

Advice for AFHTO members applying for additional QIDSS resources

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Purpose and Summary:

The 2014/15 annual ministry business plan process creates the opportunity for FHTs and NPLCs to request additional resources locally to support the QIDS initiative. Based on progress to date, AFHTO presents the following report as advice to members to help you develop your business plan for QIDS positions.

Advice to members is summarized as follows:

- Top priority for future investment is addressing the needs of approximately 25 FHTs and all 25 NPLCs that do not yet get any support at all from QIDSS (See Appendix 1 for AFHTO's understanding of the current status of QIDSS allocations).
- Existing partnership nodes are scalable and should be considered for additional positions. This
 - would allow them to address workload issues and create the capacity to serve more FHTs/NPLCs.
 - would save considerable time and effort required to negotiate partnerships from scratch and would likely speed up addressing and data sharing issues and other logistics.
- Health Link boundaries are a useful guideline for allocating QIDSS positions to un-served FHTs and NPLCs and/or to strengthen existing partnerships. Taking this approach will make it more likely that there are natural, practical reasons for the parties to deepen partnerships and share information. The geographic proximity is critical for high-touch interventions such as quality improvement and change management work. May help to mitigate concerns over infrastructure needed for remote access to EMR data.

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- Applications should recognize that factors adding to the complexity of QIDSS work and thus their overall impact. Factors include number of FHTs, sites and physicians and particularly the number of different EMRs in the partnership
- Partnerships should be formalized as previously recommended.

On behalf of members, AFHTO will be advocating with the ministry that:

- Sufficient funds be allocated to Host organizations for reasonable travel, remote access and other costs including legal. With virtually all the QIDSS now in place there will not be any flexibility to meet travel and other expenses not provided for in the initial allocation. AFHTO will also be advocating for early guidance from the ministry on this funding or QIDSS will be effectively grounded for the first five months of the year while the hosts await approval. This would be a severe setback at this early stage.
- AFHTO recommends against adding teams to partnerships or joint applications unless the parties have agreed locally in advance.
- Partners should not be forced to work together under pain of not getting any access to the QIDSS program. Teams should be able to make use of entry/exit provisions in agreements to find or create clusters that are most likely to meet their needs within the resources available. If the ministry has any guidelines or requirements regarding partnership entry and exit it should clarify them for the field.
- AFHTO should continue to be funded to provide direct support to QIDS Specialists and Host FHT EDs to facilitate knowledge exchange, spread best practice, tools such as a standard MOU and privacy toolkit, and coordination/leadership to advance the EMR vendor/supply chain strategy.

Background

The ministry's establishment of 34 QIDS Specialist positions in mid-2013/14 created an opportunity to advance the use of data for quality improvement within FHTs and to support partnerships, knowledge transfer and collaboration across the system. Host and partner FHTs have made remarkable progress in the few intervening months. The lessons learned from this rapid deployment are valuable and should begin to inform investment and planning decisions as soon possible. The observations and advice offered below are based on the collective experience of the host and partner FHTs, the QIDS Specialists, the provincial QIDS team and others involved in the roll out of the program (See Appendix 2 for the analysis of the aspects of the QIDS Specialists utilization)

In early 2013 AFHTO conducted a consultation exercise¹ which resulted in a recommended "schema" for allocating QIDSS positions, namely:

- Strong preference for partnerships amongst Teams
- The number of EMRs to be supported
- Differences in QI, technical and EMR maturity
- Compatibility of partners in terms of governance type, size, implementation wave

¹ ***Recommendations on the Optimal Configuration of the Quality Improvement Decision Support Specialist (QIDSS) Role*** (<http://www.afhto.ca/wp-content/uploads/QIDSS-recommendations-2013-01-31.pdf>) Jan.31, 2013.

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It is far too early to suggest a target number of QIDS Specialist positions that should be established to support AFHTO members and their combined panels of 3,000,000 Ontarians. What is known is that the 34 positions allocated in 2013/14 were an excellent start and have been extremely well received. Over 90% of the positions were filled within five months of approval. The initiative has also had the desired effect of fostering new levels of knowledge sharing and collaboration across teams as 31 of the 34 positions serve more than one FHT and the cadre of QIDS Specialists have formed an increasingly interconnected provincial community of practice.

