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MNP

The Association of Family Health Teams of Ontario (AFHTO)

Recommendations on the Optimal Configuration of the Quality Improvement Decision Support Specialist (QIDSS) Role

January 31, 2013

1. CONTEXT

In late 2012, the Ministry of Health and Long-Term Care (MOHLTC) announced they would fund a number of Quality Improvement Decision Support Specialist (QIDSS) positions in Family Health Teams across Ontario through the 2013/14 operational planning process. The FHT Annual Operating Plan Submission Package stated, "This new position is meant to assist FHTs in meeting their quality improvement objectives through data standardization and extraction, information production and on-going analysis." (See Appendix A for the full announcement of the QIDSS position.)

In addition, the new roles are seen as an important enabler to build capacity for on-going quality improvement across the sector. While the first set of quality improvement plans (QIPs), to be delivered April 2013, will not require data to be extracted from EMR,[1] "primary health care organizations are encouraged to identify additional indicators and priorities that are specific to their region or patient population for which to target their improvement activities."[2] As the QIP mandatory indicators evolve in future years, EMRs can be expected to become a key data source.

2. METHODOLOGY

In order to provide advice to its members and to the ministry regarding the optimal configuration of the QIDSS roles, the Association of Family Health Teams of Ontario (AFHTO) engaged MNP to undertake a short consultation exercise. The consultation was led by Ian Brunskill; Ian leads MNP's health practice and has conducted numerous engagements in the area of primary care information management across Ontario over the past eight years.

During the first two weeks of January 2013, MNP completed in person interviews, telephone interviews, telephone based focus groups, and a workshop to obtain insights from key leaders within Ontario's FHTs on the introduction of the new role. (See Appendix B for a list of participants.) The sessions were structured so that each session brought together individuals with similar perspectives – with a session for each of the following: FHTs with existing decision support (DS) capabilities, executive directors, physicians, and FHTs with minimal-to-no existing DS capabilities. Throughout the sessions, a standardized interview guide (see Appendix C) was used to guide the discussions, with questions focused in the following areas:

[1] Two of the three mandatory indicators specified for the first set of QIPs – same day/next day access when needed, and patient experience – will require survey data to be collected. For the third mandatory indicator – primary care appointment post discharge from hospital – the Ministry has indicated it will provide the data.

[2] Jan.18, 2013 memo to FHT Leaders from Assistant Deputy Minister, Negotiations & Accountability Management Division -- *Quality Improvement Plans (QIPs) in Primary Health Care*

- Functions and competencies
    - Description of key functions this role should perform
    - Time allocation
    - Data sources necessary
    - Products to be developed in the short term (6 months) to long term (2 years)
- Distribution and supervision
    - Geographical distribution of QIDSS positions among Ontario's 186 FHTs
    - Description of how direction is given to role
    - Description of how incumbents would stay knowledgeable about environment

This report summarizes key discussion points and findings from the consultation and provides a number of recommendations for consideration by AFHTO's members and by MOHLTC. AFHTO members were subsequently invited to submit their feedback on these recommendations in period January 23 – 31, 2013; this is summarized in Appendix D.

3. KEY FINDINGS AND RECOMMENDATIONS

The participants in the consultation sessions recognized the importance of the QIDSS role and we heard numerous comments acknowledging the ministry for recognizing the necessity for these roles and creating this funding opportunity. The level of commitment to improve information management and quality improvement within the participants was readily apparent with people making themselves available to participate in the consultation sessions on short notice.

The findings and recommendations arising from this consultation can be represented in the following six themes.

- **The Primary Purpose of the Role**

  The mandate of the QIDSS role as described in the draft job description is very broad – ranging from IT centric functions such as data query development through to high touch change management activities associated with clinical quality improvement

  In order to identify what participants felt were the priority areas of focus for this new role, we asked them to identify on a continuum of information management activities the optimal location for this position in both the short term and the long term. The continuum we described had six elements:

  - Implementing data standards / data cleansing
  - Writing queries / extracting data
  - Analysing the data to create reports that help to inform decisions
  - Supporting managers / leaders in decision-making processes
  - Supporting staff (including clinicians) to improve data quality/understanding of information flow
  - Supporting clinical staff with clinical process change / improvement

  A significant portion of the respondents noted that *the priority in the short-term would be to focus on the initial elements of this continuum, in particular data standardization and cleansing*. Working with clinicians to identify the optimal way of entering data into the EMR in order to support data extraction and analysis was identified as a critical short-term activity by many of the participants.

Participants saw that the *role would evolve over time to help develop the culture of measurement for quality improvement* and become more focused on some of the elements towards the end of the continuum. This would never be a complete shift as there would always be an ongoing need for query writing, data cleansing, etc.

