

Back to the Future: Health Quality Ontario's Programs to Support Quality Improvement in Primary Care



Demonstrating and Celebrating the Value of Family Health Teams

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Cheryl Chapman, Mark Robson, Wissam Haj-Ali



Agenda

- Brief overview of Health Quality Ontario
- Advancing improvement in primary care
- HQO Programs
 - Access & Efficiency
 - bestPATH
 - Primary Care Performance Measurement Project
- Questions & Discussion

About Health Quality Ontario

Health Quality Ontario (HQO) is an arms-length agency of the Ontario government, mandated to evaluate the effectiveness of new health care technologies and services, report to the public on the quality of the health care system, support quality improvement activities and make evidence-based recommendations on health care funding. Visit www.hqontario.ca for more information.



Bill 46

The Excellent Care for All Act

Ontarians want a high-performing health system that is:

- Accessible
- Effective
- Safe
- Patient-centered
- Equitable
- Efficient
- Appropriately resourced
- Integrated
- Focused on population health

HQO's Strategic Framework

Our Values: Transparency, Passion, Innovation, Learning, Integrity, Collaboration

Vision	A healthcare system that is sustainable, improves continually and uses evidence to optimize population health and provide excellent care for all Ontarians.				
Mission	A catalyst for quality, an independent source of information on health evidence, a trusted resource for the public.				
Transformative Objectives	Accelerate the use of evidence to deliver demonstrable improvements in the quality of health services		Drive a culture of quality, value and accountability throughout the health system in Ontario		Foster partnerships and integration among the distinct components of the health system
Quality Aims	Patient, family and staff experience	Access	Safety	Quality of life	Efficiency and effectiveness
OUR ROLES					
Focus the system to a common quality agenda	Build evidence and knowledge	Broker Improvement	Catalyze spread	Evaluate progress	
Establish priorities, goals and targets and mobilize system leadership around a common agenda to maximize impact for Ontarians.	Generate or access the evidence and knowledge needed to provide quality care and improve population health	Develop the tools and supports need to accelerate the adoption of evidence-based best practice. Foster the development of quality improvement capacity in the system	Guide, support and collaborate within the system to spread knowledge about best practices, measurement tools and implementation strategies. Mobilize system capacity for improvement.	Demonstrate accountability by providing timely and relevant health system monitoring, measurement and reporting. Access progress and report to the public.	
HQO PERFORMANCE MANAGEMENT					