However, there are still approximately 25 FHTs without any access to a QIDS Specialist and dozens more who are working in QIDS partnerships where the available resources are stretched across multiple FHTs, EMRs and sometimes huge geography. None of the 25 NPLCs has access as yet to this program. The purpose of this note is to update the allocation advice based on early experience.

Addressing Service Gaps and Strengthening Partnerships

Partnerships among teams are the best way to obtain optimal value out of the QIDSS investment. The approach is also strategically apt as sharing talent and resources also accelerates capacity building, data comparability and EMR inter-operability all of which will serve to reduce fragmentation.

Several host EDs report “excellent” relationships between partners. These were all partnerships that were accepted as proposed, many of which had some element of formal or informal collaboration prior to the advent of the QIDS program. Some partnerships that *were* modified also report very collegial, productive collaborations. But ALL the partnerships that are self-reportedly not working as well as expected are partnerships that were modified after the initial application. The challenges in these partnerships include:

- 1) Large number of partners, particularly where they are widely dispersed geographically: Although some of these partnerships are able to come to consensus on direction and action, most report that this is very challenging, from both a philosophical as well as practical logistic perspective.
- 2) Partners with divergent interests: Even when the actual number of partners is not that high, the diversity of structure, past experience and/or foci between different teams makes it difficult to generate consensus and action
- 3) Large number of EMRs: All partnerships report that dealing with multiple EMRs is a considerable (though not necessarily fatal) challenge to managing the work of the QIDSS. On average, there are three different EMRs per QIDSS FTE, with some dealing with as many as five
- 4) Partners with varying degrees of progress in EMR use and engagement with QI: Not surprisingly, some teams are more advanced in the use of their EMR and engagement in QI than others, related to how long the team has existed, how long their EMR has been in place (if at all!) and previous experience with QI programs, among other factors. It is difficult to focus on tasks that are of equal utility to all partners. Some partnerships are able to manage this by deferring the needs of the more advanced teams to facilitate progress with less advanced teams however this is obviously not a sustainable solution.

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- 5) FTE allocation too low to attract candidates. Where partnerships have been allocated less than a full FTE for their QIDSS, there are significant challenges in recruitment. The difficulty is compounded where there are multiple EMRs and geographically dispersed partners. This is also not a sustainable solution as it substantially increases the workload of the QIDSS, likely past the point of feasibility.
- 6) Privacy and data ownership: Questions have arisen across the province regarding data ownership and permitted uses. Underlying arrangements between physicians, FHOs and FHTs vary considerably which creates a great deal of due diligence obligations on partners. There are also major differences in awareness of and confidence in the interpretation of privacy requirements.

Recommendations:

A top priority for future investment is addressing the needs of approximately 25 FHTs and all 25 NPLCs that do not yet get any support at all from QIDSS. The existing partnership nodes are scalable and should be considered for additional positions. This would allow them to address workload issues and create the capacity to serve more teams. This would save the considerable time and effort required to negotiate partnerships from scratch and would likely speed up addressing and data sharing issues and other logistics.

Partnerships should be formalized as previously recommended. Last year AFHTO noted that the FHTs most committed to IM / QI adoption but most in need of help should be made a priority. Teams making applications as a partnership should assume that developing and finalizing partnership arrangements will consume considerable attention of the EDs involved. Thought should be given to demonstrating the commitment in advance by reaching written agreement in principle and consensus on resource sharing and priorities prior to making application for new positions.

AFHTO recommends against adding teams to partnerships or joint applications unless the parties have agreed locally in advance. Ideally such additions would take place through the entry/exit mechanisms provided for in formal agreements. Where additions have been made outside local processes it has tended to slow partnership development overall and to complicate logistics and change management while offering little new capability to the added teams.