It is anticipated that the QIDSS positions will use a variety of data sources; these include the FHT EMR as the primary source but also include any other scheduling and billing systems within the FHTs.

- **Allocation of the New Positions among FHTs**

The ministry has indicated that there are likely to be 20 to 40 QIDSS positions established in fiscal year 2013/14. Given that there are 186 FHTs in Ontario, all acknowledged this would provide a good start for advancing use of data in FHTs to improve care, but further expansion of capacity would be required in future years.

Looking at the optimal distribution of the resources available in 2013/14, the general consensus from the consultation was that the positions present a strategic opportunity to support partnerships, collaboration and knowledge transfer across the FHT sector, and that *strong preference should be given to proposals that demonstrate partnership between two or more FHTs.*

There are a number of factors that could be considered in establishing these partnerships; for example the relative importance of sharing a common EMR within a partnership versus the importance of geographic proximity. Through the discussions, *the following priority schema evolved,* and was generally well supported:

a. the *geographic proximity* of partner FHTs
b. whether potential partners are using the *same EMR*
c. *compatibility* of the potential partner (include factors such as the relative size of the FHT, whether or not it is an academic FHT, the FHT's QI philosophy, etc.).

As FHTs form partnerships related to the QIDSS role, we recommend that *a single FHT act as the employer on behalf of all members of the partnership, and that this FHT has an explicit agreement with each of the other partners regarding the level of support that will be available from the QIDSS.* It may be helpful to begin with simply a description of the number of hours that will be provided to each of the partner FHTs – over time and with experience, this may evolve to agreements related to the level of service to be provided rather than a crude input measure such as hours of service.

Given that some FHTs are located in rural settings, participants noted the challenges of sharing of these resources across large geographies. Despite these concerns, the priority accorded to supporting partnerships between FHTs was generally felt to apply even in rural settings. The *use of technology to assist with bridging the distance between rural FHTs and the need for periodic travel* should be explicitly considered in the funding process for these positions; these may involve remote desktop access technologies, and the use of video conferencing technologies such as OTN, FaceTime or Skype.

Given the limited number of positions that are available, the question is how to support the maximum number of FHTs to be able to perform at a high level, and to spread this across all FHTs over time. FHTs are at very different levels in the maturity of both their information management and quality management processes. Applying the framework of the Roger's Adoption Curve (divided into the stages of early adopter, early majority, late majority and laggards), this suggests that this *first set of positions should go to FHTs that are in the "Early Majority", i.e. they are committed to advancing their IM / QI adoption, but are most in need of help to do so. AFHTO should continue to*

work with the Ministry to assess the impact of these positions and plan for continued capacity building across all FHTs. Expectations regarding depth of FHT participation in QIPs would need to follow in line with the pattern of adoption and maturation of IM / QM capability.

- **Provincial Level Resources**

  While the initial job description for these positions that had been prepared by MOHLTC focused on a single type of QIDSS position, through the consultation there was *strong support for the notion of utilizing a small number of these positions to be focused at a provincial level*. In our experience, and applying lessons from other sectors, we suggest that a small number of provincial level resources (2-4) can bring skills and expertise that significantly enhance the value of the local resources. Examples of value added functions at the provincial level include:

  - fostering coordination and collaboration among the local QIDSS resources, including supporting FHTs in the orientation of new QIDSSs, leveraging knowledge from those FHTs already engaged in sophisticated use of data, and sharing lessons learned from across the partnerships
  - developing deep specialization in specific EMRs in order to act as an "escalation point" for local QIDSS with challenging EMR specific questions and issues
  - bringing strong data analytical/epidemiological skills to support local QIDSS with complex analytical problems
  - articulating the degree to which the QIDSS role has enhanced information management capacity across the FHT sector to support planning for continued capacity building
  - linking with similar resources in other sectors (eg. the Regional Decision Support Specialists – RDSSs- within the CHC sector) to support projects such as indicator development.

  Appropriate organizations in which to house these resources include existing information management organizations such as CIHI or ICES, funding organizations such as a LHIN, provincial organizations working with FHTs such as AFHTO, or a single FHT acting on behalf of the sector to house the provincial resources. Regardless of the host organization for these positions, the nature of the work to be performed dictates that it will be important to recruit individuals who are comfortable carrying complex responsibilities and accountabilities while operating with little direct authority and control. No matter which "house" is chosen for these provincial level resources, the role must be strongly linked to the FHT sector as a whole. This is discussed under "Governance Considerations" below.

- **Human Resources Considerations**

  As noted above, the job description for the QIDSS role is focused on the "local QIDSS role". A *separate job description – and commensurate salary – would be needed for the provincial level role*; in our experience this position would require a minimum of Masters level preparation and previous experience within a health setting.

