in their focus on and approaches to quality and safety at the board level. They ranged in size and focus from small rural to large urban teaching hospitals. The interviews with the five CEOs and one board chair were conducted by telephone (using semi-structured interview guides) in November-December 2011. All interviews were recorded (with permission) and were analyzed, compared and mapped to explore key themes. These interviews were part of a larger project to explore the current status of healthcare governance in Canada.

The Impact of the ECFA Act on Five Ontario **Organizations**

The ECFA Act was passed into law in June 2010. Among other requirements, the act requires hospitals in Ontario to develop and post annual quality improvement plans; create quality committees to report to each hospital board on quality-related issues, including annual quality improvement plans; and link executive compensation to the achievement of quality plan performance improvement targets.

Interview participants from the five Ontario organizations were divided in their views of the legislation and the impact that it has had on their organization's quality work with their boards. At one end of the spectrum, the CEO of a large teaching hospital stated:

"I think it is one of the most important pieces of legislation introduced in this province to really help to improve quality of care, not just the review and the governance but overall quality. I think it really is very important."

He observed that the act had made little impact for his organization and board because they met most of the requirements already. However, he emphasized that it was needed to move many other organizations in the same direction:

"I have spoken to many other colleagues, I have been to other organizations, and I am aware that not all organizations had a quality committee or quality of care committee, and not all had directors as engaged in quality as they are now, post introduction of the ECFA Act. So in other organizations, I believe it has changed the approach to quality. Not only do I believe, I know: I know it from speaking to my colleagues and to directors and other organizations."

A CEO in a community hospital expressed surprise that the Act was needed, that other organizations would not have had the required structures and activities in place:

In many respects when we looked at the minimum requirements for the ECFA Act, to see where we were relative to compliance with the new legislation, lots of these things were already in place for us. We'd been doing patient satisfaction surveys for many years, and we'd had a quality committee in place for many years. Of course we hadn't done a QIP (quality improvement plan) in the way that we were required to now under the Act, so that was new for us.... I was a bit surprised when the legislation came out that there would be hospitals out there without a quality committee, who weren't participating in patient satisfaction surveys, and that kind of thing. I think most hospitals were a little surprised that those things weren't universally in place across the sector.

While one board chair observed, "I don't think we've really changed our way of thinking or our strategies very much. We've always been focused on patient safety," for others the act became a distraction for both their boards and staff as they dealt with the quality improvement plan and the executive pay-for-performance requirements.

The Quality Improvement Plan and Indicators **Template**

CEO and board chair reactions to the legislated requirement to complete the quality improvement plan (QIP) template and submit it to Health Quality Ontario were mixed. For some, it caused no changes for their board reports; one CEO noted that the ECFA Act just heightened awareness at the board level:

"I would say that the ECFA Act ... certainly has brought more attention on the part of directors to the legislation, and they may have a heightened awareness, but it hasn't actually changed the way that we deal with quality measurements and reporting in the organization."

Several other participants voiced their frustration with the template and submission requirements. The CEO of a smaller organization observed that the measures emphasized with the legislation reflected provincial priorities that were not issues for rural hospitals, and had resulted in some "non-value-added activities." In smaller rural hospitals, Emergency Department waits are not as pressing an issue as in larger urban facilitates. In another case, a CEO noted that his hospital's ventilatorassociated pneumonia and central line infection rates were already "down around zero, [but] there was huge pressure to develop an improvement plan for that."

Another participant concurred with that view, noting that the board was distracted from the organization's quality strategy because members became preoccupied with compliance with the ECFA Act and completion of the indicator template, which were not all relevant to the hospital's own goals and scorecard. She noted:

... measures emphasized with

the legislation reflected provincial priorities that were not issues for rural hospitals, and had resulted in some "non-value-added activities."

"The Excellent Care for All Act was a huge barrier for us because it distracted a lot of attention from the work at hand.... It really got us caught up in what we have to do to be compliant with the legislation, and that was very, very distracting."

The requirement that the board has to sign the QIP elevated the anxiety of this board's members about the templates and further focused their attention on the indicators spreadsheet template. This CEO noted that the requirement to sign off the QIP "reinforced the attitude, 'we'll pay attention to the things that are mandatory because somehow they must be more important than other things'."

Other experienced boards also faced some confusion when trying to understand how to reconcile the fit of the new QIP documents with their organization's existing quality strategic plans. The ECFA Act's influence varied depending on the nature of the extant planning processes, foci/goals and the format of the quality plans. Organizations with less experience may opt to use the QIP template as their sole document. Others may have a format that is amenable to merging with the QIP format. "The quality plan under the ECFA Act is the main quality plan.



We have departmental quality initiatives that are going on, not that the board really is too aware of those," commented one CEO. However, the act's requirements may result in several quality plans in an organization: one for regulatory reporting and another (one or several) tailored to local strategic and improvement needs. Several CEOs indicated that their organizations had decided to maintain their plans and include the QIP as a subset.

Participants from smaller organizations commented that completion of the template and submission of the reports put additional pressure on their staff and managers as they did not have the same resources that were available in the larger hospitals. One interview participant commented that:

"With all the new legislation and the new standards come a whole lot of bureaucracy and reporting and accountability and contracts and monitoring. In small organizations that's particularly challenging because the same people do all of those things; we don't have special departments to work on things. So it's getting very, very challenging in terms of measuring and monitoring, and making sure, and a lot of these processes that are being imposed on us don't necessarily add value to the patient experience."

Another point of disagreement was the appropriateness of the inclusion of a financial measure, total margin, as one of the effectiveness indicators on the improvement targets and initiatives template. One CEO noted the importance of balancing attention to both financial health and quality. Another participant expressed strongly that this was not the place to include finance indictors that were covered by other agreements; this was political tinkering that detracted from the quality focus, "Because you have other kinds of agreements that are signed off, this ought to be about quality, the things that we have not paid attention to as much as finance."

The interviews occurred as organizations were preparing for the second round of QIP submissions for 2012, and participants commented on how the planning cycle would be different this time and what would help the process. The timeline was very short for hospitals to complete and submit their first round of QIPs in 2011, and some participants indicated that this adversely affected the planning process. The longer time available to prepare QIPs for 2012 may permit fuller planning and engage more staff in the planning of improvement priorities.

Another CEO remarked that although the QIP template had made it easier in some ways to create the plan, and that Health Quality Ontario had published a document with feedback (based on their review of the 2011 QIPs that the 152 Ontario organizations had submitted),1 more explicit guidance was still needed:

"I believe that there's still a better job that that group [Health Quality Ontario] could do in helping organizations really understand what they wanted.... I think that they need to be more helpful [to] hospitals on exactly what it is they expect, and I'm hoping that comes this year.... I think if they showed exactly what they were looking for ... and what they would consider some best practice examples, that would be helpful. I think hospitals received some inconsistent information from them as we were going through the process leading up to the due date for the first QIP."

Creating Quality Committees

Creating quality committees was not an issue for these organizations because most had already had a functioning quality committee for some time. In one smaller organization, the board's governance committee had carried out the quality oversight responsibilities. The CEO explained that in response to the ECFA Act, the board now has a separate quality committee, "So now we have a quality committee of the board, we have a governance committee, and we have our resource management committee; those are the three main committees."

The main structural change for most of the organizations was to their quality committee membership. ECFA Act regulations require the addition of the senior nursing executive, a representative from

the Medical Advisory Committee (MAC), and another representative who was not a member of either the College of Physicians and Surgeons or the College of Nurses of Ontario. One CEO noted that the chief of the medical staff was already part of the organization's committee,

"So the decision that we made related to changes in the Public Hospitals Act, and the ECFA Act was to put a non-nursing, non-physician professional practice leader on the quality committee of the board, so that's been in place for about 10 months now."

Changes to board membership in regulations under Ontario's Public Hospitals Act appeared around the same time as the ECFA Act quality committee membership regulations. PH Act regulations stipulated that the senior nursing executive, the president of the medical staff, and the chief of staff (or chair of the MAC) would become non-voting members of hospital boards. One CEO noted that this caused some additional distraction as the board and senior leaders sorted out the implication for roles.

> ... pay for performance appears to be a new practice for many smaller organizations

Pay for Performance

Although pay for performance appears to be a new practice for many smaller organizations, this practice has been in place for some time in larger Ontario teaching hospitals as well as in healthcare organizations in other parts of Canada. The requirement that a portion of senior executives' compensation be tied to achievement of improvement targets appears to be the most contentious component of the ECFA Act, according to a number of interview participants. Their concerns are linked to the perceived inequities caused by introducing pay for performance tied to the QIP measures and improvement goals in the context of the provincial pay freeze. One CEO stated, "I think the most troubling thing for most hospitals was the intersection of the wage restraint legislation and the introduction of pay for performance at that time.... I think that is no way to introduce pay for performance." Another CEO agreed, noting that the pay-at-risk provision amounted to a compensation rollback for most executives.

The organizations did not all have comparable executive pay arrangements. Some executives, mostly in the larger teaching hospitals, already had bonus clauses, so they just had to realign some portion to attach to the ECFA Act measures. One CEO indicated that this was a minor change. Another was supportive of the provision but noted that the board had some difficulty in deciding how to re-apportion the percentage at risk in total and the proportion of that aligned with the quality plan. A third CEO described the board's consternation when the executive leaders proposed that their at-risk compensation should depend on achieving 100% of an ambitious stretch goal. She noted:

Two of the members of the compensation committee of the board, which is the committee that makes the decisions about the allocations of the performance incentives, said in the corporate world this would be unacceptable ... if we only got 50% of the way to where we want to go, that would be a failure.

Several interview participants described the challenges (and perceived inequity) of being responsible for improving outcomes of processes that are not under the executives' scope of control. One noted that the board does not always appreciate the complexity of improvement:

"In terms of the board, I think it takes a while to get them to understand the complexities of quality improvement, the complexities of having really challenging targets and the real complexity around changing clinical practice. And that it takes a long time to change the clinical practice, and then from the sustainability perspective it becomes a real challenge."

One interview participant observed that many of the ECFA Act measures relate to processes that require physician behaviour change, and this is difficult when there is little leverage with medical staff, who are not employees and are difficult to replace in the context of a physician shortage:

"The biggest problem is that when you're looking at setting targets, you have to make sure that those targets are within the scope of control of the managers involved. I think some of them are little bit outside of that; some of them really were dependent on a lot on medical staff and physician practice, which we don't always have a lot of influence on.... So we did have a couple of issues this year with physician practice that were very difficult to influence, and I think that has impeded our performance in terms of reaching some of those goals."

Challenges Facing the Organizations and their **Boards Relating to Quality**

Participants observed that the political environment and regulatory context relevant to the quality agenda was becoming increasingly more complicated and confusing for their boards. Government and accreditation agencies each have their own agendas, goals, language and requirements; it can be difficult to show how these relate to the organization's own strategy, as one CEO pointed out:

"We have so many people and agencies looking over our shoulders. We have government inspectors from various ministries, we've got Accreditation Canada, we've got lab accreditation, and they all overlap. And they all have their own language too, so it makes it very confusing. I think it makes it even more confusing for the board, because we have a quality agenda for the ECFA Act, and we have a quality agenda for accreditation, and we have a quality agenda for some other piece of legislation, accessibility or whatever it might be, and I think the board has some difficulty in keeping all that straight and how it all relates to the organization's strategy, et cetera."

... goals emphasized by the government and Health Quality Ontario have created tensions for some boards in balancing local needs and provincial targets.

The CEO was not optimistic that the situation would change:

"I think there's a lot of awareness; some of these things are out there. I don't know if there is a lot of political will to change much of it, because it's very political - the environment. Sometimes you wonder; sometimes you think it's more the politicians driving the bus than the practitioners."

Another CEO commented that this increase in regulatory requirements - including the "extraneous noise around the ECFA Act" - has prompted the board and quality committee to become much more focused on compliance rather than improvement:

"This year it has been tougher because of all the extraneous noise around the ECFA Act. A lot of it, particularly at the quality committee, and even at the main board, was, 'Here are the compliance issues.' And there've been a lot of other compliance requirements over the past year that have affected boards: there are the broader public sector guidelines, all those kinds of things; it's a real struggle to try and keep all the balls in the air when boards are accountable now for so much more. They feel their accountability and sometimes they just default to getting very narrow in their focus. 'There's this compliance issue; are you compliant? Let's move on to the next compliance issue.' And they're losing the forest for the trees around getting down to focus on quality in a broader perspective."

One participant summarized on a positive note:

"We don't have very many like hospitals immediately around us, so while I'm talking to my colleagues on a regular basis, you don't always get a chance to say, "What are you doing with this and how is that going for you?" So we don't know where we are sometimes on the continuum, but we're hoping that some of these things will bear fruit, and if they don't work out we'll try something else to make sure that we keep quality as a prime focus."

Discussion

Based on the responses of those we interviewed, it is clear that the new Ontario legislation, The Excellent Care for All Act, has had an important impact in raising the profile of quality of care and patient safety issues for the boards of Ontario hospitals. At the same time, the implementation of the ECFA Act has required adjustments for boards in some organizations that were already focused on quality performance. For these boards, the act inserted additional priorities and measures that were not viewed as critical issues for their organizations. Although these boards could have maintained their focus on the priorities established before the act, the goals emphasized by the government and Health Quality Ontario have created tensions for some boards in balancing local needs and provincial targets.

These unintended tensions are being addressed in several ways. Some boards are broadening their quality plans to include new priorities, others are creating parallel scorecards: one linked to the QIP process, the second for internal use. Health Quality Ontario did not establish a minimum number of goals for hospital quality improvement plans, but they acknowledge that "too many priorities may lead to diluted efforts" (Health Quality Ontario 2011: 5). In practice, most hospitals selected only a few Priority 1 ("high priority") goals and could decide to include both local issues and provincial priorities in their goals, so this issue may be only a transitional problem.

Still, in the short run, the new Ontario legislation may have blunted the effectiveness of some boards that had already developed a clear strategic focus on quality and patient safety issues. Effective policy requires a continued system focus on accountability for quality and patient safety performance. But greater autonomy for those hospitals that have already demonstrated strong performance might enable them to maintain their previous efforts and limit the consequences of the current prescriptive approach. A strategy of "earned autonomy" (Mannion et al. 2007), where high-performing organizations are given greater freedom to set goals and allocate resources, might enable government to maintain oversight, while not limiting the effectiveness of local leadership. The evidence of the impact of earned autonomy policies in the United Kingdom is limited, although a recent study found that managers in two Foundation Trusts (FT) (hospitals that were granted greater freedom from regulatory regimes) saw their hospitals as more autonomous and more capable of service delivery improvements than hospitals that did not have FT status (Anand et al. 2012).

The linkage of executive compensation to the QIP goals was complicated by the concurrent government restraint on executive compensation, producing the potential for penalties but no possible compensation benefits for hospital senior leaders. Perhaps not surprisingly, some hospitals opted to create limited targets for the goals that were linked to performance; some, in fact, set targets below current performance, an approach that violates the intent of these reforms. Pay for performance is an intuitively appealing idea, but often difficult to implement in a way that fosters broad system improvement rather than paying for small gains or leading to explicit gaming (Doran et al. 2006; Lindenauer et al. 2007; Petersen et al. 2006).

The most critical issue is whether the government's efforts through the ECFA Act to engage boards and heighten their attention to and accountability for quality and patient safety translate into organizational and system-wide improvements. Many of the focal issues (and accompanying core indicators) identified by the government and Health Quality Ontario have been difficult to improve. These include healthcare-associated infections such as C. difficile, pressure ulcers and falls. While increased emphasis on these issues will enable organizations to prioritize activities, the number and nature of these problems will be difficult to remedy, given the limited improvement capability and capacity of many hospitals and other organizations. These organizations may lack sufficient expertise and support needed to maintain high levels of infection prevention and control, and ongoing quality improvement efforts.

Hospitals were the first set of delivery organizations asked to create quality improvement plans. The Ontario government has signalled its intention to engage other healthcare organizations in setting quality improvement goals. Thus most of the attention to date has been focused on quality and patient safety performance within delivery organizations. However, there is growing awareness of the important challenges of ensuring safety across the continuum of care (Jencks et al. 2009; MOHLTC 2011). This is already evident in the addition of "integration" as a core quality area in the hospital quality improvement plans developed for 2012-2013. Hospitals are now being asked to set targets on readmission rates and ALC (alternate level of care) days. Influencing these measures requires system changes, not just departmental or organizational improvements. Thus the emerging challenge is to create quality improvement plans and system accountability that ensure effective and safe care across referral networks and levels of care.

Conclusion

The Excellent Care for All Act in Ontario is an important step

in creating responsive governance. The implementation of the act has helped to raise the bar on quality of care and patient safety in Ontario hospitals, and has helped to align governance activities with the core work of hospitals – delivering high-quality care. Our research focused on a small number of hospitals identified by experts as having high-performing boards. Several of these hospitals reported difficulties in reconciling these new external demands with their ongoing strategic agendas for improving services. Effective policy must create an environment where all organizations focus on improvement, but where regulation does not limit the capabilities of leading organizations to achieve even higher performance. HQ

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Improving Care for British Columbians: The Critical Role of Physician Engagement

Julian Marsden, Marlies van Dijk, Peter Doris, Christina Krause and Doug Cochrane

Abstract

Canadian provinces are addressing quality of care and patient safety in a systemic way, but obtaining physician involvement in system improvement continues to be a challenge. To address this issue, individual physicians, physician groups, the British Columbia Medical Association, the health authorities, the BC Patient Safety & Quality Council (BCPSQC) and the Ministry of Health have come together to support physician involvement and foster physician satisfaction. Building on earlier work on patient safety, in 2010 the ministry developed a comprehensive strategy for system-wide improvement, focusing on achieving critical population, patient and sustainability outcomes. Central to this plan is the acknowledged need to involve healthcare providers of all disciplines, in particular physicians.

Today, BC physicians are leading large-scale provincial clinical improvement in three interdependent areas: Clinical Care Management, Integrated Primary and Community Care, and the National Surgical Quality Improvement Program. To further physicians' key contributions to BC's healthcare system, the BCPSQC, physician-ministry committees, health authorities and the Ministry will continue to engage physicians through practice support, feedback, financial recognition and information exchange, and by supporting improvements in the care provided to patients.

rganizations that are highly successful in achieving local and system-wide improvement in patient care and health service delivery have achieved their successes in large part because clinicians (most notably physicians) played an integral part in shaping clinical services (Mountford and Web 2009; Snell et al. 2011). Canadian provinces are addressing quality of care and patient safety in a systemic way, but obtaining physician involvement in system improvement, whether at the level of their clinical practice, healthcare facility or health authority, continues to be a challenge.

To address this issue, individual physicians, physician groups, the British Columbia Medical Association (BCMA), the health authorities, the BC Patient Safety & Quality Council (BCPSQC) and the Ministry of Health have come together to support physician involvement and foster physician satisfaction. Efforts to date have been based on a renewed provincial focus on individual and population health. To achieve improvements in care, physician leaders are needed in health system design as well as delivery, and impediments to their participation must be resolved. Neither strategy is sufficient in itself; individual and population health are interdependent, and both must be addressed to achieve the quality of care that British Columbians deserve.

Physicians as Leaders in Clinical Care Improvement

British Columbia (BC) has been proactive in recognizing the critical role of physicians in health system improvement. Steps have been taken over the last decade to involve physicians as leaders for clinical improvement and to address barriers (Mountford and Webb 2009) by recognizing their unique contributions, creating educational opportunities, removing financial barriers and by mentorship.

In 2003, the BC Ministry of Health created the BC Patient Safety Taskforce and, through its leadership, BC became an early adopter of Safer Healthcare Now!, a national quality improvement campaign that launched in 2005. The ministry also supported focused clinical improvement efforts for sepsis and patient flow through Evidence to Excellence, and for access to primary care through the General Practice Services Committee (GPSC).2 Critical to the success of these efforts were the physicians recruited to lead these initiatives.

Building on this work, in 2010 the ministry developed a comprehensive strategy for system-wide improvement, known as the Innovation and Change Agenda. This strategy focuses on system improvements to achieve critical population, patient and sustainability outcomes. It is underpinned by aggressive health promotion, integrated primary and community care delivery, improvements in the quality of clinical care, and in the productivity and efficiency of health services delivery. Central to this plan is the acknowledged need to involve healthcare providers of all disciplines, in particular physicians.

To undertake this ambitious plan, linkages have been formed with communities, health authorities, the ministry and professional associations such as the BCMA. In developing these relationships, several strategies have been used to encourage collaborative physician participation. These include the provision of the following:

- Improvement training for physicians through the BCMA and the Divisions of Family Practice
- Quality improvement expertise to support divisions and practices in their improvement efforts
- · Opportunities for peer-to-peer interaction and sharing through collaboratives, webinars and workshops that are focused on improving the clinical care of patients with sepsis, cardiac and surgical diseases, and those needing intensive
- Clinically relevant indicators and measurement systems that directly support physicians' clinical practice and their efforts for improvement
- Opportunities to recognize teams who have achieved sustained improvements through the BCPSQC awards program and, of key importance

The deliberate recruitment of physician leaders to develop, guide and drive clinical improvement

Today, physicians are leading large-scale provincial clinical improvement in three interdependent areas: Clinical Care Management (CCM), Integrated Primary and Community Care, and the National Surgical Quality Improvement Program "(NSQIP)" in BC.

Clinical Care Management (CCM) is BC's province-wide effort to improve care through the application of evidence-based clinical guidelines.

Clinical Care Management

Clinical Care Management (http://www.bcpsqc.ca/quality/ clinical-care-management.html) is BC's province-wide effort to improve care through the application of evidence-based clinical guidelines. CCM engages the health system at multiple levels, from clinicians to senior leadership in the health authorities. Currently, CCM is working to improve care in the following areas: care of critically ill patients, hand hygiene, heart failure, medication reconciliation, sepsis, stroke and transient ischemic attack, and surgical checklist and surgical site infections and venous thromboembolism. Programs are being developed for antimicrobial stewardship and the care of the frail elderly.

Fundamental to the success of CCM has been the incorporation of practising physicians with expertise in the clinical area through Clinical Expert Groups (CEGs) and as provincial Clinical Leads for each topic. The CEGs are topic specific, have developed clinically relevant indicators, and assess improvement progress as well as providing feedback and clinical leadership. CEG members are clinical and operational leaders from health authorities, physicians working in the community, the BCPSQC and the Ministry of Health; they serve as a direct connection to the multi-disciplinary teams working to improve care. The BCPSQC funds the provincial Clinical Lead positions and provides a Quality Lead for each clinical area to support improvement in partnership with the Clinical Lead. Beyond the formal leadership positions for physicians in CCM, practitioner involvement varies with the stage of the initiative. For example, in sepsis improvement, each health authority has a physician champion who is working with improvement teams at the facility level, whereas the care of the frail elderly has yet to be implemented at the front line.