AFHTO's position is that partners should not be forced to work together under pain of not getting any access to the QIDSS program. Teams should be able to make use of entry/exit provisions in agreements (or the fact that an agreement has not yet been reached at all) to find or create clusters that are most likely to meet their needs within the resources available. Some QIDSS resources are simply spread too thinly and offer partners too little resource to compensate them for the effort involved (especially where clinical workflows are affected or novel data access and sharing arrangements are contemplated). This is especially true where partners do not have a legacy of working closely together. Hence it is recommended that existing partnerships should consider hiring additional specialists. Ultimately, if the ministry has any guidelines or requirements regarding partnership entry and exit it should clarify them for the field.

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AFHTO recommends that Health Link boundaries be used as a guideline for allocating QIDSS positions to un-served FHTs and NPLCs and/or to strengthen existing partnerships. Taking this approach will make it more likely that there are natural, practical reasons for the parties to deepen partnerships and share information.

Workload, Logistical Considerations, Supporting Hosts

A key lesson from the early implementation phase is that a great deal is being expected of the Host organizations. They need to act as the employer, cover overhead costs, meet the needs and expectations for disparate partnerships, often across considerable geographical expanse and have to take the lead on privacy and logistical arrangements for the partnerships to get underway at all.

One of the main logistical considerations and a critical workload driver that hosts face is EMR diversity. QIDS are supporting up to 5 different EMRs (See Appendix 2 Figure 3 for the detailed breakdown of the number of EMRs per QIDSS FTE). Much of what a QIDSS can accomplish in a given day is directly dictated by the EMR (EMR-specific functional and configuration issues, queries and other tasks that are not inter-operable, training, vendor relations and so on). The more the QIDSS has to attend to these issues the less time there is available for other less strictly EMR dependent work such as data quality, workflow, QI facilitation, QIP support, patient experience measurement and so on.

QIDSS ability to work across EMRs will improve as the QIDS initiative matures and shared EMR knowledge and inter-operability improve with it. Some modest consolidation is also likely. However, the presence of multiple EMRs will continue to be a considerable factor in estimating QIDSS site-support capacity and overall impact across the partnership.

Recommendation:

Host organizations should budget and submit for reasonable travel, remote access and other costs including legal. With virtually all the QIDSS now in place there will not be any flexibility to meet travel and other expenses not provided for in the initial allocation. The ministry should also give an early guidance on support for travel costs or QIDSS will be effectively grounded for the first five months of the year while the hosts await approval which would be a severe setback at this early stage of the partnerships.

AFHTO Support For QIDS Hosts And Partners

Following are some of the steps AFHTO is taking to assist hosts and partners:

1. Direct support to QIDS Specialists: AFHTO and the provincial team have made a priority of a “high touch: approach to supporting QIDS and making sure their skills and commitment are supported by a common sense of direction and mission. This includes
 - Weekly province-wide knowledge sharing check-ins
 - Targeted learning events such as the two day QIDSS Symposium convened in January
 - Reaching agreement to share QIDSS work plans province-wide. A priority setting framework and facilitation are available to assist in those cases where there are challenges in documenting work plans
 - Communities of practice organized by EMR, with EMR-vendor specific training plans
 - Extensive field visits from the QIDS practice lead

2. Host ED support: In response to the partnership status survey and interest from the field, a monthly Town Hall has been established to identify issues and track progress. As of mid-February issues are organized into the following buckets:
 - Recruitment
 - Partnerships including MOU implementation
 - QIDS Specialist sharing and logistics, including work plans
 - Ministry issues (funding, travel, reporting expectations)
 - Privacy (multiple issues noted)
 - Data sharing

3. Standard MOU and QIDS Privacy Toolkit: A law firm was retained through a competitive process to develop a benchmark MOU (end-Feb) and toolkit (mid-March). A webinar is planned for late March to launch the products and improve awareness.