Advancing Improvement in Primary Care

Improving Quality in Primary Care

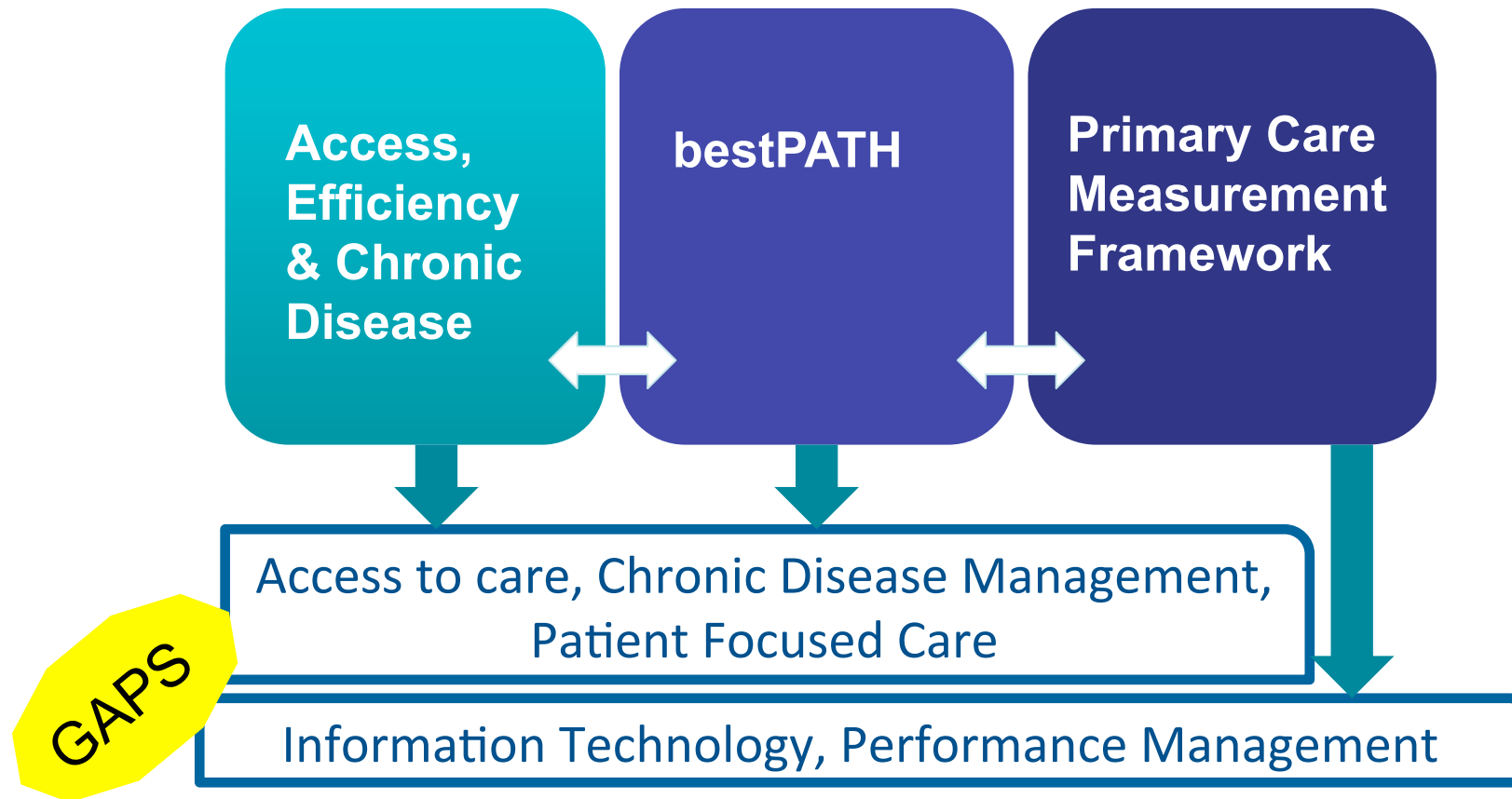
- Acknowledging the essential role primary care plays as part of a high-performing healthcare system
 - First point of contact, access to a variety of health care providers/services
- Significant reforms in primary care such as evolution to more group-based practices & interdisciplinary models
- Ontario's Action Plan for Health Care highlights key areas needed for improvement including
 - Faster access • Local integration • Focus on quality & evidence based care

Improvement Opportunities

Remaining Gaps

- Access to care
- Chronic disease management
- Information technology
- Performance management
- Patient focused care
- Accountability