Integrated Primary and Community Care

The creation of a system of care that integrates services delivered by community physicians with services in health authority facilities and other community organizations is a crucial improvement goal. Physicians, health authorities and non-governmental organizations work to improve access and the availability of programs to help keep individuals out of hospital. However, these improvements are often undertaken within one area of care and are not always coordinated with the rest of the community services available. Work is under way to incorporate efforts into an aligned system-wide transformation.

The Divisions of Family Practice are foundational to addressing the complexity and coordination of patient care in their communities as they assume responsibility for the health of their patient population. Physicians working in collaboration with their geographic health authority have addressed many issues, including sharing patient information across practices with the health authority and with the patient, automated primary care and specialist communications, measurement of the quality of practices in key clinical areas (see CCM above), and provision of urgent access and primary care attachment.

BC surgical programs will have accurate, rigorous and valid outcome data.

National Surgical Quality Improvement Program

The BCPSQC, in collaboration with the BC Health Services Purchasing Organization, has brought the American College of Surgeon's NSQIP (http://www.bcpsqc.ca/quality/bcnsqip.html) to 24 BC surgical centres. Together, these facilities perform 90% of the surgical procedures in the province. NSQIP is a clinical measurement system that provides risk-adjusted 30-day surgical outcomes for operations performed at participating facilities. These data allow comparison of outcomes with peers so that areas of improvement and leadership can be recognized. In addition, NSQIP provides advice on quality improvement strategies, on-site peer assessment and clinical quality evaluation. This approach is dependent on surgeon engagement and leadership, and has been highly successful in improving surgical care in the United States.

This is the first time that BC surgical programs will have accurate, rigorous and valid outcome data. Each site has organized a NSQIP team led by a surgeon champion, anesthesiologist, surgical clinical reviewer, quality improvement specialist and an administrative leader. NSQIP teams guide local improvement using the outcome data and multi-disciplinary "action teams."

NSQIP sites in BC have come together and formed the Surgical Quality Action Network (SQAN) (www.bcpsqc.ca/ quality/surgical-quality.html) to provide a provincial vision and learning coalition for surgical quality improvement. Through the Surgical Quality Action Network, NSQIP sites receive non-risk adjusted reports based on their NSQIP data submissions, data they use to guide their own improvement initiatives. The vision is "top enabled," and the improvement in care is "bottom driven." The SQAN's immediate goal is to accelerate improvement for all NSQIP sites while demonstrating local improvements in surgical outcomes by November 2012.

Helping Clinicians Lead

To build the capabilities of physicians to engage productively in quality assessment and improvement, several formal initiatives are under way to support education for medical leaders and to expand the efforts of the Practice Support Program. BCPSQC offers the Quality Academy, a project-based, mentored education program designed for professionals who learn the principles of quality improvement including: process and systems thinking; personal and organizational development; involving patients, users, carers, staff and the public; making improvement a habit: initiating, sustaining and spreading change; delivering on cost and quality; problem solving/internal consultancy skills; and innovation for improvement (Bevan, 2011) and undertake projects. Vancouver Coastal Health Authority is also working with the University of British Columbia's Sauder School of Business and the BCPSQC to build a leadership program for department, program and division heads. Similarly, the General Practice Services Committee and Simon Fraser University have developed a leadership training program to support physician leaders involved in the Divisions of Family Practice.

The conscious effort to support physicians in the evolving healthcare system has resulted in satisfaction rates that parallel those seen across the country (National Physician Survey 2010). Surveys, monitoring retention patterns and interest in physician leadership roles can be used to assess the engagement fostered by the initiatives and should be a focus of future research.

Supporting Individual Physicians in Practice

Physicians in individual or group practices face a number of pressures that limit their ability to engage with the larger health system. Changing societal expectations; pressures to serve patients in the face of limited numbers of physicians, in particular in rural areas; limited availability of locum services; low reimbursement; antiquated or non-existent information systems; and ongoing system re-organization have all added to the stress of practice (Thommasen et al. 2002). In BC, some of these factors have been addressed through expansion of University of British Columbia Faculty of Medicine enrolment, through payment changes and by the strategies implemented by the General Practitioner Services Committee, Shared Care Committee and Specialist Services Committee all of which have implemented deliberate strategies to foster physician leadership and involvement in efforts to improve care. In addition, efforts have been focused on building the relationships with health authorities and supporting individual practice.



Relationships with Health Authorities

With the consolidation of hospitals in BC in the late 1990s, an unintended consequence was a sense of individual alienation and a polarization of care into community and health authority/ regional spheres. Many physicians disengaged from the health system, with the result that the anticipated clinical efficiency and economies of scale did not occur. It was apparent that the relationships between physicians, the new health system and their communities had to be rebuilt. Rebuilding these relationships has taken a decade and has been based on two strategies: development of the Divisions of Family Practice and creation of compacts between the health authorities and physicians.

Divisions of Family Practice are community-based groups of family physicians working with their health authority, the General Practitioner Services Committee and the ministry toward common healthcare goals (https://www.divisionsbc. ca/provincial/home). The divisions provide physicians with a stronger collective voice in their community while supporting them to improve their clinical practice, offer comprehensive patient services and influence health service decision making. Divisions have been instrumental in building effective information systems for care and evaluation, designing service delivery, ensuring patient attachment and supporting colleagues. They have formalized the clear role for division members as leaders in guiding healthcare in their communities and health authority.

To bring physicians and organizations to a common understanding of goals and strategies, newly created compacts written or unwritten descriptions of what an organization and those who work for it owe one another - have been of value. Compacts specify the responsibilities and mutual interdependencies of partners (Edwards et al. 2002). The process of creating such an agreement acknowledges and defines the goals, aspirations and expectations of all parties, and provides a common

framework for the requisite inter-professional and inter-organizational relationships. Perhaps, more significantly, the process fosters mutual respect and trust (Edwards et al. 2002; Liebhader et al. 2009; Reinertsen et al. 2007; Sears 2011). Compact development has been successfully used at the BC Women's Hospital and Health Centre.

> Physicians play a critical role in the design and delivery of healthcare for British Columbians. Many are engaged in these efforts and yet many are not.

Supporting Office Practice

Regardless of the type of practice, its location or the method of payment for services, the importance of helping to make the physician's job easier through system design has been long recognized in BC. At the practice level, optimizing care and access and office efficiency though advanced access and group visits has been a focus of the Practice Support Program, an initiative of the General Practitioner Services Committee (http://www.gpscbc. ca/psp/practice-support-program). The program provides selfassessment modules and learning sessions on a variety of topics relevant to primary care. Physicians' time while attending the learning sessions is also funded. In conjunction with ministrysupported information technology deployment into physician offices (http://www.pito.bc.ca/) and the Divisions of Family Practice, physicians are now better connected, can operate more efficiently and have a clear role as leaders in guiding healthcare in their communities and health authority. The successes achieved to date are detailed on the Practice Support Program website.

Physicians play a critical in the design and delivery of healthcare for British Columbians. Many are engaged in these efforts and yet many are not. What can be done to further the key contributions of physicians to our healthcare system? In BC, the efforts of the BCPSQC, the physician-ministry committees (General Practitioner Services Committee, Shared Care Committee and Specialist Services Committee), the health authorities and the ministry will continue to make doing the right thing easy through practice support, feedback, financial recognition and information exchange, and by supporting improvements in the care provided to patients. The quality of clinical care is the fundamental contributor to system sustainability and patient/ client experience. In this context, the leadership needed to transform the performance of hospitals and health systems must come primarily from doctors and other clinicians (Mountford and Webb, 2009). We must support physicians to make this so. HQ

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Julian Marsden is clinical director with the BC Patient Safety & Quality Council, a clinical professor, UBC Department of Emergency Medicine. He has had clinical duties in the Emergency Department of St. Paul's Hospital, Providence Health Care, since 1992.

Marlies van Dijk is the director of clinical improvement with the BC Patient Safety & Quality Council. Her primary focus is working to improve the quality of surgical care through clinical care management and the BC Collaborative of the National Surgical Quality Improvement Program (NSQIP).

Peter Doris led the drive to bring the National Surgical Quality Improvement Program (NSQIP) to British Columbia. His passion for recognizing the value of physician leadership in driving improvements in care is demonstrated in his work as the physician champion of NSQIP at Surrey Memorial Hospital since 2006. Together with a team at the BC Patient Safety and Quality Council he is now guiding the implementation of NSQIP across 24 hospitals in BC.

Christina Krause brings a variety of health care experience to her role as executive director with the BC Patient Safety & Quality Council. Her passion and interests include the use of social change models and network theory in efforts to engage and mobilize stakeholders to improve quality of care. More recently, this has expanded to include social media to create enhanced connections and shared learning.

Doug Cochrane is the chair and provincial patient safety & quality officer of the BC Patient Safety & Quality Council, and Past Chair of the Canadian Patient Safety Institute. Dr. Cochrane is a professor at the University of British Columbia in neurosurgery, a certificant of the American Board of Pediatric Neurological Surgery.

Notes

- ¹ Evidence to Excellence is an academic organization established to improve clinical and operational outcomes for Emergency Departments across British Columbia (www. evidence2excellence.ca).
- ² The General Practice Services Committee (GPSC) is a joint Ministry of Health and BC Medical Association committee that is responsible for developing and implementing strategies that allow for optimum use resources allocated in the Physician Master Agreement to support improvements in primary care. The Divisions of Primary Care, based on the experiences in Australia and New Zealand, are an initiative of the GPSC (https://www.divisionsbc.ca/provincial/home).

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o system has made substantial improvements in quality of care without the engagement and empowerment of clinicians to design and lead quality improvement efforts. In one of two interviews that speak to the role of physicians, Chris Carruthers (CC) interviews Ward Flemons (WF) – a professor of medicine at the University of Calgary and a leader in quality improvement - who talks about the critical role of creating and supporting physician leadership in quality improvement. He also discusses the importance of aligned expectations around quality and clear and strong accountabilities for quality.

CC: I noticed in your biography that you've obviously had a strong interest in quality and safety, and before the amalgamation you put some groups together that included physicians, to address the issues. Could you start by telling us how you got that going and how you got the physicians involved? WF: Yes, I think a history lesson is always interesting. You learn from mistakes, and you learn from things that worked. It's an interesting history in Calgary. A lot of the work on quality and safety was in place before I took over, but it really came from the predecessor of Accreditation Canada. They surveyed the landscape and said, "Either Calgary doesn't have a quality plan at all, or it's very rudimentary." This was the first survey of the full region; before, we were all separate hospitals, like Ontario.

There was a really insightful and pretty powerful chief medical officer at the time (in Ontario the equivalent position might be chief of staff). The bottom line is, he said, "They're right; we don't do this very well and we have to do something better; this is a reason to make a major change in how we do business. We have a whole pile of analysts all working on the finance side, and yet that's not our business. Our business is healthcare." He was able to make the argument at the executive level to create a new entity within the Calgary Health Region that was focused on quality and had a physician leader. He got a lot of the analytical power in the region reassigned to report on the clinical side of the equation rather than on the financial side. He also got new funding for teams of physicians - they were called quality consultants at the time – at a departmental level, to lead quality in their department.

CC: One of the key issues was, there had to be additional resources. It wasn't voluntary on top of their existing clinical workload?

WF: Absolutely not voluntary; it was investment up front.

CC: Were they token stipends, or were they appropriate?

WF: They were appropriate. I was the first one in the Department of Medicine, and they paid me one third of my time.

I don't think you can afford to, nor would you want to, tell physicians, "You do your day job and then we'll pay you for quality on the side."

CC: Based on income relative to clinical? If you're going to get physicians involved, you have to pay market value, don't you?

WF: Yes, I truly believe that. Now, it's a question of what physicians you pay and what you pay them for. I think you pay for leadership. I don't think you can afford to, nor would you want to, tell physicians, "You do your day job and then we'll pay you for quality on the side." I think the expectation should be that quality is one of the reasons we get paid - however we get paid, fee for service or whatever – so you appeal to the greater good to participate in the projects. But the person who's actually taking the 30%, or 50%, of their life to lead it, to come up with the plan and be the backbone, I think you have to pay those physicians.

CC: Was it difficult to recruit docs to these roles?

WF: By and large it wasn't too bad. Partly, it was the person who was recruiting; they got the former head of intensive care for the entire region. Like most critical care guys, he was visionary and very forceful, but he knew what he was doing. When he called you, or he called a department head and said, "We've got this new program; I need somebody out of your department to participate," people paid attention. They knew that the region had taken it seriously by putting money up front. They'd hired somebody on a full-time basis to do a lot of the lifting, and then they'd got them attached with the data analysts. That's what got me interested – access to data in the region. I was an outcomes researcher: that's what I was interested in.

CC: Going back to the very beginning, after Accreditation Canada's report, was leveraging resources out of administration a challenge, or did they buy in up front, without balking at freeing up the resources for the physicians to do this?

WF: One thing you learn over the years is, often there's not a lot of unified vision at the very top in terms of how to move things ahead. Everybody's got their own idea, often a strongly held position. The docs, as represented by the chief medical officer, have a different perspective from the chief nursing officer and a different perspective from the chief operating officer. In this case, their very influential and visionary chief medical officer could convince his colleagues around the budget table that they needed to invest in this, and he used the Accreditation Canada report as the leverage to convince them. Once he was able to get that sign-off from his colleagues at the executive suite and from the CEO, he started building what he thought was the right way to go. But I think that as time went by, there was strong support and buy in from the whole organization. Initially, there were probably some challenging discussions to get the money put aside, but when they got it working, I think it was supported throughout the entire organization.

CC: Once they'd got some early outcomes and results, the investment seemed good?

WF: I think it's like anything; everybody's sitting back, asking "Who's involved; how likely is this to succeed; and have they made enough of an investment to be successful?" Once it's starting to look good, people want to know how they can join, as opposed to how they can ignore it. I think you do that partly with the leaders you put in place and what you signal by investing in it. Also, there's the model, and how successful you are at communicating the vision for why this is important and what it's going to accomplish.

Interview continues on page 96.

Supporting the Use of Research Evidence in the Canadian Health Sector

Michael Wilson, John Lavis and Jeremy Grimshaw

Abstract

Interventions to support evidence-informed decision making have increased in recent years, but they are often fragmented across different clinical, management and policy environments. Many of these efforts also place varying emphasis on supporting the use of research evidence, with some choosing to focus more on expert knowledge and/or media coverage and others focusing on supporting the use of actionable messages arising from high-quality, relevant and optimally packaged research evidence. In this paper, we profile five Canadian contributions - EvidenceUpdates, Rx for Change, Health-Evidence.ca, Health Systems Evidence and the McMaster Health Forum - that allow providers, managers and policy makers to efficiently find and use research evidence when they need it. These contributions are critical for supporting both local and global efforts to provide optimal and costeffective care, improving the quality of care and strengthening health systems.

esearch evidence is an important input into decision making for both healthcare providers and for health system managers and policy makers. Research evidence can inform decisions about which programs, services and drugs to provide as well as decisions both about health systems (i.e., strengthening or reforming health system governance, financial and delivery arrangements within which programs, services and drugs are provided) and within health systems (i.e., how to get cost-effective programs, services and drugs to those who need them) (Lavis et al. 2010).

Notwithstanding this potential, there are notable examples of research evidence not being used (or used inconsistently) and/or decisions and recommendations being made that do not reflect the conclusions of high-quality research evidence. For example, in clinical practice, studies have found significant deficits in adherence to recommended care processes (McGlynn et al. 2003; Schuster et al. 1998) as well as prescribing practices (Shrank et al. 2006). At the level of policy making, an examination of the use of research evidence in recommendations made by World Health Organization (WHO) departments found that the development of recommendations rarely drew upon systematic reviews and concise summaries of findings (despite WHO guidelines emphasizing the use of systematic reviews) (Oxman et al. 2007). Similarly, a review of recommendations made by the WHO and the World Bank in five health-related policy domains found that of the eight publications examined only two cited systematic reviews, and of the 14 recommendations made only five were consistent with both the direction and nature of findings from systematic reviews of effects (Hoffman et al. 2009).

In Ontario, the need to inform decisions about patient care and strengthening the health system using the best available research evidence (thereby avoiding situations as outlined above) has been made explicit in The Excellent Care for All Act, 2010 that was proclaimed in June 2010 (Ministry of Health and Long-Term Care [MOHLTC] 2012a, 2012b). Indeed, the MOHLTC has provided clear signals that it is prioritizing the use of research evidence to inform the development of policy by requiring training for civil servants in finding and using research evidence, incorporating assessments of the use of research evidence as part of performance reviews, and mandating the use of a "Research Evidence Tool" that requires civil servants making submissions to the minister or to cabinet to explicitly document the key sources for research evidence that were searched and declare that relevant findings were used to inform the submission. However, such internal "user-pull" efforts need to draw on broader efforts that allow providers, managers and policy makers to efficiently find and use research evidence when they need it.

Knowledge Translation

The field of knowledge translation attempts to support the use of research evidence to inform practice, management and policy. There are many terms used to describe the same or similar processes (Graham et al. 2007; Straus et al. 2009), with the terms "implementation science" and "research utilization" often used in Europe, and "diffusion" and "dissemination" commonly used in the United States (Straus and Haynes 2009). A cross-sectional study using data from 2006 documented the number and frequency of terms used in 12 healthcare journals to describe knowledge translation and found that 100 different terms were used across the 581 articles that described knowledge translation research (McKibbon et al. 2010).

Despite the diverse terms used, the field of knowledge translation is focused on moving beyond the passive dissemination of research evidence to more effectively supporting its use (Straus et al. 2009). The field faces four important challenges in doing so: (1) research evidence competes with many other factors in decision-making processes; (2) providers, managers and policy makers may not value research evidence as an input to decisionmaking processes; (3) the available research evidence may not be relevant to the issues or context at hand; and (4) research evidence is not always easy to use (Lavis et al. 2006). While efforts to address these challenges through knowledge translation interventions have increased in recent years, they are often fragmented across different clinical, management and policy environments. In addition, many efforts place varying emphasis on supporting the use of research evidence, with some choosing to focus more on expert knowledge and/or media coverage (EvidenceNetwork.ca 2012; HealthyDebate 2012) and others focusing more on supporting the use of actionable messages arising from high-quality, relevant and optimally packaged research evidence (Straus and Haynes 2009).

Increasingly, efforts that have a focus on supporting the use of research evidence (as opposed to expert opinion or other forms of evidence) draw on systematic reviews (or summaries of systematic reviews), given the reduced bias and increased preci-

sion achieved by synthesizing the global pool of evidence about a particular topic. In addition, systematic reviews (and especially summaries of reviews) constitute a much more efficient use of time for busy healthcare providers, managers and policy makers, given that all of the studies have already been identified, quality appraised and synthesized in one document. We profile below several Canadian contributions to supporting evidence-informed practice, management and policy, both locally (e.g., toward the focus of this special issue – policy development to build a culture of quality in Ontario's hospitals as part of the Excellent Care for All Act) and globally (e.g., toward developing global guidelines to support evidence-informed policies about health systems).

Efforts toward Supporting Research Use by Healthcare Providers

Three examples of comprehensive knowledge translation efforts for providers as well as health professional leaders and managers engaged in supporting evidence-informed practice are focused, respectively, on providing access to research evidence (systematic reviews and primary research) to support evidence-based clinical decisions (BMJ Evidence Centre 2012; Haynes 2005), systematic reviews focused on bringing about behaviour change in prescribing and medicines use (Canadian Agency for Drugs and Technologies in Health 2012; Weir et al. 2010) and systematic reviews about public health interventions (Dobbins et al. 2010; Health-Evidence 2012). First, EvidenceUpdates (http:// plus.mcmaster.ca/EvidenceUpdates), an initiative of the BMJ Group and McMaster University's Health Information Research Unit, provides a searchable database of high-quality research evidence, an e-mail alerting system and key evidence-based resources such as synopses and summaries of research evidence. The citations in EvidenceUpdates are identified from 120 premier clinical journals, quality appraised and then rated for clinical relevance and interest by at least three members of a worldwide panel of practising physicians. The alerting system allows users to receive periodic updates to citations meeting minimum levels of clinical relevance in their areas of clinical interest (e.g., primary care or internal medicine). As Haynes (2005) indicates, the EvidenceUpdates service allows users to easily keep up-to-date with "need to know" studies and reviews by reducing approximately 50,000 articles per year in approximately 120 premier clinical journals to the most salient one to two articles per month (or 12 to 24 per year), which amounts to a substantial noise reduction of 99.96% (Haynes 2005).

The second resource, Rx for Change (http://www.rxfor-change.ca), provides a comprehensive repository of systematic reviews evaluating the effectiveness of interventions to change clinical practice to support evidence-based prescribing and medicines use (Weir et al. 2010). Rx for Change is primarily intended for those making decisions about which interven-

tions to include in quality improvement programs (e.g., health professional leaders or managers). The database was created to make it easier for these decision makers to access, assemble and assess research evidence in this domain, given the large volume, wide dispersion and variable quality of the available research evidence. In addition to ensuring the database remains up-to-date and comprehensive, Rx for Change includes several features that distinguish it as a unique knowledge translation tool, including (1) categorizing reviews according to whether they evaluate interventions directed at consumers or professionals; (2) quality appraising each eligible review using the AMSTAR tool (Shea e al. 2007) and only including reviews meeting a minimum quality standard; (3) providing userfriendly one-page summaries highlighting the study characteristics, key findings and conclusions; (4) providing summaries of overall findings from reviews about each grouping of interventions (e.g., audit and feedback, computerized reminders, and so forth); and (5) providing a table of results from the individual studies (including links to each study).

Lastly, Health-Evidence.ca provides a comprehensive repository of systematic reviews of the effectiveness of public and population health interventions, accompanied by e-mail updates that periodically alert users to new reviews in their areas of interest (Health-Evidence 2012). The database aims to support evidence-informed decision making in public health organizations, and therefore its primary target audience includes both providers (e.g., public health nurses, outreach workers, and so forth) and managers and policy makers responsible for making decisions related to public health (Dobbins et al. 2010). Health-Evidence.ca allows users to search for systematic reviews using their comprehensive taxonomy of topics related to public health, and each record provides a quality appraisal score as well as an outline of the review focus, type of review, intervention studied, population characteristics and intervention strategy. Lastly, brief summaries of the key findings from some of the systematic reviews contained in the database are provided.

Efforts toward Supporting Research Use by Health **System Managers and Policy Makers**

Increasingly, efforts to support linking research to policy strive to address the two factors that emerged with some consistency in systematic reviews of factors influencing research use by health system managers and policy makers, which include the timing and timeliness of research evidence being made available and interactions between researchers and policy makers (Innvaer et al. 2002; Lavis et al. 2005a, 2005b). A key strategy for addressing the former involves facilitating the retrieval of optimally packaged, high-quality and high-relevance systematic reviews, while for the latter, engaging policy makers and stakeholders in deliberative dialogues has emerged as a key strategy.

