QIDS-ESSENTIAL:

The Making & Meaning of the Quality Improvement Decision Support program

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Introduction

QIDS-Essential: The Making and Meaning of the Quality Improvement Decision Support (QIDS) Program is not an evaluation, ode, or apologia. Official reports and case studies about the QIDS program already exist and an impressive collection of substantive presentations drawn from QIDS program work are readily available. But as the unique program turned five last fall, the QIDS Secretariat within the Association of Family Health Teams of Ontario (AFHTO) decided that the milestone merited a different kind of account, one that would capture the QIDS journey with a wider lens, from both a philosophical and practice perspective.

There *is* a story to tell about that journey: a narrative less about projects, and more about people. Less about what was done and more about how (and if) it was done; less about data and indicators and more about building collective capabilities, confidence, and communities to make change in the field, from the ground up.

It is also a story about progress in primary care performance measurement -- in some cases, first steps. About promising results, admittedly not rapid nor across-the-board, but achieved with modest resources using an innovative approach that attempts -- and sometimes cements -- steps and strategies essential to demonstrating the value of team-based care. It is a story for the primary care community to learn from and share with each other and all partners in health care.

The intent is to prompt reflection about the key components and characteristics of that approach. As the quality improvement decision support specialist (QIDSS) positions were introduced, allocated and integrated into FHTs and new measurement tools launched and embraced, what fuelled the momentum? What stalled it? How far did it take FHTs in their sometimes circuitous journey along the data-measurement- performance-and-quality-improvement continuum? What can be leveraged today from the QIDS program to position FHTs as ideal partners in emerging primary care innovations?

Plenty, as it turns out.

‘Q’ in context: A look back – and forward

When the QIDS program began in 2013, no one envisioned the emergence of Ontario Health or the Ontario Health Team model or predicted the radical shifts that are now underway and to come. No one could know that the introduction of the QIDS program would in fact help prepare family health teams for this future.

Through the QIDS program, funded by the Ministry of Health and Long-Term Care (Ministry) Primary Health Care Branch and shepherded and supported by a small AFHTO secretariat, FHTs accessed new expertise and shared additional staff resources – all dedicated to unearthing, refining, and analyzing data to improve measurement, performance, and ultimately quality. Other skills were also developed and honed: relationship-building within and across teams and health settings, coordination and navigation, the ability to pinpoint the potential and value of QIDS input and provide it effectively, whether within single FHTs or across partnerships large and small.

These skills are required for working well in broad collaborations pursing common goals such as making services more integrated and focused on improving patient care, population health and system efficiency. These are attributes key to succeeding in the Ontario Health Team model, a point underscored by this document’s title: QIDS-ESSENTIAL.

‘Q’ueuing up the story

The paucity of robust primary care data that could spur performance measurement and quality improvement has long been a common lament, though that deficit has been shrinking over the past decade. The QIDS program has helped fuel that trend as part of AFHTO’s focus on strengthening evidence-based decision-making and quality improvement in primary care within FHTs and across the system.

The ‘Q’ story starts in earnest in 2013 when a fledging group of seven QIDSS scattered across the province’s family health teams came together at AFHTO’s annual conference. They had little more than a common job title connecting them. Five years later, that group has evolved into a closely knit cohort of 35 QIDS specialists who early in 2019 inaugurated their own governing

> *" It only works if you have QIDS Specialists at the table and if they are included as partners".*
>
> - *Executive Director noting key role QIDS specialist played in success of project (May, 2019)*

council, elected an executive, and created a collective voice to amplify their advocacy for primary care and advance their professional interests.

Notably named the *QI in Primary Care Council*, it now leads a growing community of practice (CoP) which was pioneered and previously run by the QIDS secretariat at AFHTO. True to the network's name, the CoP is now open to all primary care QI practitioners and currently embraces more than 70 colleagues working in various roles for a range of health organizations across Ontario.

At a recent *QI in Primary Care* monthly check-in meeting, the executive welcomed its latest CoP members, four Regional Decision Support Specialists from the Alliance for Healthier Communities. During that same call, an executive director from a northern FHT presented an update on an indicator project underway in the region, describing the contribution of the QIDSS as key to its progress. "*It only works if you have QIDSS at the table and if they are included as partners",* she said.

While the QIDSS are a centrepiece of this story, they are not the whole story. As former QIDS Provincial Lead Carol Mulder puts it: *"Quality improvement is a team effort; QIDSS are facilitators of that effort."*

Under the arc of this story are many stories. They come from people performing an array of roles: those who proposed, funded, implemented, expanded, and brought the program to life – AFHTO leaders, members and their staff, including executive directors, QIDS specialists, Partnership hosts; local and provincial board and senior leaders; committee volunteers; ministry of health officials; FHT patients and other primary care partners.

The Characters

Highlighted below are key QIDS proponents and participants with a range of roles offering different vantage points on the program. In the sections that follow, they share their particular

perspectives and (sometimes aligned) analysis on the merits and missteps of the program. The views of the government officials most closely tied to the program were sought, but they were unavailable.

The pioneers and early champions

AFHTO's inaugural CEO Angie Heydon says the catalyst for the program was tied to a strategic plan priority to advocate for the FHT team-based model of care by emphasizing evidence of its value. In 2012-2013, Angie spearheaded a proposal for Ministry funding that would enable the AFHTO membership to develop and run a program to support and drive quality improvement within and across family health teams.

After getting a green light to further delineate and detail the proposal, AFHTO worked with its members and the Ministry of Health and Long-Term Care on creating a mutually beneficial agreement. Accountability and relevance were key imperatives, as well as expectations that were manageable and meaningful.

Angie says that AFHTO members looked to the funding proposal and model that the Association of Ontario Health Centres (AOHC, now the Alliance for Healthier Communities) had developed for CHC data coordinators. Learning from that experience, they assessed what would work best for the AFHTO membership.

After consulting its members, AFHTO presented a host of recommendations on the best way to configure the QIDSS role and set up the program for successful implementation and positive impact. The recommendations included such considerations as resource allocation, governance, human resources, structures, processes and practices.

AFHTO's current CEO Kavita Mehta sat on the Board for seven years, served as president, and was active when the QIDS program was conceptualized. She says the Board was keen to move towards a culture of measurement and improvement and understood the importance of not only making the most of the investment but notably of showing the value of team-based care for the system -- better patient experience and outcomes.

Kavita says the approach was right and results were achieved, but the undertaking was ambitious, some processes had flaws, and the challenges of aligning diverse teams real. She elaborates on those success factors and barriers in later sections.

"Five years later, it's a very different experience for FHTs and for QIDSS," she says. "Despite flaws in some processes, the program met its intent to create QIDSS in the field - a coherent cohort of individuals advancing data-driven primary care and measurement, building relationships, and making small and big quality improvements. That is huge".

She says the Board lent its full support to the innovation and a band of committed AFHTO members and primary care partners populated steering committees and provided advice as QIDSS Partnerships came together (or were put together) and the program got underway.

- QIDS Program Lead - main mentor and chief advocate -- & Secretariat staff

One of the recommendations advanced by AFHTO, strongly supported by members and accepted by the government, was to fund a few central positions and resources to assist the local QIDSS in the field to maximize their value.