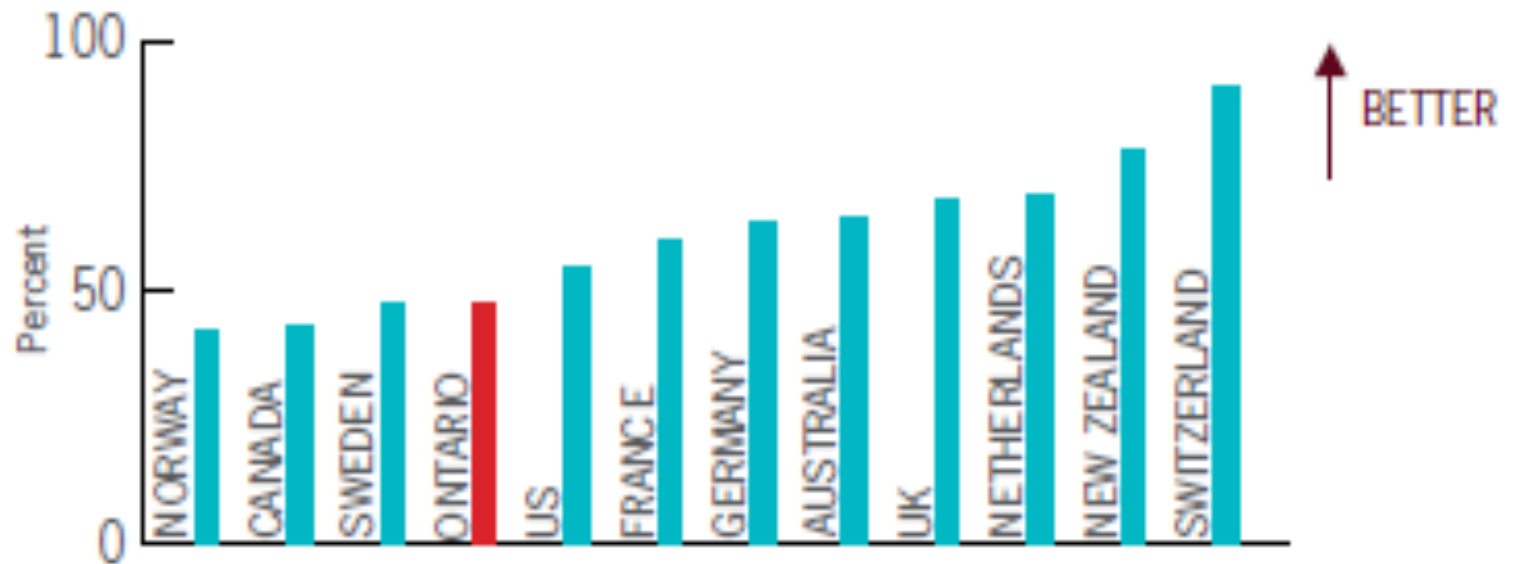
Programs Supporting Primary Care



Access, Efficiency & Chronic Disease

Waiting...for a Family Physician in Ontario

% of adults
able to see
their GP same
or next day



2011 report on Ontario's Health System; HQO

What is Advanced Access?

- Time a patient waits for a scheduled appointment
- Measured in days: Third Next Available Appointment
- *Excellent access* is
 - “See your own, don’t make them wait
 - Accommodating a patient’s day & time of choice

Primary Care Learning Communities

Access, Efficiency + Chronic Disease Management

- Access & Efficiency
 - Improved **access** to primary care, **efficiency** in the delivery of primary care & maintained/enhanced **continuity** of care
- Chronic Disease Management
 - Identify chronic disease patient **population** & opportunities for quality of care **improvements**
- Preparing practices to do further clinical QI improvement **initiatives** e.g., bestPATH; LHIN-based QI work

Learning Community: 3 Main Elements

Active Learning Cycles

- Model for Improvement, Chronic Disease Prevention & Management Framework
- Clinical Practice, Evidence-based Guidelines

Infrastructure Gateway

- A virtual on line real-time workspace
- Capturing wisdom of the group, helping, sharing, collaborating

Support

- QI coach
- Champions
- Learning Sessions
- Resources including webinars, Road Map, Work Book

Summary of Past Results

Advanced Access Learning Communities

Wave	Wait Times (TNA)		Continuity of Care		# of Practices
	Baseline	Completion	Baseline	Completion	

Wave 5, 6 & Beyond

Wave 5

- Started Sept 10/12 with focus on Advanced Access & Efficiency
- Mar to May/13 - Chronic Disease Management
- June to Aug/13 – Sustainability - data reporting

Wave 6

- Registration and Readiness Assessment – Nov 1 to Feb 22/13
- Target: minimum of 100 primary care practices
- Starts March 4, 2013 with focus on Advanced Access and Efficiency
- Sept to Nov/13 – Chronic Disease Management
- Dec/13 to Feb/14 – Sustainability - data reporting

2013-2014

- Waves 7 & more – Access, Efficiency & Chronic Disease
- Partnership – machealth (McMaster), Ontario College of Family Physicians, Health Quality Ontario
 - Interactive, e-learning modules; Coaching, champions; Face to face small group workshops