To facilitate the timely retrieval of research evidence, Health

Systems Evidence (www.healthsystemsevidence.org) provides the world's most comprehensive and continuously updated repository of research evidence about governance, financial and delivery arrangements within health systems, and about implementation strategies that can support change in health systems (many of which are drawn from Rx for Change) (McMaster Health Forum 2012). Where once the supply of systematic reviews addressing these types of questions seemed very limited, Health Systems Evidence now (as of July 2012) includes 54 review-derived products (30 evidence briefs for policy and 24 overviews of systematic reviews), 1,590 systematic reviews of effects (including 416 Cochrane reviews), 284 systematic reviews addressing other types of questions and 218 systematic reviews in-progress. The database also contains a continuously updated repository of economic evaluations related to health system arrangements and implementation strategies, descriptions of health system reforms and descriptions of health systems. In addition, Health Systems Evidence contains a number of features designed to help policy makers and stakeholders efficiently find and use research evidence. These features include links to independently produced user-friendly summaries (where available), scientific abstracts and full-text reports (when publicly available); quality appraisal scores for systematic reviews (using the AMSTAR tool) (Shea et al. 2007); and listings of the countries in which the studies included in the synthesis were conducted. Health Systems Evidence has also recently incorporated Canada's Evidence-Informed Healthcare Renewal (EIHR) Portal to provide policy makers and stakeholders with a comprehensive inventory of policy-relevant documents that can support healthcare renewal in Canada.

To facilitate interactions between policy makers and researchers, a number of groups (e.g., the McMaster Health Forum in Canada and the Evidence-Informed Policy Networks in Africa, Asia and the Americas) have begun to experiment with convening deliberative dialogues. In Canada, the McMaster Health Forum (www.mcmasterhealthforum.org) convenes stakeholder dialogues with a broad array of policy makers, stakeholders and researchers to work through a pressing health problem, options for addressing it and key implementation considerations. Dialogues at the forum are informed by an evidence brief that draws upon the best available data and research evidence to define the policy problem/issue, identify and describe what is known about possible policy and program options, and identify key implementation considerations for these options.

Deliberative dialogues provide unique support for evidenceinformed decision making by fostering the interplay of the best available data and research evidence with the tacit knowledge, views and experiences of those who will be involved in or affected by the issue. The preparation of evidence briefs for deliberative dialogues are also an example of how each of the

resources outlined above can be used to efficiently identify the best available data and research evidence about pressing health problems. For example, EvidenceUpdates, Rx for Change and Health Systems Evidence were recently used by the McMaster Health Forum as the primary sources used to identify research evidence to inform an evidence brief as part of the Quality Improvement in Primary Healthcare Project in Ontario (Lavis 2010). Specifically, the evidence brief used each of these resources to mobilize the best available research evidence about (1) the problem faced in supporting quality improvement in primary healthcare in Ontario; and (2) three options for addressing it (collaboratively developing principles for quality improvement, developing coordinating structures and processes to support quality improvement, and scaling-up existing quality improvement initiatives) and implementation considerations. The resulting evidence brief and dialogue summary, like all Forum products, can be downloaded from the Forum website.

Conclusion

Supporting the use of research evidence to inform practice, management and policy has been significantly enhanced by several synergistic efforts to support the use of high-quality, relevant and optimally packaged research evidence. The resources outlined above (i.e., "one-stop shopping" resources for research evidence and deliberative dialogues) are critical for supporting efforts to provide optimal cost-effective care and for making evidence-informed decisions toward strengthening health systems such as those that are the focus of this special issue about moving forward in Ontario with The Excellent Care for All Act.

With respect to strengthening knowledge translation efforts to support evidence-informed practice, management and policy both in Canada and globally, there are several key areas requiring further investigation. First, despite the many promising interventions, there are few rigorous evaluations of knowledge translations interventions, particularly those designed for managers and policy makers (Mitton et al. 2007; Perrier et al 2011). However, randomized controlled trials evaluating two of the databases highlighted here (EvidenceUpdates and Health-Evidence.ca) have found that efforts to provide tailored and targeted messaging about relevant research evidence increased the utilization of evidence-based information (Dobbins et al. 2009; Haynes et al. 2006). Second, while systematic reviews are an important tool for knowledge translation, their utility for providers, managers and policy makers can be improved by including more detailed descriptions of the interventions and ensuring they remain up-to-date. Lastly, there is a need to continue to diversify knowledge translation, which could include clinical support systems that automatically retrieve findings for clinicians (Straus and Haynes 2009), interven-

tions for rapid decision support when research is needed in a timely manner such as rapid response units (Canadian Agency for Drugs and Technologies in Health 2012; Ottawa Hospital Research Institute 2011; The Ontario HIV Treatment Network 2012) or efforts toward developing global guidelines to support evidence-informed policies about health systems (Lavis et al. 2012). Additional efforts could also include training for the science and practice of knowledge translation such those currently being led by KT Canada (Straus et al. 2011). HQ

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LINKING EVIDENCE AND QUALITY



key principle underlying the Excellent Care for All Act was the importance of evidence in guiding decisions across the healthcare system. The Canadian Agency for Drugs and Technologies in Health (CADTH) has led pan-Canadian efforts for several years to bring evidence to decisions about what will be covered and what will not be covered in Canadian healthcare. In this interview, the CEO of CADTH - Brian O'Rourke (BO) - speaks with Charles Wright (CW) about a number of the challenges and opportunities inherent in bringing evidence to healthcare decision-making. A key point throughout the interview is the range of efforts necessary to support decision-makers as they try

to bring evidence into coverage and other potentially controversial decisions.

CW: Let me start by asking how you would describe the general purpose of your organization - The Canadian Agency for Drugs and Technology and Health?

BO: More affectionately known in this country as CADTH - that's the acronym to get out of your lips! We're a health technology assessment agency. In its broadest sense, that means we inform; we provide information to policy makers in Canada regarding health technology. It can include pharmaceuticals, medical devices, medical/surgical procedures and diagnostic tests.

CW: Could you describe some of the methods, the processes, by which you fulfil that mandate?

BO: The difficult challenge with health technology assessment is trying to narrow down what you're going to look at. There are way too many technologies -pharmaceuticals, procedures, and so forth - to look at them all. So there's a very structured process for getting to what we're going assess.

Our primary customers - and we call the ministries of health our customers – are usually faced with some uncertainty regarding health technologies, and we help close that evidence gap to where they feel comfortable making a decision. To do that, we've put a structured process in place. Most countries around the world that have a health technology assessment agency, or an organization that provides that type of function, follow a similar process.

First, you need to plan and prioritize the types of assessments you'll do. In this country, there are about 25,000 drugs, and I've heard the device industry say there are over a million different medical devices. It's impossible for us to do an assessment and provide evidence on all of them, so planning and prioritization are first and foremost.

Once we come up with an agenda or a list of what we're going to assess, we get into production mode, where we get our research staff and clinicians together to look at the evidence and to produce reports or recommendations or tools. Then you need a formal process to disseminate that knowledge, to transfer it to the policy makers.

This all requires scientific oversight. At CADTH, we have a chief scientist. Her job is to be our eyes and ears with respect to the methodologies we use, the quality of our products, some of the staff training and education - both within CADTH and externally - and the evaluation. So plan, prioritize, produce and disseminate, with some good scientific oversight.

CW: That's a good overview. Let's go to some of the issues in more detail. What sort of expertise do you require in this process?

BO: First would be staff within the organization. It's important to note that we are a not-for-profit corporation; none of us in this organization are public servants. We're independent, arms-length from the ministry and from industry, so we provide good, independent, evidence-based information. Our internal staff are a good, broad mix of clinicians, physicians, pharmacists and nurses - a lot of PhD- and master's-trained scientists in epidemiology, pharmacology, public health, biochemistry, and so forth. We also have research assistants - typically with a bachelor's degree, who provide support to our scientists. We have a number of health economists on staff and a really strong component of information specialists or librarians; I think we've got one of the strongest groups of librarians in the country to dig up the information we're looking for in both the known

literature and the grey literature. We've got project managers as well, who help us keep our projects on track; timeliness is an important component of what we do. Then, a number of people come to us with an expertise in knowledge mobilization, people who understand how to develop tools or how to get that research into a format that's understandable from a policy maker's perspective or a clinical perspective. That's tour internal mix of staff.

We also rely heavily on expert advisors, so we have a number of advisory committees. We have a Drug Policy Advisory Committee composed of senior drug plan officials from all the participating jurisdictions. There's a Policy Forum; this is not a CADTH group but a group of senior officials from across the country on the medical devices and medical procedures side, and they provide advice to us. We have two distinctive expert committees. Our Canadian Drug Expert Committee is a mix of specialist physicians, family practice physicians, pharmacists, health economists, and so forth, who provide expert recommendations based on the work we do. They deal mainly with our drug portfolio. Our Health Technology Expert Revue Panel is a new committee we put together last year; it looks at all the work we do on non-drug technologies – devices and procedures.

We're also linked quite well with the academic community. There's a network called the Health Technology Analysis Exchange. We provide secretariat support to that group. Again, it's another means to getting some good expert advice from the academic community and other producers of health technologies.

CW: It's a very broad scope of relevant professional expertise.

BO: Absolutely, and for every report that we're doing, we typically also contract an expert who's a specialist in that particular area.

One other thing I should mention as well is patient input. We incorporated patient input into our processes for our Common Drug Review in about May 2010. That's an important aspect of how we do our work now.

Interview continues on page 101.

Evidence and Quality, Practicalities and Judgments: Some Experience from NICE

Anthony Culyer and Michael Rawlins

Abstract

The National Institute for Health and Clinical Excellence (NICE) is the principal provider of information about the evidence relating to effectiveness and cost-effectiveness in healthcare in the National Health Service of England and Wales. NICE regards quality as primarily to do with effectiveness, safety and the patient experience. In this paper we comment on the quality of evidence regarding these three and speculate about the consequences of widening the range of interventions for appraisal and taking more complete account of upstream determinants of health. We also comment on the type and quality of the evidence, as well as the way in which it is used, and the values – too often hidden – that permeate both the evidence and the way in which it is used.

uality, in the context of healthcare, has many dimensions, but Britain's National Health Service (NHS) recognizes three interrelated components

- effectiveness
- · safety; and
- the patient experience.

The National Institute for Health and Clinical Excellence (NICE) was set up in 1999 as an independent agency within the National Health Service of England and Wales to provide an authoritative evidential base for "clinical governance," a system-

atic way of managing and maintaining quality in hospitals and community healthcare providers. NICE's clinical guidelines, technology guidance and all its quality standards are developed by independent committees of experts including clinicians, patients, caregivers and health economists, and now includes guidance on public health interventions. The technologies considered include medicines, medical devices like hearing aids or inhalers, diagnostic techniques, surgical procedures and health promotion. All guidance is considered and approved by the NICE Guidance Executive, a committee made up of NICE executive directors, guidance centre directors and the communications director. A Citizens Council, composed of 30 members of the public, provides the NICE Board with advice that reflects the public's perspective on what are often challenging social and moral issues. NICE International offers overseas jurisdictions advice on the use of evidence and social values in healthcare policy. The topics selected for NICE's investigation are determined by the Department of Health (the ministry) after widespread consultation with experts, researchers, NHS service providers and patient representatives. The board of NICE consists of executive and non-executive directors broadly representing the principal stakeholder groups in England and Wales. NICE's scope is likely to be enlarged in the future to embrace interventions in the social care sector. Here, we focus on the contribution NICE makes through its technology appraisals, clinical guidelines and public health guidance to the information available to professionals and patients. In this context, it is the type and quality of the evidence, as well as the way in which it is used, that matters, and the values - too often hidden - that permeate both the evidence and the way in which it is used.

Evidence

Incorporating the results of medical research into clinical practice to ensure effectiveness has become entrenched in the notion of evidence-based medicine. As this approach spreads beyond clinical medicine and into the broader domain of health policy, the concept has become subtly transformed from "evidence-based" to "evidence-informed." Behind this note of realism lie, however, some fundamental questions. What counts as evidence? And, related to that, do some kinds of evidence (or ought they) carry more weight than others?

The Oxford English Dictionary defines "evidence" as "facts or testimony in support of a conclusion, statement, or belief." This begs the question of what counts as a "fact" and gets us nowhere in answer to whether some forms of evidence carry more weight than others. There are many problems with "facts," of which one, in the present context, is especially problematic. Statements, which everyone may agree to be factual, may be either false or true, or partially one or the other. For example, the statement "antidepressant drugs are used in alleviating the symptoms of depression in dementia" is a factual statement, but recent trials have shown they are no better than placebo (Banerjee et al. 2011). Similarly, the statement "hormone replacement therapy is used to prevent heart attacks" is a factual statement but false in terms of "usefulness" (Rawlins 2011).

... what is "scientific" about scientific evidence, and what differentiates it from colloquial evidence?

The kinds of falsity or truth we have in mind are empirical. Agencies like NICE need factual information in order to answer the questions with which they must wrestle in the evaluation of healthcare technologies: "Does it work?" "For whom does it work?" "Relative to what does it work better or worse?" "At what cost does it work?" and "is the expected health gain worth the extra cost?" There are, however, other matters of concern to such agencies. These include, "How confident can we be in the asserted facts?" "How relevant are the known facts to the appraisal of the intervention under investigation and its comparators?" "How complete is the factual information that is available?" and "How - as well as by whom - is the factual evidence contested?"

When non-scientists in the clinical, management or policy worlds are asked what they consider to be evidence, they typically come up with a complex mixture of both scientifically general and locally idiosyncratic types of information - so-called collo-

quial evidence (Culver and Lomas 2006; Lomas et al. 2005). Clinical or program effectiveness data compete with assertion (sometimes "expert" assertion), cost-effectiveness algorithms sit alongside political acceptability, and data on public or patient attitudes are combined with vivid recollections of personal encounters. The colloquial concept of evidence is broader than the more restricted scientific view and is generally regarded by many scientists as of poor quality. This raises the question of what is "scientific" about scientific evidence, and what differentiates it from colloquial evidence.

The things that are "scientific" about scientific evidence seem to be threefold. First, a formalized hypothesis or theory is being tested. Second, recognized and replicable methods are used to assemble evidence (as, for example, in controlled experiments such as clinical trials). Third, recognized and replicable methods are used to analyze and interpret the evidence (for example, using multivariate regression, propensity scoring or grounded theory). It is not the questions about which evidence is sought that give scientific evidence its distinctive character (Culver 1981). What makes evidence scientific is the manner in which the questions are answered, not the objects studied or questions

Within this more restricted scientific view of evidence, there are two distinctive manners of study relevant to healthcare decision making. One, relating mostly to testing hypotheses about the efficacy of interventions, uses methods that try to exclude contextual "contaminants," such as the natural variability in the skills and attitudes of doctors, the symptom presentation of patients, or the organization and funding of service delivery, as well as the more usual "confounders" of epidemiology that blur the line of causality between intervention and outcome. This type of science typically employs, for example, randomized controlled trials (RCTs) to uncover, as far as is epistemologically possible, "context-free" knowledge. The other approach, more common in the social sciences and in the environments in which decisions will be implemented, uses methods that explicitly describe and evaluate the contextual factors that might influence the practical impact of an intervention once it is deployed. This type of science employs a wide variety of methods to make judgments about the likely effectiveness of an intervention "in the field." This science - for it can be no less scientific in its principles and methods than the experimental approach to evidence gathering - is designed to provide "context-sensitive" results that appraise the facilitating or attenuating circumstances surrounding a particular decision. In context-free science, the emphasis is on what epidemiologists term "internal validity," meaning the degree of certainty with which the outcome of a trial can be attributed to an intervention rather than to some other variable. In context-sensitive science, the focus is usually on the variables for which the first approach controls, and the emphasis is on "external validity": the degree

of certainty with which a causal relationship can be generalized to settings other than those of the study. In epidemiology the former is commonly referred to as "efficacy" (the extent to which an intervention produces a beneficial effect under ideal conditions) and is in contrast to "effectiveness" (the extent to which a specific intervention, when used under ordinary circumstances, does what it is intended to do) (Cochrane Collaboration 2012). Context-free evidence is plainly less generalizable and less able to support decision making in contexts that do not approximate that of the original trial. Hence there is a need for supplementary context-sensitive evidence.

Hierarchies of Evidence?

Should the three types of evidence - context-free scientific evidence, context-sensitive scientific evidence and colloquial evidence - be ranked in a quality hierarchy? At one level, the answer might be yes. When they are available, both kinds of scientific evidence must be ranked above the colloquial as far as dependability is concerned. But the science is not always good or complete. Weak evidence sometimes requires use of either inappropriate comparators or indirect comparisons, and estimates of effect have to be derived from observational studies rather than RCTs (Chalkidou et al. 2008). Colloquial evidence comes into its own when scientific evidence is not available or is incomplete in particular and relevant respects (which it frequently is) with regard to context-sensitive matters, on which there is typically much less scientific research than on context-free matters. So colloquial evidence comes into play in a significant fashion when the issue is not whether, say, a medical procedure works in general (as might be demonstrated in US trials), but whether it is likely to work in Canada or Wales, or in community hospitals. If it is believed to work in such places, does it work well enough to warrant public funding? If it seemed to work well over the five-year period of a trial, can it be expected to continue to be beneficial over patients' expected remaining lifetimes? Or if it were introduced this year, could local services cope with the expected demand? And so on. Evidence that addresses one set of questions is not usefully, or generally, ranked in terms of quality, with evidence addressing another set of questions. Indeed, if colloquial evidence is all there is on one aspect of the performance of an intervention, then the quality of the scientific evidence, relevant though it may be to other aspects of performance, is actually relatively very poor with regard to that aspect.

Contextual facts are matters about which scientific evidence could be collected, but rarely is. If the guidance derived from a deliberative decision-making process is to be as helpful and comprehensive as possible, then colloquial evidence has two essential functions. It provides the relevant context for the context-free science, and it fills in gaps in the knowledge base - gaps that could be filled by scientific evidence but that often

have not been. The issue confronting any decision maker within a deliberative process is thus not so much how to balance the three types of evidence or to assess the weight to place on each, but rather to allow each to perform its appropriate task:

- Scientific context-free evidence is evidence about general potential
- Scientific context-sensitive evidence is evidence about likely realistic scenarios
- Colloquial evidence helps to provide a context for otherwise context-free evidence and to supply the best evidence short of scientific evidence when there is neither context-free nor context-sensitive evidence

This list is not a hierarchy and, as in the evaluation and appraisal of evidence to inform clinical decision making (Rawlins 2011), there is likewise no place for using hierarchies of evidence to inform healthcare policy.

Quality beyond Effectiveness

Decisions are informed not only by evidence about effectiveness or cost-effectiveness, whatever its kind. Values are also all-pervading (Rawlins and Culyer 2004) and range from judgments about the suitability of outcome measures, the weighting of different aspects of a healthy life on the benefit side, to the public and private expenditure consequences on the cost side; from the likely consequences of a decision for distributive justice, and how that is weighed in the balance, to the overall affordability of an intervention compared with the alternatives and the acceptability of the processes through which care is delivered to clients. NICE has sought to resolve issues of these kinds through highly consultative and deliberative decision-making procedures, which include an exercise in "direct democracy" in the form of a Citizens' Council (Culyer 2005, 2006; Rawlins 2005).

Jurisdictions that are wrestling with issues of quality in healthcare will almost certainly take effectiveness, in the sense of expected impact on people's health, as the main point of departure. It plainly makes little sense to speak of high-quality healthcare that had a negative impact (iatrogenesis) or a negligible impact ("flat-of-the-curve" medicine). An important role for NICE-type agencies is precisely to address this aspect and, indeed, to generalize it so that no care is excluded from the "insured bundle" that is more effective than care that is included in it (i.e., cost-effectiveness). Moreover, if this aspect of the quality of care is to be treated adequately, the means used by such agencies must themselves be of high quality, which is why NICE strove from the beginning to enlist the active support of the best people in populating its advisory committees and its specially sponsored research groups in universities - and never relying only on the evidence supplied by manufacturers. Quality of this sort comes at a cost - of resources and of time.

But the quality agenda inevitably needs extension beyond effectiveness. One obvious extension relates to the equity of the distribution of healthcare benefits or of health itself. NICE does not have a definitive answer to how this is best done. Indeed, it seems likely that "definitive" answers do not exist and that at least part of the best solution to this element of the quality agenda lies in establishing processes through which concerns about equity can be articulated and embodied - together with their appropriate evidential base – in the advisory processes leading to clinical guidelines and advice on the use of technologies. To this end NICE and the NHS's National Institute for Health Research have commissioned research that it is hoped will enable an appropriate extension of the usual limitations of cost-effectiveness methodologies (Asaria et al. 2012).

A further extension that also seems inevitable is to apply the evaluative quality principles used by NICE beyond the welltrodden territory of pharmaceuticals into the appraisal of other technologies such as medical devices and diagnostics, beyond these into the evaluation of public health, and eventually into the appraisal of "technologies" relating to the many environmental and "upstream" determinants of health. It is at this point that the limitations of characteristic political structures become sharply clear and why we have only ministries of healthcare rather than ministries of health. It is not merely that we lack the ability to coordinate a comprehensive health policy for quality but that we have only the rudiments of an understanding of the quantitative impact of such health-affecting phenomena and lack even the rudiments of a set of methodologies for evaluating the levers that might be pulled and the ways in which their pulling might integrate with the usual business of healthcare.

Yet another extension is into the patient experience as each patient is in receipt of care. These process aspects of the benefits and harms of healthcare, their measurement and how they might be integrated into more complete appraisals have scarcely been addressed by scholars, let alone implemented by agencies such as NICE.

NICE adopts a diversity of approaches. The scope of its appraisal is constantly widening, as is its evidential base. It certainly does not abandon RCTs in favour of observational studies, nor would it wish to discourage investigators of all kinds from developing and improving their methods. Rather, it seeks to find ways of extending the evidence base, quantitatively and qualitatively, to a wider set of factors that affect health and its distribution. Above all, NICE recognizes that facts, especially facts about "quality," never "speak for themselves," needing interpretation, contextualisation and evaluation; that values are all-pervading but may not command universal assent; and that decision-making processes need to be open, consultative and deliberative. Implicit in all these is that what are always required are the exercise of judgment and being able to account honestly for its exercise (Rawlins 2008). HQ

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Stronger Policy Through Evidence

Charles Wright, in conversation with Les Levin

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he role of evidence in improving the quality of care and the sustainability of our healthcare system is part of a number of healthcare reform efforts including, among others, the Triple Aim Framework developed by the Institute for Healthcare Improvement and the Excellent Care for All Strategy in Ontario. In this interview, Charles Wright (CW) speaks with Les Levin (LL) about the ways that evidence can be developed and brought to bear on healthcare decision-making. Dr. Levin has led work for a number of years first within the Ontario Ministry of Health and Long-Term Care and lately at Health Quality Ontario - that has led to substantial cost avoidance and quality improvement. These experiences re-enforce the importance of a close connection with decision-makers but also underscore the receptivity of decision-makers to evidence that is appropriately placed within a local context.

CW: Let me ask you the overview question - what would you say is the purpose of your organization? Tell me what it is and why it exists.