Building on momentum that started in 2012 through the first AFHTO QIDS Program Lead, the journey to QI in FHTs started. AFHTO Board member Dr. George Southey had already been working on quality improvement in his Oakville FHT with a focus on measuring indicators that were meaningful and met the expectations of patient populations. He observed that health-care systems that were grounded in strong primary care do much better than other systems when it came to improving health and saving money. He called this the 'Starfield Observation', named after the late Dr. Barbara Starfield, who coined the 4 Cs in primary care:

- **Continuity** through better relationships between patients and providers.
- **Coordination**, including better transitions between providers.
- First **Contact** to ensure access to care in ways that matter to patients.
- **Comprehensiveness** of care for all of the patient's needs

With Dr. Southey's guidance and the Board's commitment to quality, AFHTO was able to further propel its members' QI journey late in 2013 when Carol Mulder stepped into the role of

AFHTO's QIDS Program Lead. With her passion for all things quality, Carol became a driving force for the program, a mentor for QIDSS and AFHTO Secretariat staff, and a key expert for the QIDSS community, including the champions populating the program's oversight and sub-committees.

In addition to creating and guiding the QIDSS CoP, offering knowledge translation and exchange workshops, developing new projects and partnerships to enrich learning opportunities, she brought a newer, more meaningful Data to Decisions (D2D) tool to AFHTO and its members, leading it through to its 7th iteration in March of 2018.

Immersed in research throughout her tenure at the Secretariat, she was a constant on the conference circuit, presenting QIDS program results to audiences near and far. She credits others who have used their public platforms to spread the QIDS quality-work word – champions such as Dr. Danielle Martin whose *Six Big Ideas* book praises the D2D initiative and its composite quality measure as well as Dr. Rick Glazier from ICES who has collaborated on QIDS and co-presented the program's findings.

- From BETTER Now: SIX BIG IDEAS TO IMPROVE HEALTH CARE FOR ALL CANADIANS, by Dr. Danielle Martin, 2017

To me, the most exciting measurement work going on in Canada is an Ontario project called D2D, or Data to Decisions. It started as the

The D2D project builds on this work and is now starting to spread across primary care teams in Ontario. For the first time since I've been a family doctor, we have a way to measure quality of care that doesn't feel meaningless or incomplete to me. It's a measure that reflects more than body parts or lab results; it's a measure of successful relationships.

- QIDS program partners

QIDS program partners - formally and informally designated - bring expertise and insights in diverse areas such as electronic medical records (EMRs), practice improvement, patient engagement, policy, research, evaluation, and more. They come from research organizations such as the Institute for Clinical Evaluative Sciences (ICES), from post-secondary institutions -

such as Queen's, Western, and McMaster universities, the University of Toronto and the University of Ottawa - , from health-care organizations such as the Centre for Addiction and Mental Health, and from programs like EMR Practice Enhancement run by Ontario MD.

QIDS partners also include program leads from associations such as Addictions and Mental Health Ontario, data and QI coaches, technology vendors, ministry officials and health agencies such as Health Quality Ontario and e-Health whose staff sit on QIDS oversight committees. Each has brought unique skills and knowledge to the program, increasing the quantity and quality of its offerings.

Quality Improvement Decision Support Specialists

Quality Improvement Decision Support Specialist (QIDS Specialist):
What can QIDS Specialists do for you?
Carol Mulder and Greg Mitchell, Association of Family Health Teams of Ontario

What is a QIDS Specialist?

A QIDS Specialists helps primary care teams improve quality by improving access to data (especially EMR data) and helping teams use data in decision making..

Where are they?

They are all over Ontario (see Figure 1 below).

- Approximately 35 QIDS Specialists support approximately 150 teams across Ontario
- They are employed by a Host team
- On average, they support 5 teams, with some supporting as many as 9 or more
- On average, they support 3 EMRs each, with at least a dozen different EMRs represented in the whole group

What do they do?

QIDS Specialists are change agents. They **Inform and facilitate implementation of AFTHO' s collective vision for measurement.** They do things like:

- Implementing data standards / data cleansing
- Measuring and improving data quality
- Mapping and improving information flow
- Writing EMR queries / extracting data /developing tools
- Analysing data to create reports to inform decisions
- Focussing and supporting clinical process change
- Help clinicians access and use data
- LHIN-wide initiatives (data standardization, program implementation)
- Facilitating planning and "ground up" QI activities at program, Board and LHIN levels

How do they do this?

QIDS Specialists work locally and collectively at the same time. They focus on the specific needs of the teams they support and share notes with their peers relentlessly to take advantage of everything everyone is doing.

- Weekly webinars with all their peers since Oct 2013
- 5 active EMR Communities of Practice with the aim of improving the use of EMRs on issues of immediate and common priority with EMR vendors
- Online forum for posting questions and sharing solutions
- Bi-weekly eBulletins from AFHTO sharing information and resources for all members

What have they done for you lately?

QIDS Specialists have made a big difference to their local teams as well as to AFHTO members and primary care as a whole. Some of the changes they have contributed to individually or collectively include:

- Preparation of local team QIP and other required reporting
- Helping AFHTO members contribute data to D2D 2.0 (55% of members and counting!)
- Increased consistency in patient experience surveys across the membership
- Development and deployment of new EMR tools: eg Custom Form Query developed by East Wellington FHT
- Development and distribution of standardized EMR queries: QIDSS team delivered on COPD, Diabetes queries to date – CHF, depression and hypertension underway
- Contributed to the establishment of patient priorities for measurement in partnership with patients Canada
- Expansion of access to primary care reports to teams via HQO portal
- Implemented and tested an automated patient-contact system for patient experience surveys etc

Why can YOU do?
Call your QIDS Specialist – they may be closer than you think!

What can YOU do?
Help your QIDS Specialist help you by setting clear local priorities to be added to the collective agenda

What can YOU do?
Check out the biweekly ebulletin or the web site for tools to access and use your data, courtesy of the QIDSS

Don't' have a QIDS Specialist? Contact the QIDS program (carol.mulder@afhto.ca) to tap into the QIDS Community of Practice and other collective activities

afhto D2D: DATA TO DECISIONS ▶ 2.0

Dispersed across the province helping FHTs better access and use data to improve care, the QIDSS are as varied as the teams in and for which they work. They have different backgrounds and experience, and often different job descriptions; they serve disparate numbers of teams, ranging from one to nine; they report to different supervisors and earn uneven salaries; they

allocate their time and attention variously; and their experience and expertise are put to use differently, depending where their FHT(/s) are on their QI journey.

They do share a core responsibility and role articulated in the program agreement -- *"to assist FHTs in meeting their quality improvement objectives through data standardization and extraction, information production and on-going analysis."* To fulfill that role, they need a diverse range of skills and knowledge. To succeed at it, they need attributes to address the challenges of stepping into a newly defined and created position that must serve (and be shared by) multiple teams, some located great distances apart in starkly different settings with distinct populations. And they must do this in a sector without a long history of QI.

Each QIDSS has their own mix of strengths and deficits which must be matched to the needs and capacities of the FHTs they serve. As a collective, the skill sets of QIDSS tend to complement rather than mirror each other. While some see a lack of uniformity as something to be addressed, others see it as an asset. Some QIDSS describe this mix of weighted competencies as advantageous because they are able to provide help to colleagues where they need it and receive support where they most require it.

Perhaps not surprisingly, turn-over among QIDSS has been relatively high, particularly in the early years. In a survey of QIDS partnership hosts, at least 25% of respondents have had turnover in the QIDSS role over a three-year period. Of the initial seven QIDSS from 2013, fewer than three remain.

While there is more to the QIDS program than QIDSS, they are obviously intrinsic to it and the source of its success. They bring dedicated QI strength home to FHTs who employ and/or share them (not all FHTs have QIDSS) and to the scores of communities they serve. And as an increasingly cohesive and engaged group, their conversations have increased and matured over time, contributing to larger discussions about how to improve performance management and quality improvement in primary care in Ontario.