  Given the natural evolution of the role that is foreseen and described above, FHTs should *consider the employment model for incumbents of the QIDSS role*. Although some FHTs would prefer to hire a permanent staff member, others may find it makes sense to hire on a one or two year contract with the intent of these individuals will focus on data standardization and data cleanup data. The latter approach would allow flexibility to hire individuals with different skill sets as the focus transitions to the QI end of the spectrum.
  There was concern expressed in several of the consultation sessions about the potential challenges in recruiting and retaining individuals for the QIDSS role. Other health sectors in Ontario, including other primary care sectors, have been able to find high-quality individuals to fill such roles, even in fairly

remote areas within Ontario. The ability to recruit to a full time position (as opposed to part-time roles) has been a significant factor in successful recruitment and retention. Through partnering and other mechanisms, FHTs should *structure the QIDSS role as a full-time position wherever possible.*

In hiring individuals for the QIDSS role, it will be important to recognize that, although the work may appear to some to be highly technical in nature, improving data quality and using data to support quality improvement are inherently social processes and the *incumbents will need strong interpersonal and communication skills in order to succeed*.

- **Governance Considerations**

Given the increased investment in information management, and the increased expectations placed upon the FHT sector, we recommend that *consideration be given to creating a provincial committee structure to enable FHTs to guide and support information management activities across the sector*. Such a committee could provide advice to the FHTs, the provincial level decision support staff and the Ministry on matters such as the setting of data standards, sector-wide reporting, decision-support capacity, quality improvement initiatives to support the provision of better quality of care. We have seen this work well in other sectors as the committee serves as a catalyst for information management work at both the provincial and local levels.

- **Implementation Considerations**

Participants noted that FHTs would benefit from support in implementing this role. In particular, assistance with assessment of the technical and/or data analytical capabilities of the candidates during the recruitment process, orientation of newly hired individuals, and advice and support to the managers in conducting performance appraisals of the specialized resources were identified. While some of this support could be provided through the provincial level resources should that function be approved, the *ministry should consider funding a centralized one-time implementation effort* in order to reduce duplication of start-up activities in each of the QIDSS host organizations.

4. CONCLUSIONS

The introduction of the QIDSS role has the potential to be transformative and significantly increase the capacity of FHTs to improve the quality of their data and information management processes, and provide the information on which to drive quality improvement activities. We hope that the recommendations outlined in this brief report assist the FHTs across Ontario to obtain the greatest value from this important investment.

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APPENDIX A: QUALITY IMPROVEMENT DECISION SUPPORT SPECIALIST (QIDSS)

(Excerpt from 2013-14 FHT Annual Operating Plan Submission Package)

The ministry will accept and consider requests for Quality Improvement Decision Support Specialist (QIDSS) position(s) as part of the 2013-2014 Annual Operating Plan Submission. This new position is meant to assist FHTs in meeting their quality improvement objectives through data standardization and extraction, information production and on-going analysis.

The ministry strongly encourages and will give preference to requests for this resource that are shared among a collection of FHTs, where appropriate. For such joint requests, one FHT (the proponent) should include the request in their Operating Plan submission on behalf of their partnering FHTs. The proponent will also need to provide evidence that it's partnering FHTs have agreed to the shared resource.

This new position is meant to assist FHTs in moving forward with their use of data to guide clinical decision-making, develop patient-centred programs and other improvement activities. With the assignment of these resources, the ministry expects demonstrated improvements in these and other areas. The position is not intended to address current capacity issues with respect to general administrative work.

The QIDSS position must be requested in Part C of the Operating Plan Submission. Any additional resources needed to support data management must be requested in Part D of the Operating Plan Submission.

Roles and Responsibilities of the Quality Improvement Decision Support Specialist:

- Lead the development of data standardization and data input protocols;
- Undertake data analysis and report generation to allow for on-going performance measurement and monitoring;
- Support boards and administrative leadership in discharging quality improvement activities and responsibilities;
- Work with other decision support specialists on data harmonization and community-based needs assessments;
- Support boards and administrative leadership in meeting data related accountability requirements from the ministry.
- Champion the importance of data use within the FHTs

Desired Qualifications:

- University degree in health administration and planning, health informatics, information management, or business;
- Understanding of primary care and multidisciplinary team based approaches to health care delivery;
- 3-5 years' experience in a health or social services environment, specifically working in planning and/or data management;
- Knowledge and experience with OntarioMD approved EMRs;
- Experience in developing a relational database, and entering and extracting data from a relational database;
- Experience in developing and generating user-friendly performance reports;
- Demonstrated understanding of the role and importance of decision support in an organization;
- Creative problem solving skills;
- Excellent project management skills;
- Excellent analytical skills;
- Excellent communication and negotiation skills.