LL: The Medical Advisory Secretariat (MAS) is a component of Health Quality Ontario (HQO), and its mandate is to assemble evidence-based analysis, both within the unit and in collaboration with academia, especially at the University of Toronto, University Health Network and McMaster University. The purpose is to develop objective, scientifically rigorous evidencebased analysis on new and existing health technologies.

CW: It also forms a close relationship with what's called the Ontario Health Technology Advisory Committee. Could you describe that relationship?

LL: It's been described as a dyad. Through the collaboration with MAS, evidence that is contextualized by expert panels assembled by the province is reviewed by the Ontario Health Technology Advisory Committee (OHTAC). The latter actually produces recommendations based on evidence, or guidance based on evidence. So, the evidence goes through two contextualization processes. The first is through expert panels set up by the Province. Then OHTAC is responsible for prioritizing the requests for health technology assessments, which come from the Ministry of Health and Long-Term Care and from other stakeholders in the health system. These stakeholders are predominately, at this point anyway, from hospitals, but also from community-based health services. It's up to the MAS to assemble the evidence over a 16-week period for single technologies, which are then presented back to OHTAC for its recommendations.

CW: How does MAS go about fulfilling its mandate to produce evidence-based reviews and analysis and recommendations, and then go through OHTAC?

LL: I think there are two components. One is a systematic review, a search of the literature relating to the technology. It's a scientifically rigorous process, done according to a template that's set up for these reports. It aligns evidence

through a hierarchy of quality. We use GRADE, which has been universally adopted as a validated process for assigning quality to evidence; it's not just looking at the broad comprehensive analysis of evidence and comparative, where the technology is compared to other technolo-

gies. It's also assigning quality, which is a very important part of the decision-making process. If you have moderate- to high-quality evidence, there's little chance that further research is going to change your confidence in the estimate. That's the systemic review component. That's always contextualized, as I said earlier, with expert opinion. Experts are asked to provide their opinion iteratively, when the analysis is under way.

The second component, which is also coordinated by but not undertaken by MAS, is the economic analysis. That's done by two health economic units in the province - one through THETA, another through PATH. The former, THETA is at the University of Toronto and the latter is McMaster University.

If you have moderate- to high-quality evidence, there's little chance that further research is going to change your confidence in the estimate.

Using the full-blown resources of both those health economy academic units and working closely with MAS as the systematic review is under way, we'll develop a full economic analysis, usually budget impacts and cost-effective analysis.

CW: Would you say that MAS holds the reviews and that OHTAC adds a wider perspective on the implications in all of the systems and society?

LL: Absolutely. OHTAC, as a very large stakeholder and an expert group, is able to provide that kind of unique perspective,

so evidence itself is only part of that. I know there's a question coming later on the decision-making process, but OHTAC applies much more than an evidentiary lens and a health economy lens on these issues. It also provides the relevance of the evidence to the whole health system.

CW: How do you decide how to prioritize what you have time to engage in?

LL: The prioritization is actually undertaken by OHTAC. It's surprising how rarely we've had to use the template that allows OHTAC to really prioritize in an objective way. It could be effects, it could be a societal perspective, but the actual... or it could be a diffusion pressure; but the prioritization is undertaken by OHTAC. MAS enters the prioritization process by declaring what resources it has to undertake the analysis. My recollection is that at least 90% of analyses that have been requested of OHTAC, where OHTAC has regarded the analyses as being relevant, have... We've had the resources to deal with those.

CW: Apart from the scientific evidence, what are the other issues that affect the final recommendations?

LL: This goes to what OHTAC developed through a sub-committee process – the decision determinants – where there was a literature review and a discussion with key decision makers in the health system, and where the decision determinants were finally agreed to by OHTAC. There are four major determinants. One is the quality of evidence, of effectiveness and safety; the second is value for money, which is the economic analysis I referred to earlier; the third is societal and ethical considerations, which is more qualitative research; and the fourth is feasibility at a macro level. There's no detailed feasibility study, but the perspective of the health system from the stakeholders that make up OHTAC gives a rough estimate of the feasibility of adopting the technology.

Interview continues on page 105.

Who Doesn't Deserve **Excellent Care?**

Sherri Huckstep, Debra Yearwood and Judith Shamian

Abstract

Discussion on implementation of the Excellent Care for all Act, 2010 (ECFA Act), Bill 46, has focused on the hospital sector in Ontario, but it also has relevance outside the hospital setting. As primary healthcare, long-term care and home care all receive public funding, these sectors should be expected to be compliant with Bill 46. But does the act also govern government-funded (i.e., by other than the Ministry of Health and Long-Term Care) community-based programs such as adult day programs, meals-on-wheels, nutrition programs for children, and more? We propose that we cannot exclude any of these essential programs. We also consider the non-hospital sector and health organizations that do not receive public funding.

The healthcare system will be well served if we consider whether the EFCA Act's key elements should be implemented across the system both vertically and horizontally. Vertical implementation in the hospital sector could be followed by primary care, home and community care, long-term care, and the rest of the vertical silos within the healthcare system. But by taking the horizontal approach, all sectors within and outside of what we traditionally think of health would be integrated using an evidence-informed and outcome-based approach and methodology.

ill 46, the Excellent Care for All Act, 2010 (ECFA Act), was passed in Ontario to govern and strengthen healthcare organizations, including hospitals and other organizations that are provided for in the regulations and that receive public funding (Legislative Assembly of Ontario 2010).

To date, the discussion has focused on implementation of the ECFA Act in the hospital sector in Ontario, but it is essential to also examine its relevance outside the hospital setting. The obvious questions deal with what is expected from primary healthcare, long-term care and home care settings. After all, they receive public funding and are an essential part of the healthcare continuum. Based on the language of the act, all of these sectors should be expected to be compliant with Bill 46. Going one step further, however, the question needs to be asked, "Does the act also govern government-funded (i.e., by other than the Ministry of Health and Long-Term Care) community-based programs such as adult day programs, meals-on-wheels, nutrition programs for children, and more?" These types of community-based programs are an essential part of our healthcare programs or, maybe more correctly, illness programs. If the act is about excellent care for all, we propose including these essential programs, as they are important contributors to good care.

The hospital component of patient/person/client-centred "excellent care" constitutes only a minor part of the care experience of most Canadians. For example, providing an excellent care-centered approach with patients with type II diabetes would include evidence-informed, team interdisciplinary care (dieticians, social workers and more), as well as preventive care for the patient and the family. A patient receiving such a comprehensive level of care would be less likely to subsequently require dialysis, amputation or other acute care hospitalizations. By including the family in preventive care measures, we might be able to stop or delay the onset of type II diabetes in other individuals.

The EFCA Act and Considerations for the **Non-hospital Sector**

The elements of Bill 46 provide a solid foundation for making Ontario "the healthiest place in North America" as stated in Ontario's Action Plan for Health Care (Government of Ontario 2012). To achieve this goal, the EFCA Act has seven key elements that lay out the actions to be undertaken by publicly funded healthcare organizations. These are (1) establish quality committees that report on quality-related issues; (2) put annual quality improvement plans in place and make these available to the public; (3) link executive compensation to the achievement of targets set out in the quality improvement plan; (4) put patient/care provider satisfaction surveys in place; (5) conduct staff surveys; (6) develop a declaration of values, following public consultation; and (7) establish a patient relations process to address and improve the patient experience (Legislative Assembly of Ontario 2010).

The concept of quality is different in the hospital sector from the home and community care, long-term care or primary care sectors.

Keeping these key elements in mind, and considering how the non-hospital sector might comply with the act, we need to think about the following questions:

- What is quality, and who is responsible for achieving it? What does evidence-based or evidence-informed mean outside of hospital walls?
- · What are the structural adjustments needed to build and achieve the spirit of the EFCA Act, coupled with Ontario's Action Plan for Health Care?
- · How will the EFCA Act ensure that quality is improving beyond individual organizations and/or sectors to the system level?

In the following sections, we consider each of these important

1. What is quality, and who is responsible for achieving it?

The concept of quality is different in the hospital sector from the home and community care, long-term care or primary care sectors. According to Goodwin and Lange (2011: 49):

Quality and safety are not just parallel imperatives; rather, they are inextricably linked concepts that rely on each other to function effectively. Safety for clients or patients is complex when multiple organizations, regulated and unregulated paid providers and unpaid family caregivers make up the team providing care in an uncontrolled home environment.

In the hospital sector, we can develop a best practice guideline for wound care or fall prevention, and the system and environment can be structured to monitor compliance of regulated and unregulated professionals who are largely employees of the hospital or have hospital privileges. The reality in the home is very different. In the home setting while the professionals providing care follow best practice guidelines, the home environment is managed by the family and the other factors related to care are not managed and monitored by the healthcare team. Organizations that provide care in the home are held accountable to organize their care in accordance with evidence-based, evidence-informed guidelines. Furthermore, similar to the hospital sector, organizations are expected to assess the practices of their staff in accordance with organizational care standards.

At this point, similarities between hospital and home end. If a nurse goes into a home and makes an assessment on a client's level of risk of falls, the nurse can recommend how to reduce the risk of falling. For example, he or she can suggest putting away the area rug, as it poses a risk for tripping. The decision about whether to accept the nurse's recommendation is in the hands of the client and family. If the family chooses not to accept the evidence-based recommendations and the patient falls, breaks a hip or worse, where does the accountability lie?

How will we uphold the client's right to live in an environment that he or she chooses? How will quality be measured in this patient-centred paradigm? Analysis of the situation would demonstrate that the nurse provides the best possible advice, but the decision to take that advice rests with the client. Providing care in the home limits the elements of professional control over the environment and decisions that are made.

2. What are the structural adjustments needed to build and achieve the spirit of the EFCA Act coupled with Ontario's Action Plan for Health Care?

In addition to the previous issue, we also have to examine several structural issues that contribute to the implementation of the EFCA Act. Bill 46 identifies the Local Health Integration Networks (LINHs) as the responsible agency to receive and approve plans. While the accountability model is correct and might work if you have ten or more hospitals in your LHIN, how will it work in community settings, primary care offices and other settings, of which there are hundreds in any LHIN. Furthermore, many of these organizations are small or medium-sized, with limited or no resources. Let's not forget that the main economic engine in Ontario (and, in fact, Canada) is small and medium-sized organizations, which employ the majority of the workforce. Many of these organizations will not have the resources needed to build plans, submit reports and stay on top of best practice guidelines.

We need to put in place structures and/or financial supports that guarantee achievement of the EFCA Act's expected outcomes without breaking the backs of these organizations.

3. How will the EFCA Act ensure that quality is improving beyond individual organizations and/or sectors to system level improvement?

The elements of the EFCA Act are solid and will enhance the quality of care as it is applied across the various sectors, as planned. Ontarians who access healthcare, however, will not fully realize the benefit until measurements of "excellent care" are extracted at the system level. Success will come only when we measure the "in-between," which includes transitions between sectors and the impact that decisions made within one sector affect client outcomes in another.

The overall healthcare system will be well served if we consider whether the EFCA Act's seven key elements should be implemented across the system both horizontally and vertically. Vertical implementation will follow the current pattern. The act is currently implemented in the hospital sector, and this could be followed by primary care, home and community care, longterm care, and the rest of the vertical silos within the healthcare system. Another approach, and one that will lead to better care and better clinical and fiscal value, is a horizontal implementation of the act. Under this approach, for example, diabetes, one of the leading chronic diseases, can be targeted and managed in the context of population health. In the horizontal implementation, organizations or agencies involved in impacting the individual or community would be required to comply with the element of the act. By taking the horizontal approach, all sectors within and outside of what we traditionally think of health would be integrated using an evidence-informed and outcome-based approach and methodology. Communities could target areas of concern in their population, be they a chronic disease and/or a social determinant of health. By doing so, we will advance both the global and local approach, leading to the achievement of better care, better value and better health.

To implement the EFCA Act in an integrated manner, LHINs must play an active role. LHINs are established to advance the planning of an integrated system. This can be achieved by ensuring comprehensive planning, monitoring and compliance evaluation systems. Having one global framework that takes into account the elements of the act, coupled with the remaining integration agenda, will lead to a better system than the one we have today.

We aim for patient-centred excellent care; we also need to aim for collaborative integrated system partnership where government, funders, LHINs, regulators and others work smarter so that Ontario becomes the healthiest place in North America by 2020. HQ





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Building Better Healthcare Facilities through Evidence-Based Design: Breaking New Ground at Vancouver Island Health Authority

Howard Waldner, Bart Johnson and Blair Sadler

Abstract

Many of today's healthcare facilities were constructed at least 50 years ago, and a growing number have outlived their useful lives. Despite renovations and renewals, they often fall short of providing an appropriate care setting. Clinicians and staff develop a mixture of compromises and workarounds simply to make things function. Evidence-based design principles are often absent from new healthcare facilities, perhaps because of lack of awareness of the principles or because implementing them may fall foul of short-term and short-sighted budgetary decisions. In planning a new healthcare facility in 2008, the executive team at Vancouver Island Health Authority decided to adopt the evidencebased design approach. They conducted site visits to newly constructed hospitals across North America and beyond, to determine best practices in terms of design and construction. These engagements resulted in the implementation of 102 evidence-based design principles and attributes in Victoria's Royal Jubilee hospital, a 500-bed Patient Care Centre. This \$350M project was completed on time and on budget, showing that using evidence need not result in delays or higher costs.

To date, the results of the evidence-based design are promising, with accolades coming from patients, staff and clinical partners, and a number of immediate and practical benefits for patients, families and care teams alike.

round the world, much of the current emphasis on quality and patient safety has focused on the actions and omissions of clinicians, the use of new technology and the efforts of leaders to create safer cultures and supportive environments. Until now, in the writers' opinion, limited attention has been given to the physical contexts and design of work environments. In Canada, as in other countries throughout the world, the work of health professionals is often challenged by having to deliver services in less than ideal physical environments. With many of today's healthcare facilities having been constructed over 50 years ago, and some significantly before that, a growing number have outlived their useful lives. Evidence can be seen on balance sheets of health organizations, where many physical assets have long since been fully depreciated. While a number of these settings may have been renovated, and to some extent renewed all too often, they continue to fall short of providing an appropriate care setting. As a consequence, clinicians and staff often become used to these work settings, and, out of necessity, develop a mixture of compromises and workarounds simply to make things function. This may, however, cause unanticipated or unknown risks for organizations with regard to the safety of patients and staff alike. Such concerns are clearly articulated by Accreditation Canada (2011) in their Required Organizational Practices document, which outlines risks associated with a congested work environment and the need for reduced "clutter."

... in the haste to create a new hospital, clinic or department, managers may be unaware of... the growing body of peer-reviewed articles on evidence-based design...

The opportunity to address and resolve many of these issues is provided when funding approvals are received to build a new hospital or clinic. However, it is our opinion that the potential of these opportunities is rarely fully optimized, as health leaders have to deal with a large number of competing pressures and priorities. As a result, they may fail to ensure that design principles and functional requirements adopted in new facilities are truly evidence based. It has been our experience that the absence of evidence-based design principles in contemporary healthcare facilities generally stems from two main reasons. First, in the haste to meet project deadlines in the creation of a new hospital, clinic or department, managers may be unaware of, or not fully utilize, the growing body of peer-reviewed articles on evidence-based design. On other occasions, they may defer the responsibility to incorporate evidence to an architect or design team without doing the due diligence themselves. As a result, designs may be based on staff or architectural preference, with little or no attention paid to life-cycle costing or current best practice and evidence. Secondly, as costs escalate in the project planning cycle, managers may inadvertently fall into a shortterm cost-cutting trap and disregard best-laid plans, making decisions based on capital cost alone to return the project to a number within (or close to) budget. As a result, while shiny new structures are created without evidence-based design, they may have higher than necessary operating costs and may unnecessarily compromise quality and patient safety. Additionally, post completion, capital projects often require changes or renovations in the not-so-distant future to adapt to changes driven by heightened care standards, technology and innovation. So, ironically, there is a risk that any short-term savings may inadvertently result in increased costs over the medium to longer term.

The "Evidence" for Evidence-Based Design

For years it has been assumed that optimal physical environments, while desirable, were unaffordable to design and construct. Challenging this presumption, a multidisciplinary team set out to examine the actual cost and quality implications of building a hospital designed on the best available evidence (Berry et al. 2004). Creating a "Fable Hospital," an ideal, albeit theoretical facility that incorporated proven evidence-based design innovations from recently built or redesigned hospitals, the authors developed a business case for better healthcare facilities. Touting a message that was both simple and profound, Berry et al. (2004) argued that health leaders need

to be aware of a growing and compelling body of evidence that correlates the design of the physical environment of a healthcare building to health outcomes and quality. Through their work, the authors showed how the careful selection of appropriate evidence-based design factors such as oversized single rooms, double-door bathroom access and natural lighting can significantly improve a range of quality and outcome indicators, and at the same time reduce operational costs. For example, citing a study by Ulrich (1984), the authors pointed out that benefits of one factor, the provision of natural daylight and an attractive view, reduced operational costs by \$500 per case due to a reduced length of stay. According to the study, in situations without this single attribute, length of stay and resulting care costs did not decrease.

While the work of Berry et al. (2004) and others has been well received, it has done little to the change mainstream thinking and practices of health leaders. Nevertheless, the authors' characterization of an imaginary amalgam of the best design innovations created a compelling vision for the future of healthcare design. This case was recently strengthened by Sadler et al. (2011), who wrote a follow-up article titled "Fable Hospital 2.0: The Business Case for Building Better Health Care Facilities," which incorporated more recent innovations and evidence-based design features such as improved signage for guests, respite areas, the use of environmentally responsible building materials and hydraulic ceiling lifts in patient rooms.

On the ground, and in parallel to academic pursuits, the Center for Health Design – a not-for-profit research group in California – has, since 1993, been trying to bridge the research– practice divide, creating a movement of like-minded planners and health leaders with the singular mission to design and build better healthcare facilities. The premise of their organization is to bring forward-thinking health organizations together to collaborate and share learnings from the direct application of evidence-based design to create continuous improvement and innovation. Their work has been coined the "Pebble project" - the use of the word "pebble" signifying the ripple effect of throwing a pebble (an idea) into a pond and watching the impact (its adoption) of the ripple (The Center for Health Design 2012).

The "Fable Hospital" - Vancouver Island's **Royal Jubilee Hospital**

Sufficiently captivated by the "Fable Hospital" analysis and the work of the Center for Health Design, the executive team at Vancouver Island Health Authority (VIHA) sought membership with the Center in 2005, becoming Canada's first "Pebble" affiliate. Tasked with building a new care facility, VIHA leaders consulted extensively with other Pebble members and conducted site visits to newly constructed hospitals across North America to determine best practices in terms of design and construction.

These engagements resulted in the implementation of 102 evidence-based design principles and attributes in Victoria's Royal Jubilee hospital, a 500-bed Patient Care Centre (PCC). This \$350M project, which broke ground in July 2008, was completed in December 2010 on time and on budget, using a P3 (public-private partnership) contract methodology, which in effect proved that using evidence does not need to unnecessarily delay builds or drive up costs.

... the provision of natural daylight and an attractive view, reduced operational costs by \$500 per case due to a reduced length of stay.

In November 2010, the Centre for Health Design was invited to visit the PCC to critique VIHA's journey and the application of evidence-based design principles. The verdict was incredibly positive, with the assessors publicly announcing that, in their opinion, Berry et al.'s (2004) Fable Hospital was no longer an imaginary amalgam of design attributes, but now existed - in Canada, in Victoria - at the Royal Jubilee Hospital site. Evidence supporting their claim is visible throughout the state-of-the-art facility, with virtually all of Berry et al.'s suggestions living on in the PCC. Some examples of the evidencebased design principles outlined in Berry et al.'s (2004) Fable Hospital, now realized at Victoria's Royal Jubilee Hospital include the following:

- 83% of all rooms are single patient rooms with a private en suite bathroom
- A pullout bed settee for family members, to promote their overnight stay, in every room
- Standardized design and equipment in every room
- A quiet hospital, with sound-absorbing construction and the absence of overhead paging
- Hand-sanitizing areas and sinks in every patient room (1,400 sinks throughout the building)
- Maximized use of natural light (large window in every room), fresh air in each room as a result of opening windows, and HEPA filtered air in appropriate locations
- Decentralized nursing stations with optimum visibility and accessibility to patient rooms
- Dedicated meeting and teaching spaces for staff and students on each floor

Additionally, there are many other examples of evidencebased design incorporated into the PCC that go beyond the scope of the original Fable Hospital concept and were recently outlined in Sadler et al.'s (2011), "Fable Hospital 2.0," including a ceiling-mounted patient lift at the head of every bed, an electronic health record input station at every bedside (smart beds), a total separation of clean and dirty materials and supplies, a dedicated patient rehabilitation facility on every floor, use of sustainable (green) materials, and a staff gym and cafe. Further information on this project, including video and images, is available at http://www.viha.ca/patient_care_centre/.

TABLE 1. Key performance metrics to be evaluated at the **Patient Care Centre**

| 1. | Hospital-acquired infection | | |
|-----|---|--|--|
| 2. | Patient falls | | |
| 3. | Adverse events | | |
| 4. | Work-related injuries (all causes) | | |
| 5. | Staff injuries related to patient handling | | |
| 6. | Medication errors | | |
| 7. | Length of stay | | |
| 8. | Medication use for delirium | | |
| 9. | Labour costs (overtime, sickness rates, etc.) | | |
| 10. | Use of ceiling mounted lifts | | |

The final move of patients into the new facility took place in December 2011, when a number of mental health patients transferred to the new psychiatric Intensive Care Unit.



These engagements resulted in the implementation of 102 evidence-based design principles and attributes in Victoria's Royal Jubilee hospital

To date, the results of the evidence-based design are promising, with accolades coming from patients, staff and clinical partners, and a number of immediate and practical benefits for patients, families and care teams alike. Further, the build has received numerous awards, including the 2007 Journal of Commerce Project of the Year, the Best International Project at the 2010 Public Private Finance Awards and the Community Award at the 2011 Commercial Building Awards. However, as can be expected after any major move, there are some minor teething problems to resolve as patients and staff settle into their new home at the PCC and adapt to their new, redesigned work

Still in the very early stages of the application of their evidence-based journey, VIHA remains cautiously optimistic, with only "soft" data supporting assumptions around cost and quality improvements at this point. However, it will not be long until the early implications of Canada's first truly evidencebased care setting become apparent, as data (pre and post move) are presently being collected and carefully analyzed by a team of internal and independent external reviewers (details of some of the key areas being measured are shown at Table 1). While we can share only the promising beginnings of VIHA's experience in this article, we feel that with the evidence-based design and construction of the PCC, a corner has been turned in building better healthcare facilities. We strongly encourage other healthcare organizations to join the Center for Health Design and VIHA in the quest to enhance quality and safety by incorporating evidence-based designs into capital projects. Our patients, families and communities should expect nothing less. HQ

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Quality Legislation: Lessons for Ontario from Abroad

Jérémy Veillard, Brenda Tipper and Niek Klazinga

Abstract

While the Excellent Care for All Act, 2010 (ECFA Act) provides a comprehensive approach to stimulating quality improvement in healthcare, there are other examples of legislations articulating strategies aimed at the same goal but proposing different approaches. This paper reviews quality of care legislations in the Netherlands, the United States, England and Australia, compares those pieces of legislation with the ECFA Act and suggests lessons for Ontario in planning the next stages of its healthcare quality strategy.