The change in QIDSS Conversations

In the program's early days: little email interaction or info exchange between QIDSS. Individual inquiries were sent directly & solely to QIDS Program Lead; no distribution list; no sharing of lessons learned:

> "…. Are you aware of any family health teams that have been making significant progress in improving these indicators (what change ideas they are using)?"

NOW

QI in Primary Care Community of Practice (formerly known as the QIDS CoP) online exchanges feature large list-serv of engaged members, with contributions from quality specialists from all regions.

QIDSS initiate the discussions; issues change and expand as threads grow.

QIDSS requests for info, advice, materials receive timely, positive responses from QIDSS. Examples:

Q: Can any team share the indicators they report on for their Smoking Cessation Program? Documentation for program within Accuro? Would be great if don't mind sharing!

A: This is the form that one of my FHTs uses. Modify it if necessary.

Q: Looking for feedback/info on data-sharing feature of TELUS PSS allowing remote communication/chart access between different EMRs. Any teams using this? Would greatly appreciate knowing if teams able to successfully data share with local hospital.

A. I support teams able to data share. While in hospital through a remote connection they can access patient's medical records from multiple clinics. Usually, the provider accessing the chart through hospital is either patient's primary care provider or another physician on team since small rural setting where physicians work beyond FHT. … Teams able to data share between clinics. Patient's home chart can be updated based on info put in by another clinic.

QIDSS Speak: Reflections from the field

The link between the QIDSS and FHT patients may not always be a straight line or immediately apparent, but it is there – often housed and hidden in health-care experiences. Imagine that a QIDS specialist reviewing yearly patient survey results develops new queries for poor performance areas – for example, post-transition care -- and the analysis from the data pulled from the EMR sparks changes to processes or practice that bridge gaps and reduce patient anxiety and caregiver confusion.

Or consider the real-life story about a special kind of book club that one QIDSS started in her FHT this year. At its launch, clinicians and administrative staff alike report that they left the meeting more empathetic, educated, and informed, thinking about how to use what they learned into their day-to-day interactions with patients and families.

There is perhaps no better way to glean the meaning of the QIDS program than to hear from the people who literally gave it legs, working for Family Health Teams week-in and week-out, on the ground, in communities across the Ontario. Their experiences and insights are a critical part of the QIDS story, their accounts and analysis essential evidence for understanding and evaluating the province-wide experiment called QIDS.

A handful of them describe their experiences, share their views about where the QIDS program has taken them as individuals and members of a community of practice, and reflect on changes made and to come in primary care performance measurement and QI in Ontario.

Cameron Berry, CHIM

- QIDSS since March 2013
- QIDS Partnership Host: Kawartha North Family Health Team
- Serves 3 teams: Kawartha North; City of Kawartha Lakes; Haliburton Highlands
- Notable: Founding member of the QI in Primary Care Council
- Quotable: Cameron calls the first five years of the QIDS program “critical,” saying it has shown success and results that improve health care.

"*When I started, I had no idea there were other QIDSS! It took six months for me to find out. Being a QIDSS was one thing in the start and it's another now." …"There's now a system for generating better data for cancer screening -- which has improved exponentially over the past five years. Any FHT without a QIDSS would struggle to do that report. But it is what you DO with that report that matters. We still have a long way to go on measurement and on making improvement cycles the norm."*

His story

Before settling into his current position serving the teams in the Kawartha North QIDS partnership, Cameron worked in other environments, including urban, academic FHTs and acute care; he got his start in Peterborough Hospital providing SIMS support. He also got exposed to the culture of multiple part-time jobs. With the Kawartha North partnership, he has found his niche - and his stride -- serving three teams, rotating weekly among them, with one day working from home. The arrangement gives him enough flexibility and works well with his results-driven, proactive style.

"I say, 'here is something I can do, and I pitch it to the doctors. …There is a salesmanship aspect to the job. I've often thought that QIDSS could benefit from sales training." He says he pursues "what pains people" and suggests solutions.

Those solutions seem to run right across the partner FHTs. While some of his peers produce discrete work for each FHT, Cameron often works on one project across all FHTs – producing the same EMR data quality project, for instance. That said, he also says if one FHT is working on a time-sensitive project, he goes where the urgent demand takes him.

Views on 'Q's past, present and future

Cameron's take on what the QIDS program has accomplished is both practical and profound: *"The success of the QIDS program is the idea that QI is doable; you can change things and do it fairly easily. And bridging silos is key to that, the most effective way – better than work-arounds."*

Cameron says that wasn't immediately or always apparent. He says when FHTs were mandated by HQO to submit annual Quality Improvement Plans – even without compulsory indicators -- that provided a focus for the QIDSS. *"It helped create a base – somewhere to start."*

Cameron, one of the founding members of the recently inaugurated *QI in Primary Care Council*, sees two overriding purposes for the Council: to provide a strong networking channel for the QIDSS CoP and to advocate an increased role and resources for QIDSS and primary care QI. *"The QIDSS Council is there because it's needed! We have a lot of work ahead of us, with funding cuts and the amount of health-care change happening. To think past the task in front of you."*

He has no doubts about the durability of the QIDSS network: "*There is a bond there. We will continue to be a tight network of colleagues in the field who are facing the same problems. We will continue to need, help and interact with each other and share solutions*."

He says it is too early to answer whether the second purpose is achievable: *"Will the network work as an effective player lobbying for QI and the QIDSS role, given financial resources and current environment? I'm hoping the Council could be helpful in that respect."*

"More QIDSS would help! Double them instead of (teams) having them every third week; increase awareness of the whole process." Cameron believes this story matters: "*We still have a long way to go, but the QIDSS with FHTs have gone so much further (than those without QIDSS)."*

Points of pride

Cameron has been very active in AFHTO working groups and committee, serving on the Quality Steering Committee from 2015 to 2017. He was much involved in testing the D2D tool and in its subsequent refinements and additions. That effort was clearly worth it to him. *"I am most proud of all the D2D work. All the indicators were used in our Quality Improvement Plans. All three FHTs made these a priority and saw action on them."*

He says QIDSS can point to improved rates in many areas -- volume of appointments increased or increases in cervical cancer screening, for instance. *"It is nice to have small projects and see the wins.*" Other one-off efforts such as changes to EMR tools, improving and standardizing a custom form, are not so tangible or quantifiable but he says they still can make a difference. Working on small-data projects like writing programs to analyze data seems to be a sweet spot

for Cameron – and apparently helped create "an anti-bacterial pharmacy" and improve urinary tract results.

What hindered and helped

From Cameron's point of view, the biggest challenge to the QIDSS and the program is physician buy-in and change management. *"That's the first challenge – to get the doctors on board. If they agree to let you in the door, you can do so much; if they won't open the door, you will be blocked."* He acknowledges that there is a big learning curve for QI and thinks some doctors see change as a negative thing.

Differences in governance models matters too. He says in Haliburton, he deals with the physicians; in the City of Kawartha Lakes, with the interprofessional health-care providers (IHPs) who are FHT employees. He says it is easier to get traction on QI when working with IHPs because they are FHT employees: *"In a community-based FHTs like Kawartha North, change is easier to implement."*

The second challenge? "Money!" Meaning resources for QI that he knows have an impact.

There are other barriers to making and measuring quality improvement changes, including the many factors that are outside the FHTs control – a reality when only 30 percent of the population is seen by FHTs. That makes meaningful measurement around things like opioids prescribing can be challenging.

