

# **Aligning and Pursuing Quality Goals:** The Role of Health Quality Ontario

Anthony Dale, in conversation with Ben Chan



**T**he 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 (HQQ) – 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.

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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 long-overdue 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.

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**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 evidence-based 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 ground.

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**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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