Notable among the commonalities that the EFCA Act shares with the selected examples of legislation are mandatory reporting of performance results at an organizational level and furthering quality improvement, evidence generation and performance monitoring. However, the EFCA Act does not include any elements of restructuring or competition, unlike some of the other examples. Key to successful transformation of the Ontario healthcare system will be to propose a package of changes that will deal systematically with all aspects of transformation sought (including structural changes, payments systems and elements of competition), will garner support from all the actors, and will be implemented consistently and persistently. Benchmarking on the implementation and impact of reforms with the countries presented in this paper may be an additional important step.

uality of care is a key focus of health system reforms, and in recent years many countries in the Organisation of Economic Co-operation and Development (OECD), including Canada, have developed strategies aimed at improving healthcare quality and patient safety (OECD 2010). Øvretveit and

Klazinga propose that national strategies for quality of care can be targeted at different types of health system stakeholders: professionals, healthcare organizations, medical products and technologies, patients and financers (World Health Organization Regional Office for Europe 2008). The generic elements of these strategies relate to legislation and regulation, monitoring and measurement; assuring and improving the quality and safety of individual healthcare services, and assuring and improving the quality of the healthcare system as a whole. Various combinations of quality improvement approaches (such as quality assessment, standards-based quality management, team problem solving, and patient and community participation) are suitable for these functions as part of the respective quality strategies.

In Ontario, the Excellent Care for All Act, 2010 (ECFA Act) (Legislative Assembly of Ontario 2010) proposes to address quality improvement in healthcare by (in addition to existing accountability relationships) mandating quality committees at an organizational level to monitor and report on the quality of healthcare services, tying the compensation of top executives to the achievement of targets linked to their quality improvement plans, mandating regular patient and staff experience surveys, and formalizing patient relations processes and healthcare organizations' patient declaration of values. Further, the legislation strengthens the role of an arms-length organization to government, Health Quality Ontario (HQO), in stimulating evidence-based healthcare reforms and quality improvement in the province. This new role comes in addition to the initial role of HQO, which was to report regularly to the public on the performance of the Ontario healthcare system. This legislation builds on other legislations such as the Public Hospitals Act (Ministry of Health and Long-Term Care [MOHLTC] 2012a) and the Local Health System Integration Act, 2006

TABLE 1. Summary of examples of health system legislations directed at improving quality of care

| Jurisdiction | Legislative initiative | Current status | Key features related to/mechanisms for quality improvement |
|-------------------|---|---|--|
| England (NHS) | National Health Services Act (2006) Establishes Primary Care and Foundation Trusts and a framework for monitoring and regulating them | Implemented, with adjustments and changes to Quality Accounts and reporting each year developed by Monitor | Mandatory public reporting of performance measures by NHS Foundation Trusts, supervised by Monitor |
| | Health and Social Care Bill (introduced in 2011) Broad-scope initiative | Passed into law in 2012 | Increased competition with patient choice Introduction of value-based payment Enhancing role of Monitor, including provision for regulating competition and supporting integrated care and continuity of services |
| Australia | Broad-scope reform built on the agreement of state and federal governments in 2010 | Restructuring legislation passed (2010) Legislation establishing payment authority and defining the role of quality organizations passed (2011) | Restructuring of hospitals into small networks and, changes in funding arrangements between national and state governments Establishment of performance monitors and mandatory reporting regimes Establishment of funding and payment authorities |
| The United States | Patient Protection and Affordable Care Act (2010) Broad scope reform initiative to address access to health insurance, quality and cost of healthcare | Legislation passed in 2010 Implementation of many quality features begins in 2012 | Combination of mandatory and voluntary performance measures reported to the public Structural delivery changes — piloting Accountable Care Organizations with mandated quality activities and incentives for cost control |
| The Netherlands | Health Insurance Act (2006) Broad scope restructuring building on market competition Objectives include improving efficiency, quality, innovation and responsiveness to consumers | Abolished Hospital Planning Act, removing central controls on capacity New law to license hospitals based on quality and transparency of hospital administration and financial management | Regulated competition and consumer choice to improve quality and efficiency Regulators/supervisory agents include a competition authority, a care authority and public health inspectorate Removes central control on hospital capacity Revisions to hospital payment system Plans to allow for-profit hospital care |

(MOHLTC 2012b), and addresses the role of professionals, healthcare organizations and patients in improving the quality of healthcare services, when using the classification proposed by Øvretveit and Klazinga (World Health Organization Regional Office for Europe 2008).

... regulation of healthcare in England is now comprised of two main elements: regulation of the quality and safety of care offered by healthcare providers... and regulation of the market in healthcare services...

Still, if the ECFA Act provides a comprehensive approach to stimulating quality improvement in healthcare, there are other examples of legislations articulating strategies aimed at the same goal but proposing different approaches. This paper reviews legislations of quality of care in select countries (the Netherlands, the United States, England and Australia), using the framework proposed above, and suggests lessons for Ontario in planning the next stage of its healthcare quality strategy.

Quality Legislation Abroad

Over the past few years, a number of countries have embarked on high-profile reforms implemented through significant legislative initiatives. While the scope of some of these initiatives is often broad, many are driven by concerns about quality of care and include key features directly targeting healthcare quality. These broad-based initiatives seem the most appropriate source of lessons for future developments in Ontario, since the ECFA Act aims at driving system change through a quality improvement, evidence-based paradigm. The most significant examples selected by the authors are England, Australia, the United States (US) and the Netherlands, which present common features and a shared concern to drive change through multi-pronged policy interventions all related to quality improvement. We expand below on legislation in the four countries and present a summary in Table 1. In addition, there is also targeted legislation regulating many aspects of healthcare delivery including, for example, training and licensing of professionals, certification of organizations, and mandating the public reporting of specific performance indicator results such as hospital-acquired infection rates (Aiken et al. 2010; Halpin et al. 2011).

England

The National Health Service Act of 2006, which set up Primary Care and Foundation Trusts, established Monitor as the organization responsible for authorizing and regulating National Health Service (NHS) Foundation Trusts (Parliament of the United Kingdom 2006). Since 2010, Monitor has required the Trusts to report annually both to Monitor and to the public on a set of quality accounts (Monitor 2010). The objective of quality accounts reporting was to encourage a focus on quality improvement and engagement with clinicians and patients. The reports were also intended to provide an opportunity for Foundation Trusts to describe performance and their improvement goals, supplemented by benchmarking information to identify quality outliers. Monitor's scope of reporting on quality of care was then limited to Foundation Trusts, those financially successful hospitals who had earned independence from central control, and to a particular activity - the regulation of the healthcare market.

Monitor's role will evolve significantly now that the Health and Social Care Act, which received royal assent on March 27, 2012, has passed into law (Parliament of the United Kingdom 2012). This act is a broad-based NHS reform bill covering a number of policy areas including promoting choice and competition, changing the emphasis of performance measurement to clinical outcomes, better integration of healthcare and services, reconfiguring services and improving quality of care, among others. As a consequence of the act, Monitor will now become an economic regulator, with objectives to promote effective and efficient providers of health and care, promote competition, regulate prices and safeguard the continuity of services (www.parliament.uk 2012). Therefore, regulation of healthcare in England is now comprised of two main elements: regulation of the quality and safety of care offered by healthcare providers, currently undertaken by the Care Quality Commission, and regulation of the market in healthcare services, currently the responsibility of Monitor (in relation to Foundation Trusts) and the Department of Health.

... the [Australian] federal government's initial restructuring proposal... was highly controversial - it proposed to move both money and power away from an area traditionally controlled by the states

Australia

In 2010, the most far-reaching reforms to the health system in Australia since Medicare were initiated through an agreement by the Council of Australian Governments (COAG 2012). The objective of the agreement is stated as "improv[ing] the health outcomes for all Australians and the sustainability of the Australian Health system." The agreement provides for major structural reforms that include establishing the national government as the majority funder of public hospitals, formation of small hospital networks to be run by local clinicians,

and funding of these networks on an activity and performance basis. Changes to structures and governance were designed to be more responsive to local needs, provide for greater transparency and improve the quality of care. Although the federal government's initial restructuring proposal in March 2010 was highly controversial - it proposed to move both money and power away from an area traditionally controlled by the states - it was ratified at the COAG meeting in April 2010, and implementation of the agreement began soon after.

As part of the implementation, The National Health Reform Act was passed in 2011, implementing the changes in funding and establishing independent performance authorities - the Australian Commission on Safety and Quality in Health Care and the National Performance Authority - to oversee the national standards. The legislation also mandated reporting of nationally comparable performance data for local hospitals and health services.

The United States

The healthcare system reform effort in the US culminated with the passage of the Patient Protection and Affordable Care Act (PPACA) in early 2010. The act includes many features that are intended to support quality improvement throughout the system and improve healthcare efficiency and effectiveness. From a federal perspective, the notable features with respect to quality improvement are implemented using the federal government's Medicare program purchasing power. They include mandating public reporting of performance information by institutions caring for Medicare patients and provision for a pilot accountable care organization program for delivering care to Medicare patients. Accountable care organizations would include multiple care providers, be accountable for both the cost and the health outcomes of an assigned population, and be required to improve care to reach cost and quality targets set by the payer (i.e., Medicare) (Deloitte 2010). Key among the seven capabilities that an accountable care organization must demonstrate is the capacity to promote care quality, conduct quality improvement initiatives, measure and publicly report performance, report on costs and coordinate care (Singer and Shortell 2011). Accountable care organizations would be eligible for "shared savings" payments linked to performance on quality standards in five key areas: the patient/caregiver experience of care, care coordination, patient safety, preventive health and the at-risk population/frail elderly health (HealthCare.gov 2011a).

The PPACA also establishes a value-based purchasing



program for Medicare that is intended to provide a financial incentive to hospitals to improve quality of care. It requires public reporting of performance measures, starting with quality of care measures related to hospital-acquired infections and patients' perceptions of care among other areas for all patients receiving services from the hospital, not only Medicare patients (HealthCare.gov 2011b).

The Netherlands

Broad-based system reform legislation (The Health Insurance Act) became effective in 2006. While the structural changes addressed in this legislation focused on the operation of the health insurance market and contracting with care providers, these steps were taken with the objective of improving quality, efficiency and responsiveness to consumers through increased competition and loosening of some central government regulation (Maarse 2009). This legislation was set within the broader context of other pre-existing quality-focused legislation that includes regulation of the provision of care by professionals – revalidation, disciplinary processes and peer review. A pre-existing Quality Act also established four requirements that all providers of care must fulfil and that echo some features of the ECFA Act, including publishing both an annual report detailing the quality control policies they have applied and reports on the quality of care they have delivered (Legido-Quigley et al. 2008). Current policy debates address the introduction of performance payment in various healthcare sectors and the merging of several quality-related agencies in a new National Quality Institute that should be functioning by January 2013.

Common Themes in Recent Quality Legislation and Lessons for Ontario

There are a number of common themes among the examples reviewed:

- They contain elements of mandatory public reporting of quality performance measures.
- They include the establishment of new or empowerment of existing authorities to supervise or regulate reporting and to provide centralized support for quality improvement.
- They include changes to payment and funding methods for healthcare organizations, specifically rewarding or incenting quality.

In addition, some of these pieces of legislation include requirements to establish and meet specific performance targets. Two of the broad-based initiatives (England and the Netherlands) also have measures that promote increased competition among providers of care, while the US provision for accountable care organizations requires different providers to cooperate to coordinate care.

The Affordable Care Act mandat[es] public reporting of performance information by institutions caring for Medicare patients...

Finally, reforms in England, Australia and the Netherlands all have means of promoting or supporting patient choice to improve quality. They also speak to lessening centralized, bureaucratic control of health systems and increasing local and organizational autonomy (with provision for public reporting and accountability for results) as a way to stimulate quality improvement.

It is important, though, to recognize that leadership and governance arrangements (comprising elements of priority setting, performance monitoring and accountability) have little commonality in a study of seven countries - including two of the countries presented in this paper (England and the Netherlands) (Smith et al. 2012).

The ECFA Act aims at ensuring that appropriate structures and processes driving quality improvement at a system level are in place and requires mandatory public reporting of results and outcomes to drive improvement. It shares a number of common features with the legislations presented above, notably mandatory reporting of performance results at an organizational level and furthering the quality improvement, evidence generation and performance monitoring role of an existing organization (Health Quality Ontario). However, it does not include any elements of restructuring or competition, unlike some of the other examples. What appears to be unique in the ECFA Act is a repeated emphasis on the use of data, information and, in particular, evidence in supporting planning, quality improvement and performance measurement. More importantly, perhaps what is unique in this legislation is the wide support it received from a variety of health system stakeholders and from political parties (Canadian Patient Safety Institute 2010; Ontario Hospital Association 2010; Ontario Medical Association 2010).

The broad-based legislations presented above share the same objective of implementing and sustaining a culture of continuous quality improvement but include larger structural changes than the ECFA Act. In some of the examples reviewed, the structural and funding changes proposed made the legislation controversial and were contentious, as in the cases of the US and England and, to some extent, Australia. In contrast, the ECFA Act received broad support from system stakeholders and a renewed commitment from health system actors. In a context of hard budgetary constraints, some of the plans to deal with structural changes to the healthcare system in Ontario will have to be delineated to define a path that would improve patient-centredness, build on the culture of quality improvement nurtured by the ECFA Act and drive efficiency gains. Ontario's Action Plan for Health Care (Government of Ontario 2012) and the report of the Commission on the Reform of Ontario's Public Services (also called the Drummond Report) (Ministry of Finance 2012) propose a number of ways that could build on the ECFA Act and help design a full package of reforms required to transform the system into one that is patient-centred, focused on quality improvement and affordable. The key - and the difficulty in successful transformation will be to propose a package of changes that will deal systematically with all aspects of transformation sought (including structural changes, payments systems and elements of competition), will garner support from the actors, and will be implemented consistently and persistently. Benchmarking on the implementation of reforms with the countries presented above may be an additional important step toward a successful transformation of the Ontario healthcare system. Indicators supporting this international benchmarking function may include change in clinical outcomes for indica-

tors related to governments' priorities, support of reforms by clinicians and healthcare leaders, progress in the area of patient safety, and progress in reducing avoidable hospitalizations and hospital readmissions. HQ

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EG: Richard, you mention a quality framework. Is it a specific framework, or is it something that your organization developed?

RE: It's one that we developed. When I say "framework," it's the boxes of what we oversee or how we manage quality, and who's accountable for what. I'm happy to share that if you're interested. It's nothing fancy, but it does lay out roles and accountabilities for the Board, for the Board's Quality Committee, the Medical Advisory Committee, senior management, quality teams, quality council, and the engagement of staff on our quality teams at the front line. Staff see this engagement as part of their work.

When we get our patient satisfaction scores, we share them broadly throughout the organization.

EG: Yes, I would be interested in looking at it. The reason I asked is, everybody is always going to somebody to say, "Well, what is our framework; how can we use it, look at the best processes?" But what I hear you say is that you developed it because it has meaning for you; it's working for you. It has very clear accountabilities; it says who's involved. That's the most important thing, because you've not only made it at home; you make it work at home.

RE: Right. And I think, going back to the accreditation piece and the previous two surveys we had, there's always a good feeling when someone tells you you're doing a great job – that's probably the best part of those processes. But the actual recommendations don't contain anything significantly substantive, aside from maybe a couple of things that we asked the surveyors to put into the report.

EG: If I'm not mistaken, that's often the case.

RE: Yes. I think there might have been four or five recommendations in each of those last two reports.

EG: Richard, I want to confirm something about those weekly meetings, and, by the way, do you have a name for them?

RE: "The wall." We go to a wall in the Emergency Department, where we review all the metrics and have a discussion about our progress on them.

EG: But it's the people who are involved; it's the staff plus the senior leaders, so you're sharing metrics with the staff. Everybody knows exactly what's going on, where things are going well, and where something needs some improvement. Then you do the problem solving on the spot, right?

RE: In some cases. Sometimes, it will just be a discussion of here's

where we are. Everybody smiles, gets back to work and that's fine. But at other times, you're looking at things like patients who have left without being seen, or how long it took us to admit patients to the inpatient units. These are daily statistics, so staff may see metrics a week at a time or a few weeks at a time. There are graphs. How long were those Triage Level Four and Five patients waiting to be seen yesterday? Are we meeting our targets? That's key. If we're meeting our targets - whether we set them or the Province set them - there's a positive feeling. You can go back to work and say, "Hey, we're doing a good job here." It's never perfect, but it's going to translate positively into your interactions with individuals, and some of those metrics involve patient satisfaction.

There are other ways that we get those patient satisfaction messages back to our departments, too. Our quality teams focus on this, so there are all kinds of things to move the bar with regard to quality. If the Emergency Department feedback says that wait times are a problem; or in the Family Birthing Unit, pain relief is a problem; or in Critical Care, coordination of care is a problem, we go back and look at those opportunities for improvement and try to make things better for our patients.

EG: I guess the piece that really resonates for me, and I'm putting on a different hat, is that often staff don't know what the results are; they're almost kept in the dark, or the results that they do know about are the negative ones.

RE: When we get our patient satisfaction scores, we share them broadly throughout the organization. E-mails go out hospitalwide; reports go to the Board. We make sure we report them in the open session of our Board meeting, hoping that our media will pick up on them and share them with our public. We share them with the MAC; we attribute the successes that relate specifically to physician questions on those patient satisfaction surveys. We don't just get them and sit on them; we want to let people know that they're doing a good job, but we also include the bullet points, the things we need to work on.

EG: That gets us to the next question. When you're looking at the results, I think you have a really good understanding of what helps you focus not only on the successes, but also on doing some collaborative - and that's my word, not yours - problem solving on trying to close the gap, to make it more meaningful. You've talked about the patient experience before, so patient satisfaction. Is that the NRC Picker tools or something else?

RE: No, it's NRC Picker.

EG: It's for both Inpatient and Acute?

RE: Right, and it shows results for medicine, surgery, obstetrics and the Emergency Department. When we get results that show we're the leading performer or a tie for leading performer in the Province, the CNE and I will often walk up to the Nursing Units



Geulph General Hospital Quality Comittee: (I-r) Eileen Bain, VP Patient Services and Chief Nursing Executive, Karen Suk-Patrick, Director Organizational Development, Anna Leah Desembrana, Director Maternal/Newborn, Merle Seegmiller, Director Ambulatory Care, Melissa Skinner, Director Quality and Professional Practice, Helen Martini, Quality and Patient Safety Specialist, Jacqueline Malonda, Quality and Patient Safety Specialist, Joyce Rolph, Senior Director, Richard Ernst, President and CEO, Sue MacNeil, Director Food Services and Environmental Support, and Maureen McCafferty, Senior Director and Chair of the Committee

and say, "Hey guys, this is what you've done." I say often, because we never get there enough, although they've had consistently high results, especially in some of our surgical areas. But if we have a reason to go up and say thanks to the staff, recognizing there's only a fraction there at any one time, it does create an opportunity for recognition. Through our employee surveys and our Healthy Hospital surveys, our staff have indicated that recognition is important to them. It feeds back into patient satisfaction.

EG: That was the next part of the second question. Is there a linkage between those patient satisfaction results and the staff satisfaction survey? You mentioned that staff want recognition from the staff survey results. It seems that as you find out results you purposefully go up and really stimulate that conversation among the staff: "This is great, you're doing great work," and so forth.

RE: Yes.

EG: Is there another piece of the staff survey results that also links back? At the beginning of our conversation, you said that if staff aren't happy, patients won't be, either.

RE: Right. There's been research emerging over the past 10 to 15 years that correlates nurse staffing and nurse engagement with positive patient outcomes - my CNE can quote chapter and verse on this. I use the phrase "happy nurses = happy patients," but I know it's more scientific than that. One of the things that we've been involved with is the RNAO (Registered Nurses' Association of Ontario) best practices; we're now in the third year and we're a Best Practice Spotlight candidate. We expect to complete that and have the designation by April 2012. It provides a structured approach to engage front-line staff and focus organizational leverage on how we affect patient care and improve patient satisfaction, so that's just another of the things we do to raise the level of staff engagement.

EG: What about the other disciplines?

RE: It's funny, that does focus on nursing, but I think people here generally feel they're part of a team. We went through an exercise a number of years ago to develop a new mission, vision and values for the hospital; I've probably done it twice in the last 12 years. Our staff feed into this and the Board basically approves it. Teamwork is a value and accountability is a value; that speaks, I think, to how we want to work together, but also to how we each have distinct roles to play. I don't hear of other disciplines feeling left out, and I know that when we went through our Emergency Department process, everyone – the bed allocator, the housekeeper, the porter, the diagnostic folks from the laboratory and imaging – they all made contributions to changing what we did there to deal with patients. They really felt engaged as part of that team.

EG: You talked previously ago about clinical champions, and I've heard you talk about senior leadership in particular, so you and the CNE or you and the Chief of Staff really are engaged. You go to that point of care, you talk with the staff about what's happening and you commend them. But what about other clinical champions? Have other people in your organization taken up that drive to be a clinical champion and make a difference, along with your senior team?

RE: I think that the contributions from some of our physicians have been unique here. In particular, I think back to the physicians in our Emergency Department and in our Department of Hospital Medicine, even to those in the diagnostic areas, who are part of changes that need to be made to work collaboratively, to do things better for patients. They've bought in because it makes their environment better as well. I think when we had this meltdown a few years ago in our Emergency Department, its genesis was that our halth care providers didn't believe that people were getting the care they were entitled to. We had to change the way we were doing things. Throwing more money at the issue wasn't the solution; doing things better, safer and more effectively was. These physicians dedicated many hours of time to the process of lean methodology, value-stream mapping, being on committees, problem solving, trying things, finetuning them and correcting them, so I think the leadership here has been remarkable – from a patient experience viewpoint.

EG: Solution starts at the top, doesn't it, Richard? I think that the work you and your colleagues have done as senior leaders, and frankly as boards, probably has stimulated that. You set the bar and said, "This is where we're going; this is the direction we're going in," which is really great.

RE: Yes, we'll talk about the board in a minute. It's a unique situation, too.

EG: How have patients or family members been engaged in that transformation in your organization?

RE: Our mission statement is that we will provide quality patient-centred care, and, again, that's developed at the grassroots. We have lots of open dialogue with patients and families on the Nursing Units but no formal council. In 2006 we hired our first Patient Relations Coordinator, and this provided a role to deal with patient issues or concerns, and also to build relationships and engage our patients in our community. Last year we invited a survivor, the widower of a woman who died in this hospital, who had shared his story at a social event I attended. I said to him, "You need to come to our long-term service awards dinner and talk to our staff, share your experience." It was remarkable; there was probably not a dry eye in the house, but I think every single person who walked out of that room was proud of what we're doing here at this hospital.