He says while the QIDSS growing strength as a collective is an advantage, they are still a group of individuals with different job descriptions whose work may not be sufficiently focused on change. He sees this as an accountability and leadership issue. While some FHTs are huge QI champions, not all EDs direct QIDSS' attention and time to change issues. *"If FHTs are doing that, what are they doing for QI?,"* he asks.

That's one of the reasons Cameron pegs leadership as "paramount" to his work as a QIDSS and to QI in general. Cameron says the strength of the executive director is an important success factor. Cameron reports directly to his ED, who he say keeps a close read on the FHT pulse. *"The ED knows and will tell me if something will fly or not."*

The significance and impact of central support also should not be underestimated, he says. Cameron calls the regular coordinated opportunities for collective communication hugely significant. *"The weekly QIDSS calls and CoP provided by the AFHTO QIDS program secretariat opened my eyes to the whole thing."*

Meghan Peters, BA

- QIDSS since 2013
- QIDS Partnership Host: City of Lakes FHT
- Serves 9 FHTs: City of Lakes; Espanola and Area; Parry Sound; Powassan; West Nipissing; Northeast Manitoulin; Assiginack; Manitoulin Central; Huron Shores;
- Notable: A QIDSS since the very start - October 1, 2013 -- one of the original seven QIDSS first hired.
- Quotable:

> *"The QIDS program has created a need and a want for QI which has led FHTs past measurement to improvement. It took a year for some FHTs because EMR capacities and functionality weren't in place.*
>
> *But the importance of data and its impact is now a given. We are doing standardized indicator work across FHTs not just to measure, but to increase performance."*

Her story

Meghan was no stranger to team-based primary care, EMRs, or the distinct challenges of delivering health care in northern communities and across expansive geography when she became one of the first of 34 Quality Improvement Decision Support Specialists hired to help Ontario FHTs become better equipped at measuring performance and improving the quality of care.

Before becoming a QIDSS, she had worked for more than five years for a physician group in the busy City of Lakes FHT. She saw the kind and quality of care the team provided, getting patients in crisis into programs and wrapping care around their lives. Despite earning her degree in education, she began taking on more responsibility and becoming increasingly interested in

what the FHT was trying to do. She started pulling stats and data, getting to know the EMR, looking for outcomes, providing information people didn't know was available.

She landed the new position and lost no time putting a new plan of action into play. After interviewing and surveying the teams, it became obvious the first focus was EMR knowledge and functionality. From there, she tackled programs, including annual work plan priorities like hospital discharge and palliative care. Over the years, she streamlined and aligned the teams' reporting. She has also been active in AFHTO committees.

With nine teams, and a host FHT with four sites, the City of Lakes FHT QIDS partnership is the single largest QIDS partnership grouping. It covers vast distances and requires that Meghan serve a huge range of FHTs, urban and rural alike, from large to one of the smallest in Ontario. Given the daunting demands and logistics involved, Meghan's description of the job as "a juggling act" seems an understatement.

Views on 'Q's past, present and future

Meghan says the QIDS program has created a need and a want for QI which has led FHTs past measurement to improvement. *"Some FHTs move more quickly than others. It took a year for some FHTs because EMR capacities and functionality weren't in place. But the importance of data and its impact is now a given. We are doing standardized indicator work across FHT not just to measure, but to increase performance."*

While there have been significant shifts in culture and competence since the start of the QIDS program -- when some teams didn't even have access to their EMRs – she notes that there are those in the North East who have no QIDSS support. She says the future must include a growth in capacity and support, adding that relationships with physicians and other team members are established over time and require much upfront and ongoing attention. (A request for a second QIDSS for the area has been submitted, but there is no response yet.)

Since Meghan believes in building leaders from within, she is encouraged by the growing maturity and agency of the QIDSS community of practice. She sees great potential and promise

in the new QI in Primary Care Council. *"I think it's going to be great,"* she says, noting she's eager to see how it develops while she is away on maternity leave.

Meghan's seniority with the QIDSS makes her comments about the Council and CoP particularly salient. She believes the cohesion and collegiality of the community of practice is essential. *"The collective matters. I remember a time when it was not there or was only three or four people, and how lonely it was not to be able to reach out to people. The CoP that has grown over the years and become even more valuable. Learning among teams and across QIDSS, hearing and sharing stories, successes and failures, is hugely important."*

Points of pride

A previous member of the EMR data management committee, Meghan was involved in the launch of D2D and counts among her most satisfying accomplishments the fact that all her teams have participated in the QIDS program signature performance management tool.

"For me, D2D was a great conversation starter with teams. I used it to lead to a QI initiative or to open discussion to certain topics, such as why rates aren't increasing and how we can improve our numbers." She says performance was "a mixed bag" with some FHTs making great strides and others staying the course. That FHTs can now compare their performance to peers is progress in itself, she says.

Meghan points to another development as a major accomplishment – the move from more and more joint efforts among teams to even broader collaborations with multiple teams and partnership organizations. This is where she sees greatest impact. She describe two projects to illustrate her point:

- A Falls Prevention screening program that brought together her QIDS Partnership, the LHIN and public health that was rolled out by multiple players who learned from each other
- The standardization of indicators across NE FHTs. All the teams worked together to standardize 12 programs, agreeing on the measurements they would all use for common programs. This drew on and further developed the FHTs collaborative strengths and ED leadership, with the process enabling the partners.

What hindered and helped

The multiple challenges inherent in serving nine teams show up daily in Meghan's work, adding the complicating issues of timing and logistics to her daily tasks and making planning more complex. Working for nine FHTs, moving between four sites in one of them, stretches time and capacity.

"There are the distances and winter driving and it's taken me five years to develop strong relationships with all the teams. If there were another me, we could do much more."

Still, Meghan readily lists the many things that have helped her do her job and make a difference – like having the same EMRs across the partnership, for starters, which was very helpful from an operational point of view.

She says she is fortunate that her QIDS partnership understands that the point is impact – not just tracked hours. *"That's huge – having a common goal plus supports from effective leaders in solid partnerships."* She says the strong QIDS partnership led to her being able to make the most of her position. She adds that the regional network of 23 FHTs, set up by the partnership, that meets regularly is also helpful for all participants.

Meghan is also quick to credit AFHTO, the support that the QIDS Program secretariat provided and increased over the years, along with the valuable relationships that developed.

While some claim that the QIDSS' lack of a homogenous background and skillset is a disadvantage for the QIDS program, Meghan sees nothing but benefits from having a very diverse group of colleagues with different strengths who rely on each other. She admits that her strong suit is program development and implementation and not IT/software, so she is always keen to hear from her peers about data collection and reporting or to learn what the data gurus are doing and discover the latest technological trends and offerings from third-party vendors.

Lindsay McGee, BHA, RN

QIDSS since 2016
QIDS Partnership Host: North Perth FHT
Serves 2 FHTs: North Huron; North Perth
Notable: RN, Quality Manager, Creator of Book Club
Quotable:

> *"The QIDS Specialist knows your staff, culture and working relationships and is more apt to bring about change than external consultants."*
>
> *"I watched as our access to data evolved and grew. There was a positive shift and the QIDS role had a lot to do with that."*

Her story

Lindsay calls herself a *"bit of an unusual QIDSS*" but there are other phrases to describe her and what she brought to the North Perth QIDSS position: multi-talented clinician with experience in different sectors and roles – hospital clinical informatics analyst and manager, long-term care QI practitioner, primary care clinic RN and FHT quality manager. Add to that innovative thinker with the verve to break new ground.