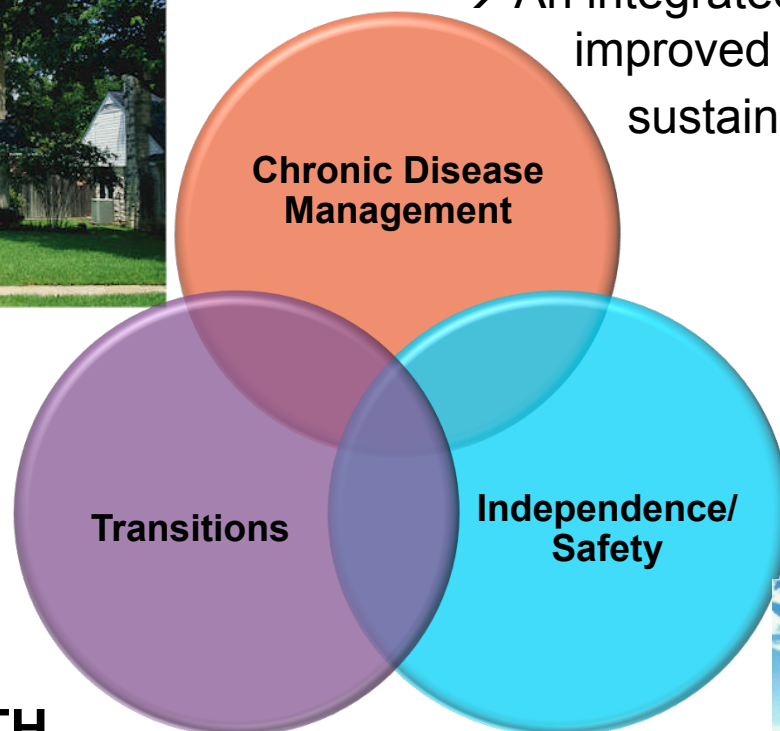
bestPATH

bestPATH - Enabling System Transformation



Goals for Ontario's Health System

→ An integrated system producing improved outcomes, experiences and sustainability: Future State, A Place



Execution: bestPATH

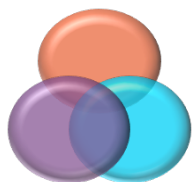
→ Driving system change through implementation of evidence-informed practice and process redesign



bestPATH Partners

- System partners from across the healthcare sectors have been consulted and contributed to the design of bestPATH; they will continue to be engaged throughout the initiative
- Our partners have been engaged to:
 - Publicly endorse and support bestPATH
 - Identify opportunities to align bestPATH with existing initiatives
 - Develop and/or provide education
 - Demonstrate leadership
 - Build capacity for change management
- Both formal arrangements (e.g., MOU) and informal working relationships will establish and deliver on our shared goals

bestPATH Assets



Change Packages

- Evidence informed
- Vetted by expert panel and staff in the field
- Endorsed by leaders in Canadian and Ontario healthcare standards



HQO Quality Framework

- Includes the best of IHI Model for Improvement, Lean and Six Sigma approaches to quality improvement



Web Based Repository of Best Practices

- Evidence informed guides to quality improvement, change management, team building, measurement for improvement
- Evidence informed guides and links to clinical best practices



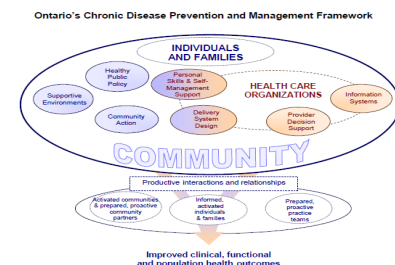
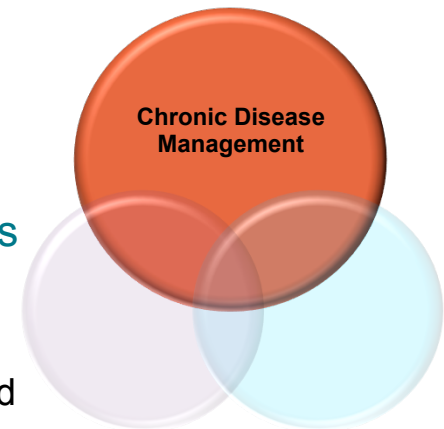
Links to Innovative and Leading Edge Healthcare Practitioners