I try to get out to the community every three months or so. I

give a presentation at a seniors' group, service club, or what have you, and I try to convey the state of the nation. Here's what's going on at Guelph General Hospital; what are your questions? The questions are wide-ranging, sometimes related to things that go on in the hospital and sometimes not. We're trying to engage the community this way. I think in our community there's a sense of ownership and involvement with the hospital. Our size really helps. We're not a gigantic hospital; our budget is about \$135 million. The hospital has been in the community a long time, and it's a close enough environment that people actually feel engaged. We have a fairly open-door policy here at the hospital, if people want to come in and talk to me or to anybody. We try to manage our complaints and concerns in a consistent way with our Patient Relations Coordinator, but if someone wants to talk to me, I'll talk to them. I won't solve their problems, but I'll listen and help to resolve their concerns.

We're just going through our master planning process now and talking about community engagement, and it's sometimes difficult to do. So once your program's set up, I'd be interested in hearing how you go through a process of selection. I find that the most challenging part is, who do you identify as people who can give you objective and meaningful input into how you can improve a patient experience.

EG: Sometimes there are attitude challenges about patientcentred care. Did you encounter that, and, if you did, what were some of the challenges or barriers, and how did you overcome them?

RE: Guelph has roughly 120,000 people. Lots of patients who come in are friends, family and neighbours; they know our staff. Quite a number of long-serving staff here may see repeat patients coming through; staff know too that if they're ill this is the place that they're likely going to come.

I think if you look back at Hospital Report results – and you have to go back a few years, you'll see patient satisfaction scores that are extremely high at a place like SickKids, not so high at other teaching hospitals, middle of the road for many community hospitals, but extremely high in the small rural hospitals.

EG: Exactly. Richard, you've mentioned the Dashboard and the role that the board play in all this. Can you say more about what they have done?

RE: Yes. I did mention our Dashboard, which has been in place for several years. It's on our website and shows issues related to patient safety, patient access and patient satisfaction. There are some financial and volume measurements too, but the point is that patient satisfaction is a metric that is tracked by the Board. We used to have a quality committee at the Board, but we dissolved it about six years ago; we felt that there was a better way for us to deal with quality. Rather than have a quality committee of maybe four or five Board members and some of our senior staff and quality people, the board decided to deal with quality as an entire board, so the first order of business in either the open or closed session was the quality report. We would present Dashboards, and we would present quality activities at the hospital. In the closed session, we might talk about some of the reviews that were under way or some of the serious issues or critical incidents that needed addressing.

When the Excellent Care for All Act came along and said that a board must have a quality committee, our board said, "Well, we've been functioning like that," and it was unanimous that the quality committee of our board would be the entire board. We've carried on with that model, and I think it's stood us very well. We'll still touch on quality issues at regular board meetings, because the quality committee in its terms of reference meets a minimum of four times a year. We put the Dashboard in my report going to a regular board meeting, because we want to get it out there and on our website so that people can see it.

EG: Your board has representatives from your community?

RE: Yes, there are 15 people on the board, four ex-officio members and 11 elected members; I think eight live in the City of Guelph and two are from Wellington County, so some are in the surrounding community.

EG: Potentially, Richard, they or their family members have been in your hospital.

RE: Oh, absolutely.

EG: So you're engaging patients at a board level in some respects too?

RE: Yes, but I'm always conscious that they're insiders, so if I was thinking of the Patient Advisory Council, you might have someone from the board on that, but I don't believe the public would view them as being objective.

EG: No, I hear you. Another concept that some boards and organizations have introduced is to begin the board meeting with a patient story. Do you have opportunities to bring in people to share their story with the board?

RE: No, but I think the very thing you're mentioning, Esther, has been raised. I'm not sure whether it was at the last meeting, but I would say that it's under consideration.

EG: It sounds like your board is really striving for quality, and your point about when ECFA came out and said, "Thou shalt have ...," you were already doing it, but were making it an entire Board responsibility.

RE: Correct. I think the only thing we had to really look at that was going to change things a bit for us was performance-based compensation; the rest had been in place for years. We've been doing the staff satisfaction surveys way back into the '90s. Every

three or four years you roll out another one and go through your lists. We're practical; you make the changes your staff recommended.

EG: Richard, do you mind if I ask about the percent response rate to the patient satisfaction survey?

RE: I'd say in the 55% to 60% range.

EG: Excellent. That's amazing.

RE: Yes. But our staff satisfaction response rate dropped considerably last time. We're just about to launch our next one. Last time we had about 350 out of 1,200 employees respond and that was down by almost 200. We're trying to determine whether it was harder for staff to find time to do the survey, or were things fine and they didn't want to complain or make suggestions for improvement. We don't know, but we send out a letter with the survey, telling everyone that their director will give them 15 to 20 minutes during their workday to complete it; they don't have to use their personal time. (Esther - we had 936 employees (80.6%) respond to our 2012 survey and our results continued to improve.)

EG: That's an incentive. We're not asking you to do it outside of work. This is important to us; we want to hear what your thoughts are.

RE: And you can do it online or on paper, whatever you're comfortable with; it's all confidential. We also follow up. Again, if we get information that's troubling, the CNE and I make the rounds talk to departments about concerns. We had a Ministry of Labour review here a couple of years ago. Some of the feedback was that there are circumstances in the hospital where staff feel unsafe or where they get abused or yelled at by patients. We went around and talked to every single department in the hospital. I went with every VP to say, "This is not acceptable. Just because this is the way things are, have been forever, doesn't mean we're not interested in making changes and making things better. We need to hear from you when there's a problem, and we need to address these problems." I think people are starting to actually believe that it's worth their while to come forward and express concerns.

That applies to the patient side of things as well. One of the reports that goes to our board is a summary of all the incidents that occurred in the hospital, whether harm is done or not. There are five different categories. When you see those numbers, it's like, "Gee, we've got a lot of problems here." And we think, "No, our reaction is, the more things that are being reported, the more open people are about identifying mistakes or opportunities for improvement." Our board always asks what's going on if they see a change in that trend line, whether up or down. They're observing and noticing these changes, and they want explanations. Back to page 15. continued from page 23

EG: When you first established experience-based facility design in your organization, many years ago, were there barriers or challenges?

JM: There are always barriers in every organization, built through decades of culture, traditions and entrenched positions of stakeholders. The best way to break down these barriers is through clinical champions who can change the culture. They can create a dynamic vision about how to include our patients and families, and share success stories about how this patient engagement results in improvements. Some departments and clinics are more attuned to this than others. Psychiatry, for example, has a long history of success with patient engagement and building a patient-centred experience.

EG: Why would psychiatry in particular be ahead of the curve?

JM: I think psychiatry is much more predisposed to group activity, inter-professional behaviour and patient engagement. Other departments may only be in the early stages of this journey. The key to raising the bar on patient and family engagement across the various clinical programs is to understand the culture of the department you're working with, leverage their strengths, and work with them to overcome the barriers between them and your desired future state.

EG: You talked earlier in our conversation about the board. I wonder if you could share a little more about your board's perspective and how that influences success of the patient experience in your organization.

JM: First of all, I believe there's a correlation between great boards and great organizations. Great boards are defined by their vision, insight, oversight and guidance. In their role as stewards of the organization on behalf of the patients and the community, boards need to appreciate the importance of patient experience and feedback. If you can achieve that, then you have captured an essential component of strong governance. Our board has a long track record of careful attention to patient feedback, and this is critical to their role.

Our board has a long track record of careful attention to patient feedback, and this is critical to their role.

EG: Some CEOs have also talked about the fact that the board has invited patients or family members to come to the beginning of board meetings to share a particular story. **JM**:That kind of initiative certainly embodies the philosophy we're talking about. For example, we start our board meetings with a discussion of a critical incident, a patient safety situation or a patient story. Concrete examples move beyond the statistics



and ground the board in our responsibilities and challenges as an organization. We set the tone at the beginning of the meeting that our board's role is fundamentally about improved patient safety, the patient experience and clinical outcomes.

EG: Is there anything else that you wanted to comment on that I haven't asked about in terms of what you are doing in your organization?

JM: I'd like to comment on the Excellent Care for All Act and the direction that quality is taking within the province. I believe that the government has really used its influence in an appropriate way to shape the quality agenda and raise the bar in all organizations. They have created a framework that will potentially be very powerful in changing the behaviour of the health provider community. The citizens of Ontario - whom we ultimately serve in our role as healthcare leaders - can now see the goals and performance for their own local organization. This is ultimately where many of the components we've talked about today come together: There's no better way to get patients engaged than to start with clear quality improvement goals and an invitation for your patients and families to come on that journey with your organization.

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AD: Is there anything you can say further at this stage about the core priorities for HQO, appreciating that you're on the cusp of launching the strategic plan?

BC: This needs to be a long-term initiative with some long-term goals, but we also need to demonstrate early successes along the way to develop a sense of momentum. One of the areas we're already moving quickly to support is related to chronic disease population – re-admissions. We're encouraging hospitals to start thinking about re-admissions or discharge transmissions in their quality improvement plans. We'll be providing evidence-based change ideas around this topic, such as making sure that this target population is being identified through risk scoring, that these individuals understand their condition and their discharge instructions, and that there is clear, documented communication between the hospital, home care and primary care. There's a growing mountain of evidence suggesting that certain models of communication can have a dramatic impact on reducing hospitalization. These activities are coming right out of the gate for 2012/2013, and we'll continue to ramp them up over the next three years.

AD: Would you like to comment on anything Drummond has said regarding the role of HQO, which is to expand it even further beyond the mandate you have today.

BC: The Drummond Report, broadly speaking, talks about more evidence-based policy making and decision making in the management of all spheres of government, and healthcare is no exception. The incorporation of the move of the medical advisor's secretariat from the ministry to HQO in April gave us an enormous platform to provide more of that type of advice.

AD: Let's switch gears a little and talk about HQO itself and the mechanics that go into building capacity to assume such a significant new mandate. What steps are you taking right now to build up expertise, bring in additional leaders and establish the resources to make this ambitious and longoverdue plan happen?

BC: A critical role of HQO will be to mobilize the leadership that's already in the healthcare system, because those are the individuals who are key CEOs of different healthcare organizations or are thought leaders. They are particularly influential in certain communities or constituencies. We are identifying these individuals and bringing them forward in different structures to provide strategic guidance in our work. One example is a government council that we've created for our Best Path Initiative on improving chronic disease management, improving the patient journey and reducing avoidable hospitalizations. This group includes a number of key thought leaders. Not only are they providing strategic advice on the direction of the initiative, but we expect that they will be salespersons for the initiative with their peers.

AD: That's really exciting. I think we all agree that the best solutions in healthcare are developed collaboratively, leveraging all the capacity and expertise of the field and the ministry, HQO and others.

Underscoring your work is, I think, the government's political desire to see change, and rapidly; probably all parties in the Ontario Legislature, let alone the people of Ontario, are thirsting for quick change in terms of health system performance improvement. Yet, at the same time, you have a very specific mandate, one that needs to be approached with a lot of care and that must be grounded in evidence. That can take time. Is there anything you can tell us about how you work within that tension, or that dynamic - the desire to see rapid change - alongside the need to be accurate, scientific and evidence based.

BC: Again, we have to take a long-term perspective to transformational change, but we need short-term gains along the way, and we need a plan for both of those activities.

AD: Undoubtedly clear communication with government and a clear understanding of expectations is part of this.

BC: One positive thing is that even in the work leading up to the creation of HQO, we've already laid many seeds of transformation in the system. We've done a lot of work to support quality improvement in long-term care homes by developing quality improvement capacity and helping leaders think about how to develop quality improvement plans. We're now seeing a multitude of individual homes getting significant reductions in falls and pressure ulcers, and improvements in other areas. It's important that we start publicizing more of this excellent work to reassure people that the transformation is already happening.

AD: Why don't we go into the question of physicians, who are generally highly autonomous. What is the best evidence under any host of procedures, services and so on? How will you approach your interactions, your relationship with the physician community in order to build the trust and confidence? How will you harness the leadership that physicians have demonstrated?

BC: How do we protect the integrity of the advice? Well, we're building on well-established processes in our team that does evidence-based reviews - processes that protect the integrity of the analysis around the evidence. We have procedures for combing the evidence, for evaluating the strength of different studies, for pooling the information, and for doing the economic analysis and putting forward recommendations. Those methodological processes are ones that are not open to interference from outside interests.

AD: So perhaps you're a bit like the DQTC - the Drug Quality **Therapeutics Committee?**

BC: Yes. Having said that, however, at the end of the day the evidence needs to speak for itself; we want a clean view of the impact on outcomes and the cost-effectiveness of these different procedures. But what we do with the evidence, how we contextualize it, how we make sure it's adopted in the right way, requires an enormous degree of engagement. We have the Ontario Health Technology Advisory Committee (OTAC), which is already an excellent forum. It involves professional associations, key researchers, the ministry and other major stakeholders. We want to build on that.

As we move forward, there will be questions around implementation that will require further engagement with the field. Sometimes when we make a recommendation, it's a simple yes or no question such as, do we fund this? But most of the time, it's much more subtle. We fund the service only under certain circumstances. We need to be working with clinicians and leaders around the tougher questions of what appropriateness criteria to use, and how do we ensure they are appropriate. What are the mechanisms for ensuring that those criteria are followed?

AD: Is there anything you'd like to comment on beyond the integrity of reaching the decision on some of these matters around physician engagement, or is that enough for now?

BC: We're going to need a broader physician engagement strategy for all our work. It's absolutely crucial for us to engage physicians. Again, a lot of good work has been done from the predecessor organization to develop physician champions. Excellent work has happened in primary care. We need to accelerate that process dramatically.

We are already strongly advocating for clearer electronic medical record vendor specifications so that EMRs will automatically be able to produce these core indicators.

AD: You just mentioned primary care, and as you know since the Excellent Care for All Act (ECFA Act) has focused first on hospitals. There's been a very strong and active relationship between the Ontario Hospital Association and the hospitals through the first quality improvement plan - now into year two. Of course, there's got to be discussion afoot about pulling in other parts of the healthcare system, and primary care may be next. Would you like to say anything about the appropriateness of that or your ability to embrace that potential new authority?

BC: When we read the act, it's quite clear that although it was for hospitals, it was eventually to apply other sectors of the healthcare system. The implication of that clause is, eventually

primary care will be included as part of the legislation. This is a great opportunity for us to start building readiness for that sector to come under ECFA Act.

You can see why it was easier to implement this in hospitals than in other sectors, because in hospitals you already have a whole set of quality indicators that are mandated and publicly reported. That gives you the structure to immediately start launching into mandatory quality improvement plans. We don't have that same infrastructure right now, but where HQO wants to be involved is to push for a standard set of primary care quality indicators, not just those in hospitals. We are already strongly advocating for clearer electronic medical record vendor specifications so that EMRs will automatically be able to produce these core indicators. We'll also be building on some new work that HQO wants to undertake on developing evidence-based benchmarks. This was strong feedback that we got from hospitals in the first round of quality improvement plans; they're looking for more advice on what those benchmarks should be.

We've already started some activities along that road. For example, we've identified hospital organizations that have hit zero ventilator-acquired pneumonia rates and leading organizations that have hand hygiene rates at 92% or above. You'll be seeing a lot of these types of analyses from Health Quality Ontario. We've identified success stories in primary care in our quality monitor series in past years. We'll need to help the field prepare for the ECFA Act by doing more activities like that so they have specific guidance on things such as what could be reasonable targets to set for everything from wait times to outcomes for chronic disease management.

AD: Switching gears back to hospitals, working closely with the hospital sector, we all know that hospitals are extremely heavily regulated organizations - by provincial governments, federal governments, independent regulators and so on. One of the most common concerns I hear working with the OHA relates to the true value proposition underlining the mammoth amount of work hospitals do in responding to the requirements and needs of different regulators and governments. I think everyone is quite satisfied and pleased with how the first quality improvement plans went. At the same time, hospitals are completing accountability agreements and submitting data and information to other regulators in government. So how are you going to build on the momentum of the relative success of year one and avoid the criticism of a paper chase that has, frankly, come to afflict other activities that hospitals participate in, in other areas? **BC**: We can look at the ECFA Act in two ways. One is that it sets certain regulatory requirements that an organization has to fulfil. If you look at it that way, it means that an organization is going to say, "Well, I have to submit an annual quality improve-

ment plan because that's what the legislation tells me to do." Alternatively, we can see the legislation in a different light, as a bold challenge to hospitals and other healthcare organizations to embrace the quality agenda. You could see this as an opportunity for the government to say that hospitals and others need to have quality improvement plans, but what that does is seed a dynamic where individual hospital leaders are setting forth bold targets and implementing them because they want to view their organization as the leader among its peers. You can see the legislation as a framework that allows organizations to share their information about how they drive improvement. Now that you've created these plans, they contain detailed information about the changes they're going to implement, and this creates a structure for organizations to share.

We have two choices. We can do the minimum according to regulations or we can accept the government's challenge. The system as a whole needs to step up to that challenge if it wants to avoid making the ECFA Act a paper-chase exercise or an exercise in regulation. The more that leaders in the system can step up to the plate and demonstrate they are driving bold strategies, the more we can avoid the paper-chase scenario. If we don't have the leaders putting forward these bold plans and strategies and implementing them, the default reaction will be more regulation.

AD: How does HQO expect to influence patient-based payment? What is your role in making sure that ministry's pricing decisions incorporate best clinical evidence and lead to best practice care?

BC: We've been talking in Canada about patient-based payment for over two decades now. It's been incredibly difficult to translate a logical noble goal into concrete results. Why is that? It's because the devil is in the details. At HQO we want to provide support to move this agenda.

To be specific, this is what we need to really understand how to drive patient-based payment: First, we have to identify who are the key target populations we're interested in, and, second, we need to identify that particular episode of care around which we want to do patient-based payment. Third, what is the ideal care pathway for that individual as he or she moves through that episode of care? Fourth, we have to identify all the evidencebased practices that we need to execute flawlessly throughout that episode of care. Fifth, we need to measure what would the cost of delivering that care be under optimal circumstances, where the patient gets exactly what he or she needs and avoids complications along the way. That provides the evidence base the government needs to implement patient-based payment. It needs to be able to say to healthcare providers, to whichever organization that would oversee this bundle of care, "This is what we are paying for, this is our expectation for quality and let's negotiate the price. By the way, we already know what the optimal price is going to be." We believe this is the missing link between the lofty ideal and the actual implementation on the

we can see the legislation ... as a bold challenge to hospitals and other healthcare organizations to embrace the quality agenda.

AD: The government of Ontario, through the Ministry of Health and Long-Term Care, is at a relatively early stage in designing its implementation plan for patient-based payment. The OHA works closely with them in that regard. Is there anything you can tell us about the nature of the working relationship between HQO and the ministry at this early phase, when it comes to implementing patient-based payments?

BC: This is the approach that we are advocating, and we're working with the ministry right now to sort out the details of how we push forward on using this approach consistently.

AD: What are the most important things you learned since HQO was given its new mandate, and how are they going to shape the future of your organization?

BC: The creation of HQO represents an incredibly ambitious but unprecedented attempt at creating an integrated quality strategy and plan for an entire jurisdiction. What has happened is that four critical levers for driving system transformation have been incorporated into the same organization - evidence-based analysis, public reporting, supporting quality improvement and making recommendations on funding. Many organizations support quality in Canada and around the world. As far as we can tell, it is unprecedented for a quality body to incorporate all four of these levers. These different areas all have their own scientific methods and approaches, their own view of the world and paradigms of human behaviour, their own culture and their own academic traditions. It's an enormously daunting and challenging task to pull these approaches into a unified organization, and quite honestly that keeps me up at night. But, when we succeed – not if – but when we succeed, we'll have the satisfaction of knowing that we were the first in the world to pull it off. The only way we can truly transform the system is to make sure that all four levers are tightly integrated and driving toward to a common quality agenda. HQ

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CC: They have to move it up to another level.

WL: They do.

CC: How do clinicians link their quality improvement efforts to a quality improvement plan or other metrics? Have you seen that link?

WL: Now that the CEOs have an incentive in their salary for some performance metrics, they report to the board on these quality metrics. There's a big appetite at the hospitals for physician leadership. Bob Howard, the CEO of St. Mike's, is very invested in quality improvement. He's gone to IHI, and he's making this a part of his mission at St. Mike's. A while ago he was talking to me about a particular unit and a particular physician who was resistant to change and to quality improvement activities. The physician said to him, "We have the best unit in Canada. Why would you want to go screw it up?" That's a very frustrating attitude, but often physicians and other clinicians get very comfortable in how they're doing things. The CEOs are eager for physician leadership that can embrace quality improvement, see it as the norm in the institution and champion those kinds of changes with their colleagues. The hospital leadership, Bob Bell and Barry McLellan and Bob Howard, are eager for us to train those clinicians and have them come to their work environment with more knowledge and skills to work on the local needs. The certificate program has both lectures and projects that they're working on at their institution as part of the learning experience.

CC: When you've trained those 40 leaders, they go back to the unit. They have to work with their colleagues. What are the keys there? How do they get the naysayers at the table? You've recruited the champions; you've recruited those who've had the interest, but how do these docs go back and bring the apathetic naysayers on board?

WL: It's really change management. You don't start with the naysayers. You have an enthusiastic champion and you start with those people who are ready to lead. Their colleagues are academic physicians. You give them data, you show them the gaps and you show them where they stand. It's change management. You help people see a reason to be interested in "Could we do this better?" You give people feedback that they're not getting an A – they're getting a B or a C compared to their colleagues. Doctors are competitive. You harness their natural competitiveness in a good way.

CC: What else is needed to change behaviour?

WL: The maintenance of certification for physicians in the US requires practice improvement. All the boards are moving to openended certification based on meeting ongoing requirements for maintenance of certification. In order to keep your certification in the US, you will have to participate in practice improvement.

Let me describe a diabetes practice improvement project. You have to collect data from multiple sources: patients who give feedback to an independent source, an audit of your charts and your practice, and also a systems review of how your office practice is organized and how this facilitates or is a barrier to the care of patients with diabetes. You take that data, you send it to the board and you get feedback about how you're performing compared to your peers, for example, whether your patients are getting foot exams and hemoglobin A1Cs; counselling about exercise and weight control; and your patient ratings of certain kinds of communication – not just a global patient satisfaction rating. Then you have to do a Quality Improvement plan based on what you learned, implement the Plan and re-measure, and send the re-measurement to the board.

CC: That's excellent, because it would obviously engage our community physicians too.

WL: Absolutely. When you make changes like this, older practitioners like me can be very resistant, but over time young people just start to realize this is how we do it. Orthopedics is particularly advanced. Orthopedic surgeons have a 360-degree evaluation that is required as part of maintenance of certification now. It includes feedback from nursing, patients and peers.