When the QIDSS role was established, it was folded into the quality manager position which she had held for eight years. That position opened her up to a stronger networking group where she could tap into others' resources – and where her background lent a more clinical lens to the QIDSS collective efforts.

Lindsay says her work across the two FHTs is very integrated, with many QI projects aligned, and that strong partnership relationships with hospital alliances mean that she approaches QI from a sub-regional lens.

Views on 'Q's past, present and future

For Lindsay, the most important impact of the QIDS program has been establishing a foothold in something that had been lacking – standardization around what all FHTs measure. *"There were*

no bench marks before, no opportunity to compare performance prior to AFHTO's QIDS program".

She says the QIDSS role brought all quality-minded people together to focus on similar challenges and find solutions, to hear what others are doing. Lindsay says as a QI practitioner, she had quickly noticed a lack of available quality data, something she saw change under the QIDS program. Accessing and pulling data from the EMR became easier, and that led to improved efficiency and reclaimed time.

"I watched as our access to data evolved and grew. There was a positive shift and the QIDS role had a lot to do with that."

Lindsay says that before the QIDS role, FHTs had no access to support for quality because primary care doesn't have huge budgets. She believes the QIDS approach provides consistency that is much stronger than accessing outside resources.

"*The QIDSS knows your staff, culture and working relationships and is more apt to bring about change than an external consultant."*

According to Lindsay, there is no stronger sign of the value of the QIDSS' collective voice than its new self-governing council. *"The leadership of the QIDSS is exemplified by the creation of the QI in Primary Care Council. It's amazing. It shows such commitment and speaks to how much QIDSS value the network as a resource and enabler of QI."*

"If QIDSS didn't find the community of practice contributed something useful to QI, there would be no desire or need for the Council. That speaks to the work of AFHTO and the solid foundation they set up."

Points of pride

Lindsay takes great satisfaction from her work on a highly successful project to reduce COPD admissions – and not just because the rates were halved and have remained low. The project was really an exercise in integration in which everyone could identify what it took to make it

happen. Lindsay has shared the lessons from that project, presenting at the AFHTO conference and telling the story to HQO's Quorum communique.

She is also delighted about the success of the FHT book club she initiated last winter and launched early spring. It is dedicated to tackling topics tied to the family health team's QI priorities, starting with opioid addiction and patient experience. At the launch, staff, ranging from RNs to receptionists to NPs, showed up to discuss *Opium Eater: The New Confessions* by Carlyn Zwarenstein.

This is no ordinary book club. Members *do* discuss books, but they also learn about health-related issues from in-house experts. For example, the FHT pharmacist shared facts and myths about opioid use and chronic pain and described what to watch for and when and how to help. They also find out about work underway to address the priority issues being discussed – the FHT's QI plan was part of the discussion. FHT members were moved by the experience and committed to changing some aspect of their daily work based on what they learned.

Being a QIDSS, Lindsay surveyed participants before and after the first book club discussion -- 100 percent of respondents gave it a positive rating – and the numbers of staff signed up for the next meeting increased. That discussion focused on another QI priority. FHT book club members read *Somebody I Used to Know* to initiate talk of dementia and early on-set Alzheimer's. The FHT memory clinic was discussed and the Alzheimer's society presented a review of their services. The book club's third meeting is set to explore mental health issues – also a QIP priority – based on a book put forward by the FHT social worker.

The book club has also had an unexpected benefit – it is a great team-building exercise that encourages the sharing of personal stories that have value for QI. Lindsay says it is also a low-budget way to bring the team together, tap in-house expertise and give people an opportunity to learn more about the top health issues they are tackling.

What hindered and helped

The barriers to success that Lindsay raises have not been knocked down but many, if not most, are bending, thanks in part to the QIDS Program. QI work is now done with more accessible and

timely data; meaningful measures and realistic targets; data quality and consistency; EMR compatibility and staff support for EMR functionality and effective use.

Some barriers are completely gone. For example, FHTs are able to find out if they are above, below, or at benchmark compared to their other FHT colleagues and the provincial average. And instead of each FHT trying to get changes from EMR vendors, there is an organized process for QIDSS to lobby for changes – collectively and much more efficiently and effectively. Further on the EMR front, Lindsay notes that there is one iteration of EMRs across her FHTs and the hospitals so physicians can access patients charts when they work in emergency.

Like many of her peers, Lindsay appreciates the collective voice of the Council as well as the individual voices from FHTs that have their own culture and place on the QI continuum. There is someone from whom everyone can learn; there is a range of backgrounds and skillsets to draw from; there are solutions that already exist that can be shared; there are successes and failures to learn from and cautions and encouragement to receive. The CoP makes all that possible.

Lindsay also credits the early and ongoing leadership from the board and executive for embracing partnerships and aligning QI within and between teams. Lindsay's QI work pre-QIDSS has also hastened progress as has forward-thinking business processes such as common policies and procedures that built a culture of working together.

Lindsay says rural health care has a greater need for integrated resources because of limited patient numbers across larger geographical areas. She believes the community and skills-based board of the FHT network is the right governance model for the FHTs to succeed.

From a former QIDSS

"The QIDS program was a good start (D2D especially, which provided comparable data when none existed); the QIDSS provided support that the FHTs were fortunate to have. It was good that AFHTO took on this role."

"Data can be seen as separate from primary care - on its own – instead of viewed together and used together to inform practice. In my work as a QIDSS, it became more than that. It was evidence to push things forward."

Like Meghan, this QIDSS (who preferred to remain anonymous) was one of the first to populate a freshly (and not fully) minted position within a provincial program that was itself being pioneered. The QIDS partnership host was not an unknown, however, since she had already worked there for about a year. She did pick up three new organizations to serve across urban communities that shared a history of working together – though not the same EMR.

Possessing a master's in health services research and a keen interest in informatics, the QIDSS took on a wide range of roles and responsibilities. She evaluated programs, developed and tracked primary care quality indicators, produced QI plans, handled project writing. She worked with interprofessional health-care providers in many improvement areas, supported executive directors and clinical leads, supplied performance data reports to doctors, chaired FHTs' QI Committees and the QIDS first Quality Committee and co-chaired a data standardization committee.

The QIDSS responsibilities, agreed to by all partners, were varied as were her contributions to each FHT. That depended on factors such as permissions, resources, context (different levels of authority) and skillsets.

The QIDS Quality Steering Committee benefited from this QIDSS' expertise and when D2D was in the works she volunteered to help with informatics testing and sat on its steering committee. She took her talent to another health-care organization in 2017, where she performs a similar role and works on a range of improvement areas, including a timely project that includes AFHTO among its partners.

Views on Q – past, present, future

She is now outside the QIDS program looking in – and back. She applauds the initiative and believes in its purpose. *"The QIDS program was a good start (D2D specifically, which provided comparable data when none existed); the QIDSS provided support that the FHTs were fortunate to have. It was good that AFHTO took on this role and coordinated activities,"* she says.

She acknowledges that change doesn't occur overnight, *"especially changes in a culture with a population with quite a lot of authority."* But, she says, you have to start somewhere and the QIDS program was a movement in the right direction that she hopes will continue.

She sees that movement as key to primary care's future – and primary care as the future focus for health-care accountability through requirements such as accreditation.

She thinks there should be a stronger push to government about the importance of D2D and better communication about its necessity in primary care. One of the principles of change, she says, is that it requires commitment and support from leadership at different levels, including from the provincial government and those responsible for the Ontario health-care system.