Recommendation:

AFHTO should continue to be funded to provide direct support to QIDS Specialists and Host organizations to facilitate knowledge exchange, spread best practice, tools such as a standard MOU and privacy toolkit, and coordination/leadership to advance the EMR vendor/supply chain strategy

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APPENDIX 1 - AFHTO's understanding of the state of the existing QIDSS allocations

# FHTs in LHIN	FHTs in partnership (AFHTO's current understanding. Partnerships may have evolved differently.)	QIDSS FTEs	Not included in any group
9	LHIN 1 – Erie St. Clair		
	Windsor FHT** Harrow FHT Amherstberg FHT Central Lambton FHT Chatham-Kent FHT Leamington FHT Thamesview FHT Tilbury FHT Rapids FHT	2.0 FTE	All are in the QIDSS partnership
20	LHIN 2 – South West		
	STAR FHT** Happy Valley FHT North Perth FHT North Huron FHT Stratford FHT Clinton FHT Maitland Valley FHT Huron Community FHT Bluewater FHT	1.0 FTE	London FHT Four Counties FHT
	Thames Valley FHT**	1.0 FTE	
	Brockton and Area FHT** Owen Sound FHT Peninsula FHT Kincardine FHT East Elgin FHT Sauble FHT Hanover FHT	1.0 FTE	
10	LHIN 3 – Waterloo Wellington		
	East Wellington FHT** Minto Mapleton FHT Mount Forest FHT Upper Grand FHT Two Rivers FHT Grandview FHT Centre for Family Medicine FHT	1.0 FTE	New Vision
	Guelph FHT	1.0 FTE	

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# FHTs in LHIN	FHTs in partnership (AFHTO's current understanding. Partnerships may have evolved differently.)	QIDSS FTEs	Not included in any group
15	LHIN 4 – Hamilton Niagara Haldimand Brant		
	Hamilton FHT** Delhi FHT Garden City FHT Niagara Medical Group FHT Niagara-on-the-Lake FHT Portage Medical FHT PrimaCare Community FHT Six Nations of the Grand River FHT Smithville FHT Welland McMaster FHT McMaster FHT Burlington FHT	4.0 FTE	Beamsville Haldimand Caroline
6	LHIN 5 – Central West – (FHTs from a different LHIN)		
	Queen Square FHT** Dufferin Area FHT North Peel FHT Halton Hills FHT	1.0 FTE	All FHTs are believed to be in a partnership
7	LHIN 6 – Mississauga Halton-(FHTs from a different LHIN)		
	Wise Elephant FHT** Dorval Medical Associates FHT Humber River FHT Central Brampton FHT West Park FHT Inner City FHT Cochrane FHT Mango Tree FHT Jane-Finch FHT	1.0 FTE	
	Summerville FHT** Prime Care FHT Credit Valley FHT OakMed FHT	1.0 FTE	Etobicoke
13	LHIN 7 – Toronto Central		
	St. Michael's Hospital Academic FHT**	0.5 FTE	Bridgepoint
	UHN (Toronto Western) FHT**	0.5 FTE	
	Sunnybrook FHT** Women's College	0.5 FTE	St.Joes
	Taddle Creek FHT** Southeast Toronto FHT Village FHT Mount Sinai FHT	0.5 FTE	Sherbourne

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# FHTs in LHIN	FHTs in partnership (AFHTO's current understanding. Partnerships may have evolved differently.)	QIDSS FTEs	Not included in any group
11	LHIN 8 – Central (FHTs from a different LHIN)		
	North York FHT** Alliston FHT Canes FHT Don Mills FHT	1.0 FTE	Markham Woodbridge
	Health for All FHT** Aurora Newmarket FHT Southlake FHT	0.3 FTE	
10	LHIN 9 – Central East (FHTs from a different LHIN)		
	Kawartha North FHT** City of Kawartha Lakes FHT Haliburton Highlands FHT	0.6 FTE	North Durham Northum-berland
	West Durham FHT** Scarborough FHT East GTA DHT Carefirst FHT	1.0 FTE	Trent Hills
	Peterborough Networked FHT**	1.0 FTE	
15	LHIN 10 – South East		
	Upper Canada FHT** Prescott FHT CPHC FHT Athens FHT	0.5 FTE	Lakelands
	Central Hastings FHT** North Hastings FHT Bancroft FHT Brighton FHT Prince Edward FHT	0.6 FTE	
	Maple FHT** Sharbot Lake FHT Kingston FHT Queen's FHT Loyalist FHT	1.0 FTE	
21	LHIN 11 – Champlain		
	Petawawa Centennial FHT** North Renfrew FHT West Champlain FHT Pikwakanagan FHT Connexion Family First Greenbelt Rideau Tungasuvvingat UOHS Westend	West Carleton FHT** Ottawa Valley FHT Arnprior and District FHT Lower Outaouais FHT Montfort Academic FHT** Rockland FHT Plantagenet FHT ESFCO FHT Bruyere TOH FHT	3.0 FTEs