If we don't hold ourselves accountable, and really be serious about our professional accountabilities to the public, the government will and should regulate us.

CC: Why don't we do this in Canada?

WL: I have an ongoing dialogue with the Royal College about it, and I've written about it. I wrote an article in JAMA comparing regulation in the UK, the US and Canada. I think we're behind. The Royal College is trying; they've been talking to the boards about using some of the methods developed in the US so that they don't have to reinvent the wheel - we're too small a country for that.

CC: One of the steps the Ontario government took a while ago was to stop paying for certain procedures such as electrocardiograms and other investigations before cataract surgery. Do you think there's a role for governments to get involved in the things we're talking about, such as maintenance and competence and certification. If the Royal College or the CPSO are slow to make changes, should the governments step in?

WL: I'd say yes. I know the US Medicare program has for a long time refused to pay for operations on the wrong limb. But I feel very strongly that physicians need to guard professional selfregulation as a really important privilege of the profession. If we don't hold ourselves accountable and really be serious about our professional accountabilities to the public, the government will and should regulate us. I have tried to argue that Canada is ripe for government intervention, because physicians are not self-regulating in a serious way.

The evidence for that is what happened in the UK, in a series of events that culminated in the Bristol inquiry. Following the Bristol inquiry, physicians are no longer self-regulating, although they do have input into the regulation process. I look at Canada and the episodes like the estrogen/progesterone-receptor testing in Newfoundland and other events like that. You just know that Canadians will wake up one day and say, "What are you talking about? You mean that this can happen in our hospitals? You mean to tell me that doctors, as opposed to every other profession, never have to take another test to prove that they are competent after they finish their training?"

CC: I would agree totally with you.

WL: You might, but believe me I got hate mail after I wrote some of those articles. I wrote one in JAMA and one in CMAJ called "Are We Passing the Test?" I had some really nasty letters.

CC: The US has always been criticized, but Medicare is a national program and can set national standards. In Canada we have no national professional standards. Each province sets its own.

WL: Right, except that we have the Federation of Medical Regulatory Authorities of Canada, and the College of Physicians and Surgeons of Ontario, which is enabled by the government, could work with their counterparts as they have to set some guidelines that influence practice. We don't have a national regulatory body, but we do have a confederation of provincial bodies that work together and try and have similar standards. The provincial bodies could implement something like this, and the Royal College could implement it.

CC: Your certificate program is focused on academic physicians, but how do we engage physicians in community hospitals? They don't have much opportunity or access to learning about quality improvement and the processes. Is that a fair comment?

WL: Well, yes and no. The American Board of Internal Medicine, which I know the best, certifies 250,000 physicians and they all have to participate in practice improvement to keep their certification, no matter where they're practising. We've developed all these products and resources that help teach them and that are highly relevant to their practice.

CC: But if I'm a physician in Hawkesbury, Ontario, or a similar community and I want to learn the basics of quality improvement, where do I go in Canada?

WL: You don't have to anywhere. You can get on the Web.

Canadians will wake up one day and say, "... You mean to tell me that doctors, as opposed to every other profession, never have to take another test to prove that they are competent after they finish their training?"

CC: But I can't find a Canadian program. It's usually American, or from IHI or something like that. Is that a fair comment?

WL: It doesn't matter. You can't tell me that an internist in Canada who's caring for diabetic patients should practise differently than in the US.

CC: Many times I hear in Canada, "Well it has to be Canadian content." I reply, "Well, in some cases, yes, but in many cases, no, it's universal." What about the costs of attending US programs?

WL: You know how much it costs me to maintain my certification in the US Board? About \$1,800 for ten years; that's \$180 a year, and that includes access to all of these practice improvement modules. By contrast, I pay \$750 a year to the Royal College.

CC: Let me go back a bit though. To have access to the resources of the American boards, do you have to be certified by the American boards?

WL: The Royal College is trying to work on that to see if they can arrange access to those resources for a nominal fee. HQ

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CC: How big was the group that you put together at that time?

WF: They developed a portfolio called "Quality Improvement in Health Information"; it was about 80 people strong. They weren't all new positions. Many were data analysts pulled out of finance; others were pulled in from population health, so many were physicians. Then they developed six or seven new positions around quality improvement, plus all the new physician positions. They started with five departments, and we eventually got that up to ten. Most had a physician at one third of his or her time, plus a quality improvement consultant fulltime. By the time they disbanded the portfolio, we had about 110 people; that was for a region with a budget of about \$3 billion.

CC: Can elaborate on why it was disbanded? Maybe it was under the reorganization?

WF: That was Alberta Health Services. It wasn't completely disbanded; it was just reorganized, and we were the best-funded unit in Alberta by a country mile and the most visionary. Unfortunately, before we all became one big happy region in Alberta, not many of the other regions had much in the way of resources, so they took what we had in Calgary and started using it for the entire province - which watered down the effect. As with many major reorganizations, the key leaders and visionaries left, so it hasn't been as successful on a province-wide scale. But it worked well on a regional scale, which was three big hospitals and about a \$2 billion budget. It's a very complicated region, but the model worked.

CC: Once you had your physician leaders from the ten departments in place, how did they work, and can you give me any examples of some positive outcomes? How did they rally the others in their department?

WF: In one way, the physicians were a gift to the department, so they went to the department heads and said, "We've got new funding for one of your physicians, so you get support for one of your physicians. If you can find a key person who's influential, then you're going to do well." I think there was a subtle hint that if you didn't do well, there were other departments that would probably like this. The suggestion was, "We don't have funding to support all the departments right now, and we may need to move funding around, depending on where we think we're going to get the best bang for the buck." By and large, department heads were motivated to find some of their senior, more influential people with had an interest in this area, and they started incorporating them as part of their executive. They started looking at it as one of the key outcomes that the department was interest in, in addition to education, clinical service and research. In a lot of departments, the quality improvement physician became part of their executive, and that physician's activities became part of the executive's monthly meetings and part of their agenda.

CC: Did they choose certain metrics depending upon the department? And did they adjust those on a regular basis? Or how did these quality and safety physician leaders pick their agenda?

WF: It was really variable. One of the downsides to doing it this way was that there wasn't a strong vision for how the work should get done. This was back in 2000, 2001, so the area was pretty new. Even though we had access to data analysts, the data itself was not fantastic. There was no formal way to train people in the key aspects of how you drive quality improvement in a healthcare department or a healthcare organization. Certainly, people wanted to see activity, and there was some reporting out, but it wasn't outcome based. The agenda was driven by the interests of the department, and primarily that meant the interest of the physician leading the quality improvement initiative, rather than the organization saying, "Here are our key strategies; we've got to meet these targets, and we've got to get you in line with what we want to accomplish." That was just a reflection of the organization itself. The leadership and the organization hadn't done this before and were pretty clueless in how you align this kind of investment with the key strategies of the region.

CC: Obviously, they've learned in Ontario from what's been done elsewhere, and the metrics flow up to the board and ultimately up to the Quality Council, so they're more part of the global strategy at the hospital.

What would you do today, from an educational point of view, if you took these physician leaders interested in quality improvement? What kind of education or advice would you give them now, and what kind do you provide now?

WF: We went through a journey, so most of us learned by going to Institute of Health Improvement (IHI) conferences. We'd go to the quality forums in December, to their pre-conference workshops, and we picked up a lot that way. Learning was sort of haphazard. Along the way I met Brent James from Intermountain Healthcare, and I was impressed that although the IHI talks good theory, Brent was actually putting it into practice. Brent had a formal training program, he had buy in from his board, he had a vision for how this would work, and he had incredible overall buy in. We started sending people down to Brent's training course; he offered, so we probably sent 20 people.

My ultimate vision was to develop our own quality and safety course in Calgary, available to quality improvement docs and consultants, people trying to lead this for the organization so they could get standard training in terms of how do you do this business, because there really isn't anything out there. We were part way down that path when the big reorganization happened, so the vision didn't materialized.

CC: So, that peer learning, going down to Intermountain and speaking with the docs and seeing how quality and safety were being applied at the front line was a key aspect in their enthusiasm and participation?

WF: I still remember the first conference we went to. You left saying, "Wow, this is really cool; there are some people doing some really neat stuff." It was enlightening and invigorating, and that got a lot of my colleagues turned on. They were saying, "Hey, we can do this stuff; we just have to learn a bit more, and we've been given this incredible opportunity and some protected time to do it." I thought it was a cheap way of getting people enthusiastic about making change, even though the conferences themselves weren't that cheap.

CC: Then what happened? Take us up to where things are now in that journey with the docs.

WF: We were very focused on the quality improvement side of the equation. Then in 2004 we had a disaster in the region: two patients died related to a mix-up in dialysis solution in our Intensive Care Units. That swung the pendulum pretty hard, not away from quality improvement, but adding in patient safety. We struggled to develop a complementary model around safety that would work with the quality improvement model we'd already built in. But the quality improvement efforts got watered down because we got so focused on safety.

Having said that, we're managing both pretty well. We needed to get some doctors involved in safety who weren't the quality improvement doctors doing the process improvement work. That meant expanding our base, but we didn't have money to pay doctors for the safety work. We had created safety committees, so we went to the chairs of those departments and said, "We would like to work with a member of your department to chair a safety committee; this is what their terms of reference would be."

We were partly successful in engaging people, and they would be doing it for the greater good, without getting a funded position for doing it. Unfortunately, that infrastructure unravelled as well when Alberta Health Services happened.

I think a lot of people are prepared to buy in if they can see what you're trying to do and why, how it ties into the greater whole, and that they'll have influence in it. If they lose that, they quickly start looking around for better ways to spend their limited amounts of time and energy.

CC: Those are very good points. What about your champion leaders? Did they disappear? Was that another reason for the momentum falling off?

WF: Yes, they did. We started to get a better idea of how to align quality improvement initiatives in the departments with regional priorities. The best example was, we had decided in 2006 that Emergency Department wait times were terrible

and that nothing short of a region-wide initiative was going to address it. We acknowledged that Emergency Department wait times were not caused by the Emergency Department but by problems elsewhere in the system. We just about killed ourselves engaging all the departments and realigning their priorities. They were used to setting their own priorities and doing what they wanted, thank you very much, so we had to slowly turn them around by saying, "You can do some of what you want, but some of what you have to do is aligned with these priorities of the region, and the top priority is the Emergency Department." We got people to the table to talk about and lead that; and the leaders swung their focus around. What finally killed it was, the region took their eye off the wait-time ball, and then Alberta Health Services happened. Everybody realized that nobody cared any more, because they were too worried about how to restructure this large organization; there was really nobody in charge. As soon as people believe that what they're doing doesn't matter to somebody higher up than them, they lose their ability to make decisions and to spend their limited budget on what they think is important. When you take away authority from them - the interest in trying to make change evaporates overnight.

CC: What about education now, in clinical quality and safety? There's IHI in the United States still, and Intermountain. Is anything available in Alberta?

WF: Well, when I decided to leave the clinical leadership role that I had, I came back to faculty full-time. Within a year I'd put together a course that the faculty now offers – a quality and safety course. We run it every other Tuesday evening for most of the year, about 13 or 14 sessions. We offer it to anybody in the healthcare system, to try and keep the thread of how do you improve healthcare alive and to give people practical advice and information they can use.

Alberta Health Services has a very small education department that is swamped just trying to get very basic information out to a large number of people. The Canadian Patient Safety Institute (CPSI) has done some work around offering training in various aspects of quality and safety, and the BC Patient Safety Quality Council led by Doug Cochrane has a quality improvement training program for people in BC. I think each province is trying to address things in a slightly different way; there are no standards that any of us are being held accountable to. If somebody in the province will do it, good on them. We're trying to keep it alive until, at least within Alberta, the next vision comes forward to say how are we actually going to do this work.

CC: Quality and safety education: any thoughts of how far it should be pushed down to the members of a department

WF: I've partnered with the Health Quality Council of Alberta on this, because it gives us the option of trying to get everybody across the province on the same page. It's been a bit challenging, but at least we have a model for it. Our focus is, what are the key things that people need to learn throughout the healthcare system - from the C-suites, the CEO and the board level, to directors, frontline providers, and people who aren't professionals but are the backbone of the system - the cleaners and the unit clerks. We've tried to outline the very basics of what everybody needs to learn. Our challenge, of course, is getting it launched, getting enough people who understand it and could teach it. We are trying to work with our office, the continuing medical education (CME) and undergraduate medical and postgraduate education. We've just barely scratched the surface, but at least we have a plan.

CC: Does the Alberta Health Quality Council have any direct relationship between metrics that are coming out of Alberta Health Services or even metrics from your local area, involving monitoring them to drive different results or change in behaviour?

WF: They certainly have that mandate, and they have access to data. I think in the past their focus was a bit like Ontario's: "How do we get the health regions to play in the same sandbox and think about the same things, and we can be a facilitator and an advocate for them?" There were nine health regions in Alberta, but with the creation of Alberta Health Services, that role got wiped off the map. I think they're still trying to find that sweet spot of monitoring to push the system forward, knowing that it's such a funny model in Alberta as the government is overseeing a single health entity. It's not like this in Ontario, but in Alberta sometimes it seems like the health minister is actually the CEO running the healthcare system, so there's a very strange accountability going on. Although the Health Quality Council does have access to data, and they could hold people accountable, what they're holding accountable is the single entity that the government's created. By virtue of that, they're holding the government directly accountable, and that relationship is still in its infancy.

CC: Yes, there are huge political changes out there.

WF: As you can imagine, with the Excellent Care for All Act in Ontario, you have a Health Quality Council almost acting on behalf of the government to hold these different entities accountable for their quality plan, the metrics they're coming up with, and how they're doing on their metrics. That isn't the model at all in Alberta. I'm not sure that it will get there because it's almost the government asking the Quality Council to hold

government accountable and governments like to have other people held accountable, not themselves.

CC: From what you know of the Ontario situation, do you think this is a good step forward?

WF: It's an interesting step. I don't know a lot about it, just the concept of forcing organizations to come up with a plan that they could be measured against. My only concern about that is, unless the data systems in Ontario are vastly better than the ones we have in Alberta, most of the data that you'd like to hold people accountable for isn't available, or it's not collected in a way that you can use. We hold people accountable for things that we can measure, not necessarily for things that we should hold them accountable for. Sometimes I think that prompts people to massage the data so that it looks better than it actually is. I'm always worried about how you put the incentives in place, and whether you've got them in the right order.

If you look at the model of Intermountain Healthcare, they first put in place very good data systems, so they could get the information they needed to run their business. Obviously they were motivated by the fee structure in the United States, but, nevertheless, they've got what appears to be believable data about things that matter, as opposed to data that you query about things that may matter less than people might think. I'm a bit worried about holding people accountable in a metric structure, if you haven't got the data system.

CC:That's a very good point. What's the momentum now? You did some fantastic work almost ten years ago, but where's the momentum in your knowledge and on the CPSI Board across Canada to address the quality and safety agenda and get physicians involved? Is it moving ahead well, is it variable between provinces; or is it stalled because of the financial crisis we're all in?

WF: I think it's stalled. Maybe it's mostly the financial problems, but I think it's stalled because of a lack of a unified vision. Everybody's off doing their own thing, doing it in different ways, with a different philosophy; and it changes so quickly that nobody could keep up with it if they tried; you'd need a program that got updated every month about who's doing what, where, and how they're doing it. The fact is, we don't have a single healthcare system in Canada - we have 13 - so everybody's doing something different. I think that makes it incredibly difficult for CPSI or a national organization to read the tea leaves and figure out how they can have the greatest impact across the country. The focus seems to shift from one topic to another, and we've migrated from safety issues to access issues, and other forms of improvement. I don't think any of it's wrong; it's just incredibly challenging when everybody's doing something different. It speaks to the idea that we don't have a unified vision for how to move forward. I think that's one of our

challenges in this environment – working collaboratively with one another to reduce the amount of work by not reinventing the wheel in every province.

CC: When you're faced with apathy in a medical staff that's not engaged, do you have any thoughts on how to engage them?

WF: Yes, I think it's important to listen. The other critical thing is data. I was pleasantly astounded at the times I've been able to get believable data and put it in front of physician leaders and say, "Here's what we could be doing; here's what we're currently doing. We're not here to debate the data; the data is the data." If they can buy into the data, they sit back and say, "Wow, that's terrible."

The example I'd give is about when we started trying to get people to buy into the fact that Emergency Department wait times had a lot to do with how services were functioning within the hospital, not within the Emergency Room. We all provided a service to the Emergency Department, a service called consulting. I was able to show them data on the average time and 80th percentile time of how long it was taking individual services, from the point of being asked to see a patient, to the time they saw the patient, to the time they made a decision on whether the patient was being admitted. Then I took that data and put it in front of people who were actually accountable.

They looked at it and said, "You mean to tell me that our department is averaging four and a half hours to make a decision to admit a patient?" We go, "Yes, and on your bad days it's getting to be nine hours." They were astounded and sickened by the fact that it was so terrible. That was hugely motivating for them to go back and say, "We've got to do better." They didn't come to the table and say, "How much are you going to pay us to get better, or what do we get if we get better?" They just looked at it and said, "This is not acceptable."

It's about trying to get data for situations where people are accountable and feel accountable, and then feel they want to change. Then, you give them the ability to change, enough resources so they can change, and the data that lets them know if they're making an improvement. The natural leaders and early adopters in any department take hold and see what they can do with it. In the right environment, I think that's extremely helpful. There are places where it doesn't work, but to me, the key is getting believable data that people can't dispute and a level of accountability that no one can dismiss.

CC: There are some cynical people that say that doctors always challenge data, even good data. That's their opening line. Any thoughts on that?

WF: I'm reminded of the data journey that Don Berwick used to talk about. He said, "Whenever you show data to a group of physicians or a group of anybody, the first thing they'll tell you is, this isn't our data; you don't have it right; this isn't our data." He said then you move past that to, "Okay, maybe it's our data, but it's wrong; there are problems with the data." The next stage is, "Okay, maybe it's our data and maybe it's not that wrong, but there's nothing we can do about it." The last stage is, "Okay, it's our data; it's reasonably valid; it isn't very good. Now what are we going to do to change it?" You have to expect and anticipate the push back at each of those stages, because nobody wants to admit that as a collective group they're not performing as well they'd like to. I think it's really important that you never show data on individual physicians; you've got to get people working together as a team and then tell team, "This is how you're functioning," not "Gee, there's a really good doctor in your group and there's a really bad doctor in your group. How do we get the really bad doctor to buck up and the rest of you laggards to start performing like this really top-notch guy?"

CC: I agree with you, but if you put averages out there, how does the individual know that he's not meeting them, or she's doing a lot less? Give him data personally, but not share it with the whole group?

WF: Yes, I think that's what you do. But you can go about it in a couple of ways. Say you're comparing hospitals to hospitals; you show the hospital its own data and you show it the average across the rest of the group and say, "What do you think?" I'm not a huge fan of doing that. My view is that a benchmark like that is always a great way to achieve mediocrity. The better discussion begins with, "Here's what we're doing as a group, and here's what we think we could do or what other groups have done. There's a gap, so what are we going to do about the gap?" I'm a big fan of gap analysis and comparing people to what they think they could do or should be able to do.

CC: You went to Intermountain; Kaiser Permanente also has good programs. Any thoughts on collaboratives or benchmarking against hospitals in Canada, and working as partners to address this issue?

WF: Yes. People are always interested in how somebody else is doing. It's probably part of our competitive spirit, and nobody wants to think that they're in the bottom half. I think it can be motivating. But what's more motivating is if it's done in the spirit that we can all get better. One of the things I learned at IHI was the concept of running collaborative projects around common topics, where groups got together and were able to see their results plus the results of other teams participating in the collaborative. Everyone was trying to help each other improve, as opposed to, "How can we improve and look better than somebody else?" I think tapping into people's natural inclination to compete, if it's done in the right way, can be really helpful; if it's not done in the right way it's potentially damaging.

CC: When you set up your physicians at one third of their time, I guess you had specific expectations and position descriptions, and what they were accountable for?

WF: Initially, not very well. I think the very first contract I signed as one of those physicians said, basically, "Just get out and start doing something. We want to start seeing some activity." They appealed to the people who were self-starters, who didn't need a lot of direction and didn't need a contract that said, "You'll accomplish this by this date or else." I think ultimately we were too unstructured when we started, and we needed better accountability and better position descriptions. At the end of the day the kind of people you want to attract are the self-starters who don't need specific marching orders. They need general direction; they need to be given a vision; they need to be given buy in to some expectations without being micromanaged. For this to be really successful, you want to attract the kind of people – and there are a lot of them in medicine – who get charged up with the idea that, "I can make this better. The healthcare system is not functioning as well as I think it could. They've given me the tools to make it better, and that's exciting. That's an opportunity I can't pass up."

CC: Very good. I don't think there's anything else. This has been excellent. Thank you very, very much.

WF: The only other thing I might add, Chris, from my perspective is having been involved in lots of quality improvement projects and watched organizations get better and then selfdestruct, I truly believe that it all comes down to culture, and I wouldn't be the first person to say that.

At the end of the day, you look for leaders and you look for unity around a common vision that gets you to a change in the culture of the organization. I think the incentive program that Ontario is embarking on has the potential in some places to change the culture for the better, and I think it also has the potential for changing culture to the detriment of the organization. I'd be just a little nervous about the impact on the culture of how this is being structured; just because it helps some organizations doesn't mean that it isn't going to adversely affect a lot of others.

CC: Good point. They need to have champions throughout the organizations, who may or may not be there when you implement this, and there are consequences. The other thing is, changing a culture takes time.

WF: Absolutely. The big problem with governments is that they want results yesterday. If they don't get the results fast enough, they change everything. That's the absolute worst thing you can do. They've got the model all wrong. They've got to invest in the right model and then stick with it and have some constancy of purpose for several years in order to start seeing the returns on their investment. I quite liked Ross Baker's book, High Performing Healthcare Systems: Delivering Quality by Design, where he looked at seven high-performing healthcare systems in several parts of the world. He has a lot of valuable takehome lessons that hopefully people are still paying attention to in Ontario.

CC: One of the key issues is to have physician leaders. Do you think governments invest enough in developing or educating physician leaders to step up and address these issues on a global basis?

WF: Absolutely not. Now if governments were smart, they would combine their efforts and put together a quality training program - maybe not just for physicians, but primarily aimed at physicians - that really addresses what physicians need to do to be successful. We always talk about physicians being the lynchpin; they're an important part of it, but they're not the be-all and end-all. Answering the question – What are the key component parts that need to be in place in any system to allow it to improve, physicians being one of them? - if we could get a common understanding of that and then a common way to address it through education, plus expectations and systems to support it, we'd be a lot further ahead than by just putting in structures like, "Okay, we're going to start measuring now, and that's going to be the motive to get everybody to improve." It's part of the answer to the formula, but it ain't the whole formula, so you'd better go back and say, "What are the other component parts in that formula?" I'm pretty sure if you've got a zero in any one of those parts, you're going to get zero at the end of it.