Points of pride

This former QIDSS says she is proudest of how her roles and responsibilities evolved with the partners. She found satisfaction in seeing how the work of the QIDSS can contribute to making a difference.

"Data can be seen as separate from primary care - on its own – instead of viewed together and used together to inform practice. In my work as a QIDSS, it became more than that. It was evidence to push things forward."

She points to QI work on patient experience which she managed and rolled out from start to finish. She used her expertise to gather and analyze survey data, create graphs and share results with teams – results based on quality comparable data specific to FHTs and targeted characteristics.

Believing in the importance and potential of providing practice-level primary care data so doctors see how they compare to their peers, she says on occasion she shared data results anonymously with some of the physicians within the teams. Some welcomed it and were happy to reflect on the results; others not so much.

What hindered and helped

She respects and recognizes the positive roles played by AFHTO's QIDS Program and the progress and support of the FHTs in the QIDS Partnership. She also identifies a range of internal and external factors (program, partnership and system) she believes affected the QIDSS experience and the program's impact.

On her own experience, she says it would have been more effective and enjoyable to work with the three FHTs as a unit, to interact more closely with the partners together. She links that to differences in physician engagement levels, resources, skillsets, culture and size – differences that could influence whether permissions or access were required or forthcoming, or the degree of difficulty in getting initiatives off the ground.

The lack of consistency in roles and responsibilities meant that some QIDSS were performing administrative assistant roles or focused solely on data extraction. She calls that "*unfortunate, not quite fair and a lost opportunity*" for a new role with *"quite the potential"* to make progress on important things such as improved rates for avoidable hospital admissions.

She does not mince words when commenting on governance and accountability issues. She cites "*structural set up and political environment"* as barriers to progress. She says that with self-incorporated physicians, accountability to the FHT is not necessarily guaranteed. That could affect the QI initiatives chosen to pursue and whether efforts would be tied solely to those in institutional QI plans.

From a larger perspective, this former QIDSS thinks the government's lack of awareness and understanding about the program, and lack of appreciation for the quantity and quality of the work, undermined to some extent the impact and potential of the QIDS program.

Milestones and turning points

"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."

- Recommendations on the Optimal Configuration of the Quality Improvement Decision Support Specialist Role, January 31, 2013, Association of Family Health Teams of Ontario.

A range of factors and influences from various sources fed into the QIDS program direction and destination, affecting the depth and pace of its progress. Some of the markers along the QIDS journey were predictable -- placed, spaced and based on mutual agreement. Some were unanticipated and unhelpful, arriving with little notice; and still others emerged and exceeded expectations, arising from hard work along the way, from seizing opportunities just around the corner, or from creating new ones because of what appears on the horizon.

The trajectory of the QIDS program is full of starts and stops, pauses and recalibrations, and progress. See Appendix A for the timeline of activities and turning points.

Merit and Missteps

Shared or similar perspectives on various aspects of the QIDS Program surface from the reflections of the QIDS characters described earlier in this document. Those aspects range from program design, implementation processes and operational issues to key enablers and barriers to success as well as areas of missed opportunity and impact. Across categories, there are merits and missteps identified – sins of omission and commission, as well as strengths in execution and outcome. In some cases, the same factor - such as the various diversities among the FHTs and the QIDSS – are perceived both as a strength and a weakness. Highlights of the themes – and the thinking around them – follow.

CHALLENGES AND BARRIERS

Program design and implementation processes

One of the common comments about the QIDS Program centred on what was described as weaknesses in the early processes around partnership formation and resource allocation. That did not necessarily lead to failure, but it meant progress was more challenging. "*Some of the groupings didn't make sense; FHTs were put together when they had different EMRs, or they were covering such large areas"*, says AFHTO CEO Kavita Mehta. Kavita also notes that early education and clear expectations from the ministry and AFHTO are key.

Her predecessor, Angie Heydon, says the need to spread and stretch the QIDSS positions across the province presented significant challenges. That there was no template for determining how to share QI resources across AFHTO's membership only added to the challenge. She notes that this was an issue that the Association of Ontario Health Centres had never had to face since each community health centre received funding for a data coordinator.

The constrained resources and the number of teams and territory that many QIDSS had to cover made their jobs stressful so the positions were sometimes seen as stepping stones, contributing to high turn-over rates with which the QIDS partnership hosts had to contend.

This point was echoed by AFHTO Secretariat staff Catherine Macdonald (now with the Alliance for Healthier Communities) and Laura Belsito who added that too few QIDSS spread too thinly could also lead to inadequate interaction with FHT staff and under-developed relationships. They also observe that a clear, consistent strategy for QI that can assert itself while still responding to system, member and partner issues is also important.

Diversities across Partnerships, FHTs and QIDSS

The province's FHTs all provide team-based primary care, but the differences between and among them are many. They differ in size – staff, patient population, geography, number of sites and distances across catchment areas -- in resources and skillsets – and in governance, leadership styles and levels of engagement.

The QIDSS Partnerships also vary widely, with the number of FHTs in partnerships ranging from one to nine, and with a ratio of QIDSS to FHT ranging from 1 to 9 to 7 to 21 to 1:1. There were also variations in the credentials and level of competencies and experience that QIDSS brought to the teams, along with a medley of backgrounds. As previously noted the different backgrounds and skill strengths were seen to be both beneficial and problematic.

The current and former association heads concur that consistent accountability across partnerships was an issue: all partnerships were not created equal and some lead partners were not held to account by the Ministry for imperatives such as effective use of QIDSS skills and expertise and appropriate support for all partners in their group.

The QIDS Partnerships differed in their approaches to sharing the QIDSS' time and deploying this resource. In a July 2016 AFHTO case study, "Building Collaboration and Increased Capacity Through Quality Improvement Decision Support Partnerships", three distinct arrangements are described and analyzed:

- Model 1, QIDSS' time is shared equally among the partners; focus of work is to ensure provision of data for the Ministry, QIPs, D2D and data analysis;
- Model 2, the allocation of QIDSS time is project based; primary focus of work is to ensure provision of data for the Ministry, QIPs, D2D and data analysis; and
- Model 3, a LHIN-wide model, three QIDS specialists focus on specific elements of Quality Improvement (strategy, data, programs and evaluation). QIDSS' time is allocated according to the projects s/he is working on; focus of work includes provision of data for Ministry, QIPs, and D2D, data analysis, strategy, evaluation.

The mixed governance structure of the FHTs and the date of their creation also contributes to FHT disparities that can affect the orientations of the partnerships. Some boards are community based; others physician led. A small number of physicians are FHT employees, but all other clinicians (NPs, RNs, dietitians, social workers, etc.) are FHT employees.

Change management and clinical engagement

While the number of QIDSS is an issue, Kavita says the amount of resources is not the only, or even most important, factor in successful execution. She believes it is how they are used that really matters, along with the level of engagement with and by partners and individual clinicians. *"More QIDSS is not necessarily going to make the difference; it depends on the host FHT, the partners' level of involvement and the definition of the work",* she says.

Kavita warns against short-changing change management – an observation shared by some QIDSS.

"The importance of change management shouldn't be diminished; it is key to quality improvement – a foundational piece. And that takes face-time with clinicians. You need the engagement of physicians so it is evident that quality can be driven by local clinicians."

She says real practical support on the ground is the essence of the QIDS program. Initiatives like D2D did show movement, she says, introducing data comparability, interactivity, and increasing transparency as members "unmasked" their results.

Angie says making change depends on ownership – and that needs to come from inside organizations and within all those associated with it.