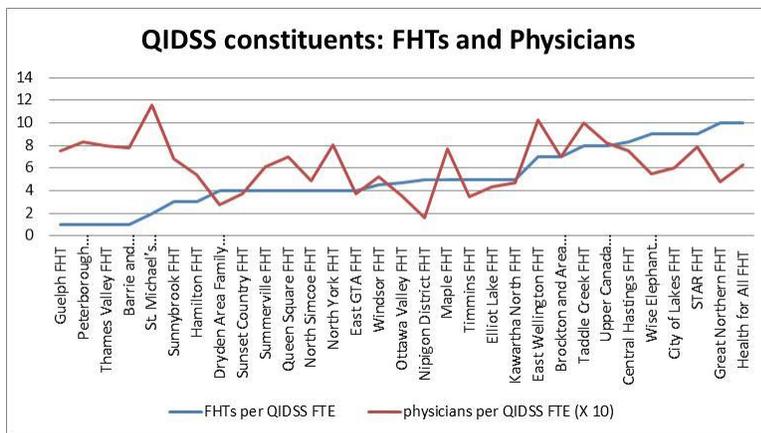
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# FHTs in LHIN	FHTs in partnership (AFHTO's current understanding. Partnerships may have evolved differently.)	QIDSS FTEs	Not included in any group
6	LHIN 12 – North Simcoe Muskoka		
	North Simcoe FHT** Cottage Country FHT Couchiching FHT Georgian Bay FHT	1.0 FTE	
	Barrie FHT**	1.0 FTE	
27	LHIN 13 – North East (FHTs from a different LHIN)		
	City of Lakes FHT** Espanola and Area FHT Parry Sound FHT Powassan and Area FHT West Nipissing FHT Northeastern Manitoulin FHT Manitoulin Central FHT Municipality of Assiginack FHT Huron Shores FHT	1.0 FTE	Baawating South Algonquin Superior
	Elliot Lake FHT Algonquin FHT Anson General FHT Blue Sky FHT Burk's Falls FHT	1.0 FTE	
	Timmins FHT Chapleau FHT East End FHT Nord-Aski FHT Wawa FHT	1.0 FTE	
	Great Northern FHT Englehart and District FHT Haileybury FHT Kirkland District FHT Temagami FHT	0.5 FTE	
15	LHIN 14 – North West (FHTs from a different LHIN)		
	Nipigon FHT Dilico FHT North Shore FHT Manitouwadge FHT Greenstone FHT	1.0 FTE	Atikokan Fort William
	Dryden FHT Points North FHT	.5 FTE	Harbourview
	Sunset Country FHT Fort Frances FHT Ear Falls FHT Red Lake FHT	1.0 FTE	Marathon
TOTAL: 33.0 FTE			