APPENDIX B: LIST OF PARTICIPANTS IN THE CONSULTATION PROCESS

Key Participants	
Name	Position
• Marg Alfieri	• Registered Dietitian, Centre for Family Medicine FHT
• Mary Atkinson	• Executive Director, North Perth FHT & North Huron FHT
• Randy Belair	• Executive Director, Sunset Country FHT
• Sean Blaine	• Lead Physician, STAR FHT
• Sanjeev Goel	• Lead Physician, Wise Elephant Downtown Brampton FHT
• Michelle Greiver	• Physician + IT/IM Lead, North York FHT
• Aynur Gurbanova	• Executive Director, Toronto Western FHT
• Jennifer Kennedy	• Executive Director, North Renfrew FHT
• Kelly MacNeil	• Executive Director, Tilbury District FHT
• John McDonald	• Lead Physician, PrimaCare Community FHT
• Lindsay McGee	• Quality Manager, North Perth FHT & North Huron FHT
• Debbie McGregor	• Executive Director, Bruyere Academic FHT
• David Pinkerton	• Lead Physician, Kingston FHT
• Val Rachlis	• Physician, North York FHT
• Sudin Ray	• Executive Director, East GTA FHT
• Keri Selkirk	• Executive Director, Thames Valley FHT
• George Southey	• Lead Physician, Dorval Medical FHT
• John Stanczyk	• Pharmacist, Delhi FHT
• Mary Vergeer	• Executive Director, Central Lambton FHT

APPENDIX C: INTERVIEW GUIDE

Functions/Competencies

1. What are the 3-6 key functions that this role should perform, and how should the time be allocated across these functions?
2. On the information management continuum outlined below:

	% Time Allocation	Skills /Competencies Required
Writing queries / extracting data		
Implementing data standards / data cleansing		
Analysing the data to create reports that help to inform decisions		
Supporting managers / leaders in decision-making processes		
Supporting staff (including clinicians) to improve data quality/understanding of information flow		
Supporting clinical staff with clinical process change / improvement		

3. What data sources – other than EMR– would be routinely used? (e.g. financial, HR data, other clinical databases)?
4. What information products are (should be) to be developed in the first six months? First two years?

Distribution/Supervision

5. Assuming, hypothetically, that there were x-y positions available in 2013/14, how should these roles be distributed? What factors should drive the distribution model?
6. Describe where the role should fit in "the" organization. How is direction received? How is performance evaluated, and by whom? Is a "provincial level" resource something that is / is not desirable? If yes, what functions should such a resource perform?
7. How do you envision the incumbents will keep current (both in terms of skills and knowledge / understanding of the environment)?
8. If this position were contingent on partnerships being created between FHTs, could this be accomplished in a timely manner?

APPENDIX D: FURTHER FEEDBACK FROM AFHTO MEMBERS

AFHTO's engagement of its members in the development of these recommendations is summarized as follows:

- 19 AFHTO members participated in the consultation process to develop the draft recommendations in the first two weeks of January.
- 16 members provided feedback on the draft recommendations in the last week of January.
- One of the 16 was reporting back agreement on behalf of the EDs of FHTs in Champlain region.
- A number of members e-mailed to ask questions about the draft recommendations.

The feedback survey asked respondents about their level agreement with the recommendations. The recommendations were listed in four groups, corresponding with the sections of the paper:

- Primary purpose of the role
- Allocations of the new positions
- Human resources considerations
- Provincial level support (this also incorporated the recommendations on governance and implementation considerations)

Responses were scored on a 5-point scale from strongly disagree (-2 points) to strongly agree (+2 points). Except for one person who responded "strongly disagree" to all items (but unfortunately did not provide comments to provide insight into the concerns), all responses fell in the range from "neither agree nor disagree" to "strongly agree".

- Primary purpose of the role received the strongest level of agreement, scoring 1.60. Comments reiterated the need to start with standardized data collection.
- HR considerations scored 1.29. The main concern was that the recommendation to consider hiring contract staff, even though it would allow greater flexibility as the role evolves, would make it too difficult to hire staff. The recommendation was re-worded to clarify that this is an option to consider.
- Provincial level support scored 1.07. While most comments were highly supportive, two thought that 1 or two positions would suffice.
- Allocation of the new positions scored 0.73. The original wording referencing the "Early Majority" was confusing to some. This has been re-phrased to clarify – i.e. they are committed to advancing their IM / QI adoption, but are most in need of help to do so. One respondent suggested the need for decisions to be based on a "readiness questionnaire", another on the "integrity and practicability of the proposal", another on the IM/QI maturity of the FHT so they could develop programs for the less mature, and another that the funds should be divided among all FHTs.