SUCCESSES AND ENABLERS

The best beacons

The Secretariat's Catherine and Laura both point to the light guiding the QIDS Program and its signature D2D: the so-called (Barbara) Starfield principles. They tie an investment in primary care to improved system quality, equity and efficiency. Among the required foundations for optimized primary care team performance, Starfield includes enabling primary care teams to collect and report data efficiently and encouraging and reinforcing excellence in team performance.

D2D Innovations

Called "one great big ongoing QI project", D2D proved effective in kickstarting measurement work and conversations about performance and QI. As D2D evolved, members' participation in the voluntary process increased significantly. A novel composite measure of quality, based on what matters to patients, providers and the system, was introduced, and a cost indicator was created for the first time.

Catherine and Laura believe that the QIDS program's ground-up approach to QI and the voluntary nature of D2D's performance measurement tool were key to successful results and increased EMR maturity. Under the watch of the QIDS Program Lead, there were eight iterations of D2D in four years involving 110+ teams or over 60% of members for each iteration each time. While other tools and resources are physician-based and static, D2D provided interactive, team-level data two times a year.

AFHTO members chose the indicators which evolved in real time in response to their input. The introduction of the quality roll-up indicator was a significant innovation; the concept of measuring quality and comparing it to total cost of care is critical to understanding and valuing the role of primary care as the health system foundation.

Evaluate as you go

In keeping with that impulse to gather and provide information to drive improvement, QIDS Program former Provincial Lead Carol Mulder conducted ongoing evaluations throughout the program. That included many methods, including partnership surveys. Results from an early evaluation are below:

Areas that were working well	**Areas for improvement**
• Invaluable support (partner, host, and others)	• Host team (partner, others, and QIDSS)
• Collaboration between teams (partner, host)	• ED engagement (partner, host, and others)
• Time allocation (partner, host)	• Work plan (partner, host, and QIDSS)
• Host role (partner, host)	• More QIDSS time (partner, host, and QIDSS)
• Relationship with QIDSS	• EMR issues (partner, host)
• QIDSS themselves	• Need to move beyond extraction
• QI expertise	• Salary parity for other IT or data analyst roles

When the FHT executive directors from the QIDSS Partnerships were asked if they had successes to share, they provided a very high response rate with overwhelmingly positive examples from a range of areas. An excerpt from a list of their self-reported accomplishments appears below.

- EMR data extraction:
    - *Building capacity to extract and analyse data quickly and efficiently*
    - *Creation of queries and PS custom forms to support reporting responsibilities*
    - *Getting data out of EMR. We were lost*
    - *we now have the ability to extract accurate data through queries*
    - *Has created queries, searches and surveys*
- EMR Data input standardization:
    - *data dictionary across the teams*
    - *Finally we are able to track data efficiently as a result of his work*
    - *Data Integrity - CCO/SAR clean up, Diagnostic coding*
    - *Assisted us with developing a method to measure specific measurements in the EMR that are not standard*
    - *Provides EMR data for quarterly reports with data integrity*
- Meaningful measurement:
    - *Helped to establish a more consistent method for providers to input data and EMR templates created in order to demonstrate program outcomes in EMR*
    - *Meaningful data capture for FHT team and physicians*

Innovative province-wide efforts, regional collaboration, partner engagement & spread

Catherine and Laura easily enumerate successful QIDSS-led projects that benefited all FHTs as well as the individual progress achieved through partnerships across the province.

They point to the provincial initiative called the Algorithm Project (see sidebar below) and to the winning North East collaboration which has produced standardized regional indicators across 23 teams. They say they clearly see the important supportive role that the QIDS program and Secretariat played in that success. They also offer that the emergence of strong partnerships with organizations such as CAMH on timely and important projects like Opioid De-implementation as evidence of the effectiveness of the QIDS program.

And a final illustration: the spread of the QIDSS model in several places, including to NP Led Clinics which introduced the QIIMS program - quality improvement and information management support.

The Algorithm Project (AP)

Established in 2014 when a small group of QIDSS interested in data mapping got together to share their experiences. The group quickly realized that there was a need to develop and test standard EMR queries to enhance the ability of all teams to extract and analyze EMR data to facilitate data clean-up initiatives and to support conversations about improvement.

In 2015, the AP team, composed mostly of volunteers, established their mission to improve access to clinical data through the development of standard queries for five major EMRs so that teams across the province can collect data on eight chronic conditions: COPD; Diabetes Mellitus; Hypertension; Depression; Osteoarthritis; Epilepsy; Parkinson's Disease; Dementia. Thus far, queries for COPD, Diabetes and Depression have been released.

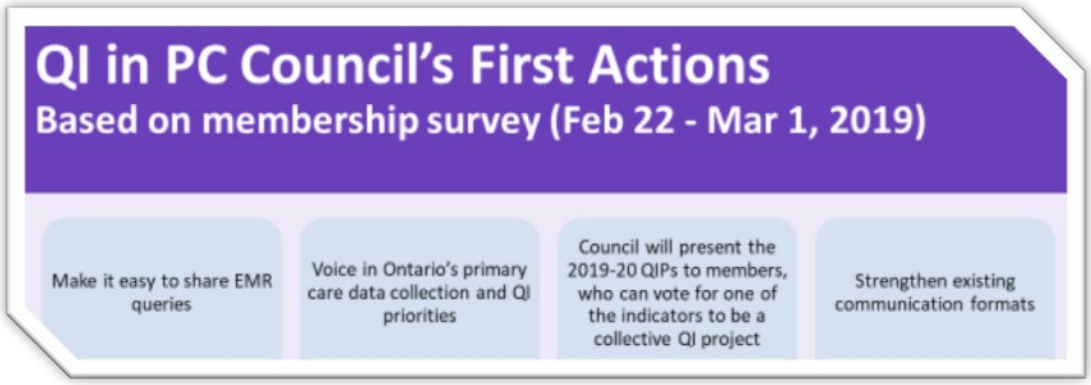
Intentional decentralization, central support, creation of strong collective QIDSS voice

It started with seven. That's the number of newly hired QIDSS who met at the AFHTO conference in 2013. Today they are a tight-knit group of more than 60 people who share their knowledge, support their peers, and learn from one another. They are also lending their collective voice, skills, and commitment to improving primary care QI. Members of the growing group come from organizations with an immpressive array of acronyms – QIDSS, QIDSS-like staff, QIIMS from NP-Led Clinics, data and information coaches from E-QIP (AMHO and CMHA QI experts), regional data coordinators from CHCs, and more.

From this group has emerged a new council called the Quality Improvement in Primary Care Council (QI in PC) which has an elected executive keenly focused on the group's declared purpose: to support the QI in Primary Care community (formerly known as the QIDSS community of practice) and strengthen collective QI capacity across the sector.

The QIDSS were deliberately employed in a de-centralized manner to encourage diversity and locally focussed work on QI priorities. They responded positively and productively to central

support and centrally organized initiatives such as D2D. And they have shown great resiliency and maturity in leading the way to ensure their collective voice and work will continue and increase.



The Moral(s) of the Story

At five years in, what is the QIDS program's impact? Has this modest investment improved how primary care works for patients or what providers know about them and can do for them?

"The QIDS program is a solution for primary care improvement that works," concludes the former program lead. She says it is a good story that should be told. Here's why:

Data access, performance measurement and quality improvement is not an ingrained part of team-based primary care and is often only cursorily connected to practice. This is not surprising. In a sector that has traditionally not been well-resourced or organized, few resources have been dedicated to this area. Providers all want to make patient care and population health better which means they need the information and analysis to know – and be able to show – whether it is improving. And if it's not, they need to use what they now know to change that.