APPENDIX 2 – Aspects of the QIDSS resource utilization

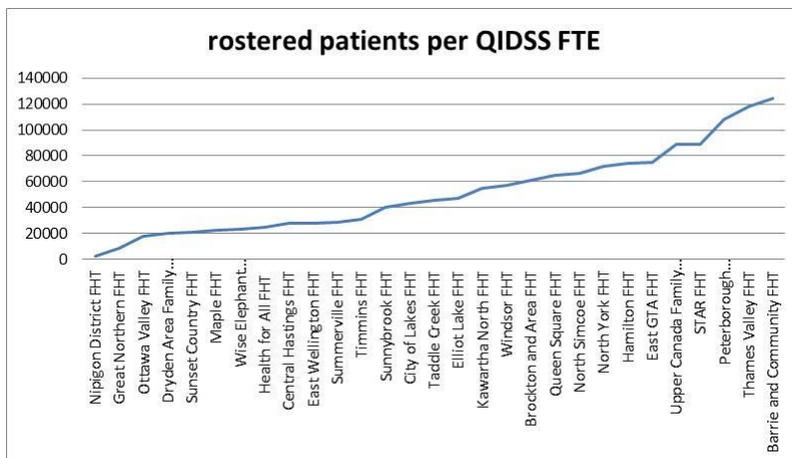
There were 34 funded QIDSS proposals which have subsequently been organized into 31 partnerships. Because some of these are part-time positions, subsequent analyses consider the FTE in the QIDSS role as well as the number of QIDSS hired. On average, there are 5 FHTs in each partnership, with 3 partnerships comprised of single FHTs and 4 partnerships involving 9 FHTs (See Figure 1). On average, there are just over 60 physicians per QIDSS FTE. The part-time nature of many of these physicians (especially in academic FHTs), may increase, rather than reduce, QIDSS workload as the part-time nature may affect physician availability for and/or interest in FHT change management work.

Figure 1: QIDSS constituents: FHTs and physicians



Based on AFHTO membership data (which is admittedly somewhat dated and currently available for only about half of the members), there are 57,000 patients per QIDSS FTE with a very wide range from 20,000 to 120,000 rostered patients (see Figure 2, excluding FHTs with missing data for rostered patient volume).

Figure 2: Rostered patients per QIDSS FTE (excluding FHTs with missing data for patient volume)



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Each partnership involves an average of 2 EMRs with an average of 3 different EMRs per QIDSS FTE. Several partnerships have only 1 EMR whereas others have as many as 5 different EMRs. Many partnerships are widely dispersed geographically, with several hours of travel time between partners.

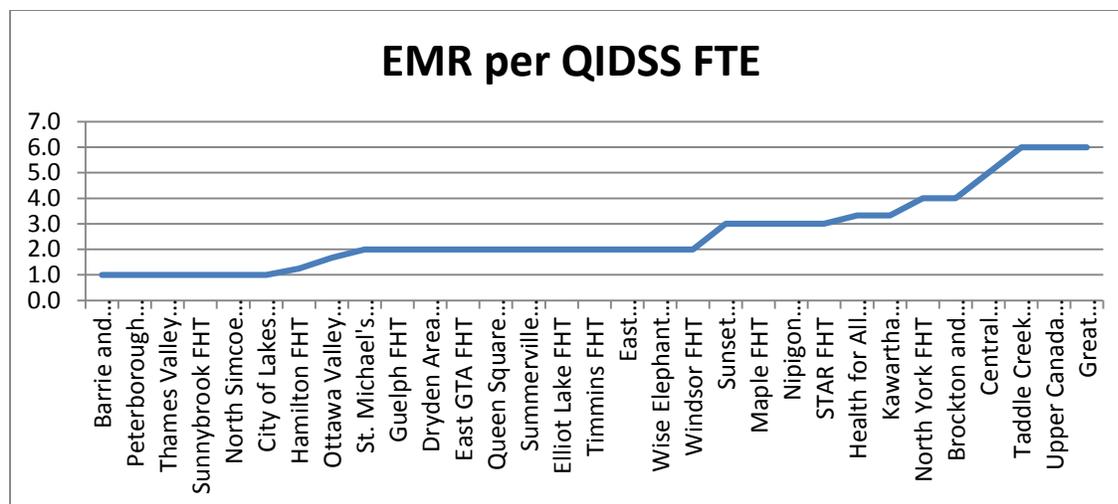


Figure 3: EMR per QIDSS FTE

There are also gaps in coverage of the QIDS program. There are about 25 FHTs and 25 NPLCs that are not yet part of QIDS partnerships. Table 1 lists the municipalities in which there are FHTs that have yet to be formally included in QIDS partnerships.