CC: They've ask for these metrics and most of the physicians don't have the knowledge or tools to effect metrics. I think it's also key, as you mentioned, that the Province take some ownership of this challenge and invest in it, which I don't think they have yet.

WF: Well, a key metric that came out four years ago was hospital standardized mortality rates (HSMRs). There's certainly a signal there, but there's a lot of noise. Say you went to a group and said, "Okay, we're in trouble here; our HSMRs are not good. We're being held to account and we need to change them, and in the next year." If you put that on a table in front of any physicians, they'd all look at it and say, "So how are going to do that? We don't understand the metric you put in front of us to the point of being able to change it, because we don't know what drives it." If you don't give people the data that they can actually do something about, that they can see how to change, it's inappropriate to hold them accountable for it. HSMR is a classic example of that, so I'm interested in what metrics people are being held accountable for. HQ

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CW: Going back to your comments about prioritization, how do you decide which issues to engage in? What constitutes your prioritization template, if you like?

BO: We get products into our portfolio mix in two ways. One is a reactive kind of approach, and one is more proactive. On the reactive side, we have two programs that produce reports and recommendations. One is the CADTH's Common Drug Review. As a new drug, a new molecule first receives market authorization from Health Canada - the regulator. Then, the manufacturer has to make a submission to us. We do our work and make recommendations on whether the drug plans should list that product. There are between 30 and 40 new molecules marketed in this country every year that we look at and make recommendations for. We also have a rapid response service, again reactive, where our customers - the ministry and people working in the health authorities in hospitals across the country - can request information from us. They have a specific question on a technology, and we provide them with whatever level of information they're looking for, again to close that evidence gap. Sometimes they need information tomorrow, so we're able to do some very quick analysis for them. Sometimes they can wait a week or a month or even three months.

Then there's the proactive side, where we scan the horizon. What are the drugs, the technologies, the procedures in the pipeline that policy makers will be faced with making decisions on in a year's time or five years' time? We listen a lot to our customers, to deputy ministers, to senior officials, to health authorities. We've positioned a liaison officer in each of our participating jurisdictions. They are our eyes and ears on the ground, working closely with ministry officials and health authorities.

More and more, our format is expert recommendations, tools and guidance documents to go along with them, but all with an expert approach.

Over the last couple of years, we've tried to focus on some priority themes, again through scanning the horizon, listening to customers, looking at their business plans, their throne speeches, and so on. We've narrowed the type of work down into a number of clinical areas. For this fiscal year, for example, we've got five priority themes: cardiovascular and cerebral vascular, infectious diseases, mental health, endocrine disorders with a focus on diabetes, and neurological disorders. We look at our priority themes every year. Our board approves them on an annual basis as part of our business planning.

We've created theme leads within our staff, individuals who

have a focus on all the work we're doing in that particular theme. They're linked with the clinical societies within that theme.

Once we have those proactive items, we have a Portfolio Committee, a central intake process where a cross-representation of our staff get together weekly to prioritize all the projects we could be working on. We have a very structured process for that as well, looking at how relevant the work is, when we could do it, what impact it would have, and whether there any risks in doing or not doing it. We identify a list of potential topics and then sit down, scope them out, prioritize them, and work with our advisory committees to develop the actual portfolio of projects.

CW: In your process of review and analysis, what kind of output do you provide? Is it conclusions? Or is it recommendations, and if so, is it who should do what? What's the format?

BO: We have gone through a major transformation at CADTH over the last few years. It grew up primarily as a research-based organization under its old name and mandate, COOHTA, the Canadian Coordinating Office for Health Technology Assessment. We sent out research-based reports with conclusions - usually peer-reviewed reports - but there weren't any hard expert recommendations to policy makers. That left them wanting more. When we introduced our Common Drug Review, we also introduced the expert committee process, and now we make recommendations to the drug plans on whether or not they should list these new drugs. We've introduced that as well for our medical devices and our procedures and diagnostics, with this Health Technology Expert Review Panel. More and more, policy makers are looking for hard recommendations for their policy-making needs. More and more, our format is expert recommendations, tools and guidance documents to go along with them, but all with an expert approach.

CW: What happens to your conclusions and recommendations? You write up the project; you make it available. Is that targeted in any way? Is there any process, or does it just go out there in the hope that it will be picked up as much as possible?

BO: In the past it was one of those processes where we would produce this very large scientific-based report – very good reports, don't get me wrong – but the process was much more passive. We would put the report on our website or maybe disseminate it and hope that it ended up on a policy maker's or a clinician's desk and that they might do something with it.

We're taking a much more proactive approach now. When our Common Drug Review recommendations are released, within about five days the Expert Committee makes the recommendation, and it goes directly to the drug plans. The drug plans, of course, are still the decision makers. We are not; we're still a recommending body. But about 92% of the time, when those drug plan managers make a decision, it's consistent with the recommendation we provided.

Similarly, in all our other work, we now develop a knowledge exchange, or a knowledge mobilization strategy or plan, for every project. At the start of the project we know who's looking for that information, how we could best translate that information, who are the groups we should be working with and how we can help implement the recommendations that might come out of a report. It's a much more active approach. Again, I'll make it abundantly clear that we're not the decision makers; there are many other factors that policy makers within the ministries have to consider in making this decision. But our work goes a long way to supporting them in their evidentiary needs.

We're always looking at the type of work we do from two aspects. One is health outcomes... the second is cost-effectiveness...

CW: Yes, I understand; that was going to be my next question. Once the work is done - the scientific work, the conclusions and recommendations, and wherever they've gone - how involved are you in implementation, whether it's something hospital executives should be doing, or heads of clinical departments, or policies the ministries should be following? **BO**: We're involved to some extent. I think it's a growing area for us. It's a fine line to walk as well, because we're not the ones involved with implementing policy, so we tend to work closely with individual jurisdictions to support whatever efforts they'd like us to get involved with. Our board has made it clear that they would like us to be a little more involved with implementation support if we can; and its implementation support of course, not implementation. We've worked with some jurisdictions that have academic detailing programs in place, to provide them with information they can use to go out and talk to clinicians.

Any of the work we do typically involves both a policy change and a practice change. We're trying to develop tools and products that speak to both of those groups, and also to the patients. We did some work on smoking cessation drugs, for example, and we produced documents for policy makers; we produced documentation for clinicians; and we produced documents for patients - and lots of different tools. We're starting to delve more into implementation support, but we recognize that there's a fine line between implementation support and implementation.

CW: How do you feel about the influence your work has had or is having on policy and funding, and executive decisions

BO: I think it's a growing influence. We've always had some influence. On the drug side it's been there since the Common Drug Review was established in 2003. But we're having influence on more and more of our projects. For example, we did some work on autism services a few years back, and the Province of Saskatchewan was looking at their policy and how much funding they were putting in to enhance their services. Following our work, they set aside \$2.5 million in new funding to enhance their autism services.

As well, we did a report last year for the Province of New Brunswick on magnetic resonance imaging (MRI). They were at the point where they needed to replace all their MRI machines, and they were faced with a tough decision on whether or not to go with the standard magnet-strength - 1.5 tesla machines - versus the more academic and newer 3.0 tesla. The newer machines cost more, so they would have been able to purchase more of the standard. If they went with the higher cost, they wouldn't have enough MRIs for the hospitals in the province, so they were faced with a very tough decision. They asked us to look at the evidence. We put an expert panel together, involving radiologists and clinicians, and we provided recommendations; they based their decision on our recommendations.

We've done some work on robotic surgery and on smoking cessation drugs. More and more we're starting to see that the policy makers require good evidence to support their decision making, and they are relying on organizations like CADTH to help them in that regard.

CW: Yes, indeed. Another aspect, though, with the growing interest in quality and even the issue of quality-based funding arising for the future, is, how do you make a connection between technology assessment and quality of healthcare services?

BO: That's a fundamental concept of the type of work we do. I don't think we ever go into a project simply to say we're about just saving money. Most of the time when we put our experts together, or even our clinicians and scientists internally, the first thing they're looking at is the efficacy, or the effectiveness, of this new technology. We're comparing it with existing technologies. Will it work? Is it of value to the clinicians and the patients? We look at the effectiveness and the harms before the cost-effectiveness and appropriateness, and maybe some of the ethical components too. To me, this whole aspect of quality is fundamental.

What it does well is, if we do a report and find, for example, that there might be overuse of a particular technology and we make recommendations to limit use of that technology, this would perhaps create some space for other technologies that might provide higher-quality care. We're always looking at the type of work we do from two aspects. One is health outcomes or safety and effectiveness; the second is cost-effectiveness or the sustainability of the healthcare system. I think there's a really close link to the quality agenda that most provinces are really focusing on now.

CW:Yes, I think that's the way things are working out for the future, more and more. Sometimes you must look at your work, your suggestions, your conclusions and your recommendations, and be a little frustrated that they're not taken up more quickly or in as much depth as you would like. What do you see as the obstacles to responding more quickly and effectively to good recommendations on health technology assessment?

BO: Some of my staff who've been working a project know the evidence and ask, "Why isn't the province doing something with this great work we've done, even when they have experts that have agreed to this or come to some consensus?"

We've got a classic story with our self-monitoring of blood glucose – the test strips that diabetics use. We primarily focused on type 2 diabetics not using insulin, and we came up with all kinds of good recommendations. We did an economic analysis, and our outcome essentially said, "If practice were to change to reflect the evidence that we demonstrated, over the next three to four years we could save between \$450 million and \$1.2 billion in this country on those test strips. Stopping coverage of the test strips would eliminate that amount of money that then could be spent on more effective things." So it can be frustrating, but I understand it.

I use two words a lot with my staff: "Be patient but be persistent." ... If the evidence is sound, the change will occur, but it does take time.

Again, it goes back to the types of things that require change – both to policy and to practice. Practice change can take an extended period of time. We've found that you need to get key stakeholders involved, and early and often. They're the clinical groups, the patient groups, maybe the clinical societies, and the policy makers. You need to understand what their true needs are. Is this relevant to their work? Are they prepared to make some policy changes? Or do other factors need to be considered, like emotion? We know that emotion trumps good policy and good evidence. Are there affordability issues that would require significant changes to a health system? I use two words a lot with my staff: "Be patient but be persistent." These changes will

happen. If the evidence is sound, the change will occur, but it does take time.

We're looking at new methods, at what other organizations are doing in a global perspective, and at what the general research community does to effect policy and practice change.

CW: Yes, thanks. Now, you're in the business of evaluating technology and drugs. What is the process for evaluating what you do in your organization?

BO: We've got a number of systems in place. We've been subjected to many evaluations over the years as an organization, because we are a not-for-profit corporation, but our funding comes from both the federal government and the participating provinces and territories. Naturally, evaluation processes have to happen. We went through a very extensive evaluation in 2009. The Conference of Deputy Ministers asked for an independent evaluation of our organization, and they looked at everything – our governance, our product and services mix, how efficient we are in getting our work done and the funding model we use. That resulted in a number of recommendations and a significant transformation for the organization.

We also get evaluated as part of our funding cycle. A significant amount of our funding comes from Health Canada, from the federal government through a funding agreement. It's a five-year cycle, so at the end of every five years there's a formal evaluation of our programs. That goes in through the federal government into the Treasury Board – a normal requirement.

With Health Canada, this year we asked if we could do not just an evaluation to meet the needs of Treasury Board; we also wanted to know if we are really making an impact. Health Canada agreed to a bit of a revolutionary type of evaluation for us. They've done it in two phases. The first focused on programs, and phase two began in March and goes until about October. Looking at our major business lines, the second phase is an overall assessment of our performance, of how we transform the organization, whether it's making a difference, our financial efficiency and our effectiveness. It's a good external evaluation of the organization. Health Canada will be talking to people who use our work, to people who maybe don't use our work because they don't see its benefit, and to ministry folks, our liaison staff, our board members and clinicians across the country.

CW: Would it be fair to say that this evaluation – this more recent one you're speaking of – is less an evaluation of surrogate issues of process and efficiency and so on, and more one of actual outcomes in terms of change in the system?

BO: Absolutely. We made that very clear, and Health Canada, through their vision as well, allowed us to move in that direction. To me that's much more important. Certainly we have all kinds of processes in place to meet the appropriate financial

stewardship that's required, but what impact are we having and are there things we could be doing differently to really make a difference?

CW: My next question, and I think you've answered in several bits and pieces, but I'll put it bluntly - why should governments continue to support CADTH?

BO: I think they need to look at us as an investment rather than an expense. They're faced with, and will increasingly be faced with, tough decisions on healthcare technologies. Take the trends happening in pharmaceuticals – there are some 2,500 drugs in various stages of clinical trials, and about 70% of those are in specialty areas. In drugs for rare diseases and in cancer - very important unmet needs that they're dealing with -the drugs will come with a different kind of a business model from industry. A lot of the newer biologics are very expensive.

We're talking a lot about personalized medicine and genomics; in some of the new diagnostic tests, we're getting co-dependent technologies. The ministries are facing tough decisions on funding. We can't fund everything that comes to us. I don't think anybody out there says we can fund every want or wish of every patient or citizen in this country, from prevention to rehabilitation to palliative care. The country would go broke. I think there is a need for organizations, groups and individuals to provide good evidence to support better decision making. That's where organizations like CADTH come in. We're independent; we're providing explicit considerations of the relevant knowledge and looking to maximize the benefit across all disease states - not one specific disease state - hoping to potentiate the capacity for providing healthcare. Again, it's about sustainability and outcomes.

To me it comes down to the rapid pace of change and increasingly complex technologies. Tough decisions will have to be made, and there need to be organizations that can support the policy makers in making those decisions.

CW: Thanks, Brian, I think we've covered the waterfront pretty well, but maybe just two more questions. First, are there any changes you would like to see in the whole field of health technology assessment, whether to the input, the process or the output stage?

BO: Yes, there are. At CADTH, we see our role as twofold. First, we are a producer of health technology assessment, but we also have a brokering role in that we can bring information about what other organizations are doing and share it across the country. We can go into the international context and some of the provincial organizations like the Medical Advisory Secretariat and the Ontario Health Technology Advisory Committee through Health Quality Ontario, and ENES in Quebec. We're working with those organizations to collaborate much more closely, perhaps developing a more common agenda of the type of work we do, with better sharing and linkages, so that we can build capacity. Again, we can't do it all, but collectively we could probably do more.

Second, we have to get better with our timeliness. Certainly, when you're looking at evidence, you like to ensure that you're doing the full gold standard methodological review: systematic reviews, economic analysis. But I hear all the time from decision makers that if you're not timely, you're no longer relevant to them. They need to make these decisions in a timely fashion. We need to get better at providing them with good scientific evidence, but sooner. So we need to use those great brains in our scientists and clinicians to develop better methodologies.

I think there's probably an opportunity for us to work more closely with the regulators as well, and there has been great work happening globally and in Canada on this. We've been working very closely with Health Canada to better understand both the proof of concept, or the regulatory aspect, and the proof of value, or the health technology assessment.

I also want to find out whether there's a way that we and the policy makers and regulators can get more upstream in determining the types of technologies that would benefit Canadians as a whole. Perhaps we could be working with industry to drive the innovation agenda or to better understand what drives their needs – their business model. I that a little more upstream work would go a long way.

CW: Well, there's been lots there...

BO: It's transparency; I think transparency in clinical information and better access to better evidence is what we all need. Certainly, we know that clinical trials are extremely expensive to run. We know there've been issues through the years on suppressing information on negative trials. I think it's extremely important that we all have access to all of the information, to make better decisions. Again, look at different methodologies to assess that information. We want to be as transparent as we can; we post everything that we produce on our website. We'd like to work with industry as well to ensure that we have full access to all the information that's out there. HQ

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CW: All of this is designed to put the scientific recommendation into a real world and local context so that it can be implemented? All of that is designed to get the science plus the real world and the local context more ready for the possibility of a policy decision or what to do with the recommendations?

LL: Yes, and the issue of a policy decision is terribly important, because universally, the traction between evidence and policy is not very strong.

CW: Exactly.

LL: But in the case of OHTAC, 85% of their recommendations have had traction on policy.

CW: What's the process now? Once the Advisory Secretariat has made the draft recommendations, I understand they're sent out to the public; they all come back and eventually OHTAC makes a recommendation. What happens to the conclusions and the recommendations?

LL: There's a defined process within Health Quality Ontario. The chair of OHTAC, at his discretion, may decide to take the recommendation and send it back to where it came from with the full recommendations. If the request came from the ministry around a single technology because they were examining a fee code, for example, or from the Ontario Medical Association because they were examining a fee code, the chair of OHTAC may send it back to - let's say the OMA - with evidence and a recommendation in response to the request. If the evidencebased analysis is much more broadly based or complex, or it's a sensitive issue regarding the technology being evaluated, or there's a potential need for an investment by the ministry related to the adoption of the technology, then it will usually go to the Board of Health Quality Ontario. HQO would do one of two things. It may decide to implement some of the recommendations itself, For example, if it needed to develop quality performance indicators and monitor, track and report on them, Health Quality Ontario could do this. If HQO decided to move at least part of the recommendation into quality, such as evidence-based payment or quality-based payment, it could do that as well. What is more common is that within the Effective Care for All legislation, the chair of the Board of HQO has direct access to and can provide advice to the ministry regarding the adoption of certain technologies or mega-analyses, which would be more aligned to disease conditions or health states. Those go through the ministry for further analysis and implementation.

CW: That brings to mind the inevitable question. To what extent are you involved in the actual implementation?

LL: Well, until now we have not been involved, but increasingly we're being asked to at least develop a macro implementation plan. What that means – it's still being worked out actually – is,

at least we have defined the key players who would be involved in the implementation. For example, if there is a recommendation that a certain technology be adopted and it has an implication regarding the fee code or the fee schedule, then we would identify that as one of the implementation components. The recommendation would go back to the Decision Determinants Committee or it would be identified or flagged as something that the Decision Services Committee may wish to address. If it needs an investment in hospital infrastructure, the ministry would need to look at it and address it with hospitals. If it's a safety issue, the ministry may want to set up a special safety committee to look at implementing the recommendation. That's all being assembled now as part of the macro implementation roadmap for the ministry to consider, but the actual detailed implementation is something that one would expect the hospitals, in collaboration with the ministry or the community-based healthcare system, to implement for the LHINs.

...the delivery of any service ... that has not gone through the scrutiny of evidence of effectiveness could be potentially dangerous, or it certainly would be construed as a waste of money.

CW: How specific does it get with the recommendations? On the basis of the evidence, such and such should be done, to paraphrase, do orthopedic surgeons have to look at it, or do hospital CEOs have to get involved? Does it ever get to that level of detail?

LL: It doesn't. It's not really prescriptive in that sense, but the recommendation may, for example, state that if the technology is really complex it may be limited to facilities where there sufficient volumes to maintain excellence for the delivery of the service that's applied to the technology. So far, it's never been more prescriptive than that.

CW: All this has to do with health technology assessment and the implications in the healthcare system, but how does it relate to the whole issue of quality and improving quality in healthcare.

LL: One could argue that the delivery of any service – or the access to any service or technology or clinical intervention – that has not gone through the scrutiny of evidence of effectiveness could be potentially dangerous, or it certainly would be construed as a waste of money. In terms of safety and effectiveness, if those two components of quality are important to driving the quality agenda, then I think it's terribly important. In fact, the way HQO has been set up, there is an expectation

that the evidentiary platforms will be the basis for moving some of the quality agenda forward. But there's a component of the quality agenda that doesn't require the full-blown evidentiary platform. I think we are just trying to find a balance as we speak and doing the formative part of HQO's existence.

CW: What values or obstacles do you see in the way of implementing good evidence-based recommendations into policy and funding decisions?

LL: What values to uptake? We're living in a jurisdiction in which the traction of the evidence and the translation to policy is probably a world-beater at the moment, and it's looking increasingly that way. We are living in a province where the translation of evidence to policy is probably the best in the world; even something that's cost-effective doesn't mean it's not going to cost a lot of money. I think that's the first issue of financial imperative.

We're living in a jurisdiction in which the traction of the evidence and the translation to policy is probably a worldbeater at the moment...

The second point is a potential barrier. We need to recognize that policy decision makers, especially when encumbered by fiscal constraint, will cherry-pick all the negative recommendations for implementation. That has not happened in Ontario, but there is a real risk it could happen. It would be a barrier to the uptake of effective technologies that are costly, even if they improve patient outcomes.

The other barrier is our funding system. It is globally allocated to hospitals and community-based healthcare. That's a significant problem, because where you have to pay for the technology at the front end, even though it's going to result in downstream events avoided and costs avoided, there's a reluctance to invest. We're finding that increasingly with non-drug technologies. There's a silent change taking place in the health system for technologies that can be very effective – non-drug technologies – at the front end; but because we've become – I call it mortgage junkies – we invest in chronic diseases amortized over 20-year periods with a compounding effect of drugs. It's cheaper to do that for the same reason that it's more reasonable to buy a house that way. You don't feel the pain.

CW: Why should governments enthusiastically support health technology assessment?

LL: Because it's the only transparent, credible, consistent and fair way to make decisions, everything else aside, and it's defensible. As we get into tougher decision-making modes or fiscal

constraint, without evidence it's going to become increasingly difficult to make those decisions in a fair, credible, transparent and consistent way.

CW: Lastly, are there any changes you would like to see in the field of health technology assessment and the way it's done in general throughout Canada, just to bring it close to home?

LL: I think that two major innovative developments have taken place in the MAS/OHTAC dyad. The first has been addressing uncertainty in evidence. We could do one of two things. We could either walk away, so we don't have the quality evidence we need for really important technologies and just leave it to passively diffuse in the system. Or, we can say that at this point, we don't have the evidence we need so we're going to evaluate this in real time in Ontario. We've already done this through field evaluation studies that have been very important and hugely successfully by any international standards. If we can do this in collaboration with other provinces, it would be terrific, but it does take an investment.

The second is in mega-analysis. Instead of looking at single technologies, there's one lesson we've learned: if you are going to make a decision on a single technology, it needs to be made in the context of all the other technologies that could be used instead of the newer technology. We're not looking for more costly technologies, but the only way you can really make a determination is through comparative effectiveness analysis around disease states or disease conditions and health states. We look for major drivers in some of these disease conditions; we just aggregate the drivers, look at the different technologies around these drivers and re-aggregate based on quality of evidence and health economic analysis. This is one of the key developments in Ontario that has been of considerable interest, certainly to macro decision makers and policy makers. I think that's going to be our future. I think that's exactly where the future of health technology assessment lies. So two things - the field evaluation and the mega-analysis.

There's a third component that I'll touch on very briefly, and that is taking the whole evidence-generating machinery – including decision making – into the pre-market arena and working with industry, regarding industry as a research and development part of our health system and applying that in the pre-market state. That's up and running in Ontario now. OHTAC is very involved in that process – to provide the health system lens to the relevance, the disruptive effect, the patient outcomes and all kinds of ethical oversight, if you like, of that process in the pre-market space. I think that's evolving, and I think it's already taking off in a substantial way in Ontario.

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