As one of the QIDSS says: It is what you do with that report that matters.

But *how* you do it matters too.

In QIDS work, the model matters. The QIDS Program is a ground-up approach not sparked by edict or external instigation. It introduces a unique way of working from within that builds new

skills and processes into teams so that performance measurement becomes the norm and leads to quality improvement. It can – and does – engender thinking, planning and acting collaboratively on issues tied to local and regional concerns or opportunities, and working to align them with provincial priorities. The model is about embracing diversity, autonomy and local responsiveness – elements that surface passion, engagement and success.

If other things matter more – central control and line of command or a desire for reporting versus using data - there are other models to follow.

The principle purpose and key advantage of one of the QIDS program's signature pieces – D2D – is to prompt action, to make a start, and to keep going, working towards improvement. Changing processes, thinking and culture as you go.

D2D advanced from D2D.1 to D2D.6, with eight iterations over four years, showing the power of getting started. The QIDS Program itself is also an example of what can be put into play by taking that tentative first step and perhaps more importantly, as expressed by several QIDSS, by ensuring that that step leads to others. Not movement for its own sake, but advancement towards the top of the stairs, with the destination of better care, better health and a better system kept ever in sight.

This is our story. We think it is a good story, but it is clear that the QIDS story needs at least another chapter, or better yet, a sequel.

Acknowledgements

Sincere thanks are due to the inimitable and highly respected former QIDS program lead Carol Mulder and her staff Catherine Macdonald and Laura Belsito. They were ever informative, helpful, and good-humored, quick to provide materials, introductions, and background – and sometimes the back story too! Thanks to the QIDS Specialists who, despite juggling multiple demands during their busiest quarter, were generous with their time and keen to share their experiences and insights. Grateful as well to the association's inaugural CEO for her informed reflections and to current CEO of the Association of Family Health Teams of Ontario, Kavita Mehta, who provided support in the midst of the tumult of health reform.

Appendix A: QIDS Program Timeline: Milestones and Turning Points

Early 2013 AFHTO consults members, issues *Recommendations on the Optimal Configuration of the Quality Improvement Decision Support Specialist.*

Recommendations centre on FHT partnerships and QIDSS position allocations (key considerations: geographic proximity of partner FHTs and overall compatibility, including EMR); human resources and implementation issues; and provincial-level resources and governance structure requirements.

March 2013 Following AFHTO members' QIDS program proposal, the Ministry of Health and Long-Term Care (MOHLTC) invites "host FHTs" to submit proposals to fund QIDSS positions as part of set up and support for QIDS partnership for 2013-14 fiscal year.

April 2013 Deadline for submissions for QIDSS funding

FHTs begin to file annual Quality Improvement Plans(QIPs) as mandated in the *Excellent Care for All Act* (2010)

August 2013 Initial implementation of QIDSS positions in FHTs begins.

AFHTO Briefs Members on Status of QIDS program


Welcome!

Members Town Hall on the QIDS Program

Wednesday, August 21, 2013

Exchange information on QIDS program status and implementation activity

Highlight implementation support available to host and partner FHTs

Get your input on the QIDS Steering Committee

Canvas suggestions on next steps and address frequently asked questions

33 FHTs approved for total of 34 FTE QIDSS positions: $75,000 in salary/FTE; 20 % benefits; $3,500 office furnishing/equipment; $4,200 IM/IT; full-year funded.

"Host" FHTs are to share QIDSS positions with partners; up to 8 additional FHTs in some groups. 110 potential partners identified.

Fall 2013 The MOHLTC makes funding decisions based on individual proposals. In many cases, funding went to "host FHTs" that had put forward their own FHT partner groupings. In some cases, MOHLTC made changes to the FHTs to be included in the partnership..

2014 Over 90% of QIDSS positions are filled within five months of approval**.**

Approximately 25 FHTs are without any access to QIDSS; dozens more working in QIDS partnerships where available resources stretched across multiple FHTs, EMRs and sometimes huge geography.

April 2014 The 2014/15 Ministry business plan includes additional resources to support local QIDS initiatives in FHTs and NP-Led Clinics. FHTs allowed to make additional proposals and AFHTO advises members on approach.

Oct. 1, 2014 QIDS Secretariat launches **Data To Decisions (D2D**) **1.0**

This supports AFHTO's strategic direction to improve care and demonstrate the value of team-based, patient-centered, comprehensive primary care.

Called "one great big ongoing QI project," it proved effective in kickstarting measurement work and conversations about performance and QI.

D2D made it possible to capture a summary of available, comparable primary care data and produce a membership-wide measurement of performance, based on what matters to patients, providers and the system.

As D2D evolved with eight iterations (to D2D 6.0) over four years, members' participation in the voluntary process increased significantly, to a high of 93% of members participating.

From 2015 to 2017, AFHTO and Patients Canada collaborate on patient surveys and focus groups to inform D2D indicators.

The Quality Roll-up Indicator created and added to D2D as a novel composite measure of quality that includes a cost component for the first time. The Quality Roll-up Indicator is based on what matters to patients, providers and the system. For the first time, , was introduced, and a cost indicator was created for the first

March 2018: Data to Decisions 6.0 launched.

2014 *An External Evaluation of the Family Health Team (FHT) Initiative*

The Conference Board of Canada, submitted to the Ontario Ministry of Health and Long-Term Care, June 2014.

2014-2015 The Algorithm Project was created in 2014 when a group of QIDS Specialists interested in data mapping got together to share experiences. The group quickly identified a need to develop and test standard EMR queries to enhance the ability of all teams to extract and analyze EMR data to facilitate data clean-up and support conversations about improvement. By 2015, the AP team had improved access to clinical data by developing standard queries for five major EMRs so all teams could over time collect data on eight chronic health conditions.

2015 *EMR Use & Organizational Focus on Quality and Quality of Care in Family Health Teams Impact Assessment.* AFHTO partnered with eHealth Ontario to evaluate the impact of D2D and examine the role and contribution of EMRs to performance measurement and QI in primary care in Ontario.

Late 2018 Ontario Ministry of Health informs AFHTO that it will no longer fund the QIDS program/Secretariat; Funding ends March 31,2019. The QIDSS are FHT employees and their positions remain funded.

Jan 2019 The QIDSS (and QIDSS-like staff) create a self-governing Council, *Quality Improvement in Primary Care* (QI in PC) with a five-member executive. The goal is to support the QIDSS Community of Practice (CoP) and strengthen collective QI capacity across the sector.

Feb 2019 The Ontario Minister of Health and Long-Term Care announces the government's plans for health system transformation and tables proposed legislation, Bill 74*, The People's Health Care Act, 2019*.

The Minister announces its intention to create a new model called the Ontario Health Team (OHT).

April 2019 In its submission to the standing committee examining *The People's Health Care Act,* AFHTO recommends that Bill 74 requires that primary care be part of an Ontario Health Team and that primary care teams be the lead of an OHT in areas with highly functioning teams that can continue to be leaders in delivering truly integrated care.

AFHTO announces that given the current environment and funding uncertainty, it will sunset the work of D2D and shift focus from measurement to driving improvement across the sector. AFHTO's Quality Steering Committee to continue to work closely with newly created councils (QI in PC Council and the IHP Advisory Council), AFHTO members, and partners to set priorities for improvement around care transitions, access, integration, mental health and addictions, and patient engagement.