Status of partnership agreements

Between November and December 2013, AFHTO made contact with 31 of 34 FHTs with successful proposals and successfully interviewed 25 of these. 7 of the 25 partnerships had some sort of formal documentation of agreement between partners. A further 10 more were well underway in the process. The remaining third either did not require an agreement as they have no FHT partners or were not making progress on the formal agreement.

Progress with formal agreement	Number of partnerships	% of partnerships
signed	7	21
nearly done (just a question of timing)	4	12
in progress -- going ok	6	18
outstanding issues to address	1	3
not started	4	12
n/a (single FHT)	3	9
contacted, no response	6	18
not contacted	3	9
Grand Total	34	100

Observations related to formal agreements

As of the end of the calendar year, only a *minority* of partnerships have completed formal partnership agreements. The nature and provisions of these documents is not known. AFHTO recently contracted with DDO LLP and is working with several interested EDs to develop a “benchmark” MOU template which would also provide for privacy and data sharing arrangements.

Observations related to partnerships (independent of formal agreements)

FHTs that report they are making progress independent of the partnership agreement are doing so through focussing the work of the QIDSS on tasks that do not immediately involve data sharing, through confidentiality agreements between QIDSS and each partner FHT or other informal means of working together.

Future planning:

1. QIDSS workload and capacity planning:

There are numerous complex and fairly independent factors which can have a decisive impact on QIDSS work load and capacity requirements. The vision for measurement and improvement capacity in the primary care sector is becoming more clear all the time. It is still early for the QIDS strategy to estimate QIDS Specialist capacity requirements with any certainty, however, QIDS Partners, AFHTO and the ministry should work collaboratively to share the following types of information to get better sightlines onto what a sustainable strategy looks like. Drivers include:

- a. Number of FHTs supported per QIDSS fte (currently 1 to 9) and geography
- b. Number and variation of sites, FHOs (and sometimes EMRs) within individual FHTs
- c. Numbers of physicians and panel size
- d. Scope: Local data and measurement for improvement needs and goals and the scope of services included in the QIDS partnership arrangement
- e. Pre-existing EMR maturity workflow optimization and data quality (may/may not be a transitional issue), if OMD incentive funding was available and how it was used
- f. Number of EMRs: Working with multiple EMRs (average of 3 different EMRs per QIDSS FTE) appears to be a significant challenge. There is no fixed limit to the number of EMRs a QIDS Specialist can support but there are no economies as yet as the numbers multiply because there is very limited overlap in challenges and solutions between EMRs. (As a reference point, AOHC has a cadre of over 70 decision support staff working with a single EMR).
- g. Availability of other supports: A number of other programs exist that can support primary care EMR and decision support optimization but they have differing priorities (eg. Cancer screening) or uneven distribution their supports (eg. LHIN funded facilitation)

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- 2) Availability of other enablers and constraints: information technology (eg remote access, software etc), legal advice regarding partnerships and contracts, privacy and data ownership policies as well as change management.
- 3) Relationships with other bodies (eg MOHLTC, HQO, Healthlink partners): In addition to the partnerships associated with the QIDS program, FHTs also are managing relationships with other bodies such as the MOHLTC and HQO (from reporting perspectives) and Healthlinks partners. These various relationships appear to be generating overlapping as well as competing demands on FHT resources, especially ED time and attention.
- 4) Congruence with LHIN and Healthlink boundaries: The degree to which Healthlink partnerships are congruent with the QIDS partnership could simplify matters for the partners, giving them the opportunity to establish structures and processes to collaborate for multiple purposes. At least one QIDS partnership is a direct match. While AFHTO staff does not have the information to assess other matches, we do know that there are 2 LHINs – Erie St. Clair and Champlain – where all FHTs within that LHIN are captured within one partnership. In 5 LHINs all partners are within the LHIN boundaries but are missing some of the FHTs. For the remaining 7 LHINs, FHT partners cross LHIN boundaries.