- Partnerships with provincial, national and international leaders
- Partnerships with Ontario clinicians conducting research related to integration, knowledge transfer, chronic disease prevention and management

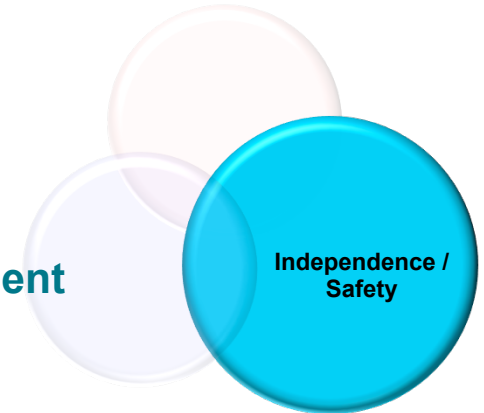
Chronic Disease Management

Key activities include the following

- Introduce decision supports to deliver evidence-informed care as evidenced by:
 - Use of chronic disease flow sheets
 - Use of clinical practice guidelines (CPGs) to guide care planning and discussion during each visit
 - Adherence to secondary prevention guidelines as per CPGs
- Use information management systems to assist in developing a proactively planned care approach and help patients become more informed by:
 - Using alerts and/or electronic recall functions to identify need for primary and secondary prevention, flag patients who require specific interventions, plan specialist consultations
 - Access to a central repository of information to help the practice to prepare for the patient's next visit
- Coordinate specialists, nurse practitioners and allied healthcare professionals, creating a multidisciplinary team with shared accountability to provide care
- Ensure continuity of care within and across care teams

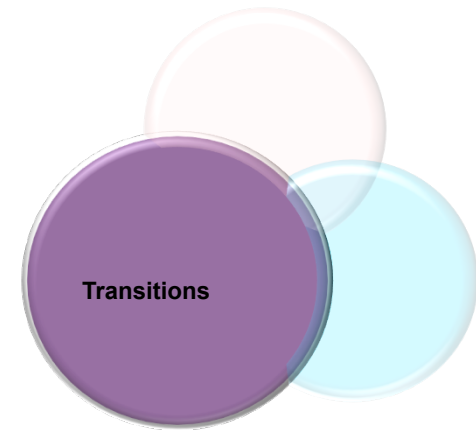


Independence and Safety



- **Assess and remedy safety risks within the home environment**
 - interRAI™ MDS tools; falls risk assessment tools
 - Proactive, timely, interdisciplinary risk remediation
- **Enable the person to take a central role in their health and create a safe environment as evidenced by:**
 - Assessing health literacy and ensuring person understands how to manage their health and care
 - Supporting development of goals that are meaningful and important to the person, negotiate a plan to reach goals and course correct
 - Assessing the person's ability to achieve health and care goals and to manage their care independently
- **Implement OHTAC recommendation 'Aging in the Community' (2008 September) to enhance the person's ability to live independently and safely in the community. Includes:**
 - Falls reduction, techniques to reduce urinary incontinence, caregiver support, targeted conditioning

Transitions



- Assess risk of readmission within 30 days of discharge; plan and schedule appropriate follow up as per readmission risk
 - For individuals deemed moderate to high risk for readmission (i.e., LACE score ≥ 10) treat discharge as a formal transfer of care
- Conduct individualized care and discharge planning including:
 - Medication reconciliation at key transition points
 - Health literacy assessment at admission; ensure person understands their care plan, therapeutic regimens, how to manage symptoms and when to ask for help

Self Directed Stream

PROVINCIAL SCALE
LIGHT TOUCH COACHING
CUSTOMIZABLE & SELF DIRECTED

- Evidence-Informed Interventions
 - Evidence based change packages: Transitions, Safety & Independence, CDM
 - Clinical improvement ideas
- Implementation Support
 - Change Management, Administrative & How-To guides
 - Low-intensity coaching support
 - Expert faculty hosted web events, reporting infrastructure
 - Web based best practices repository
- Active self-directed participation
 - Registration, Results Reporting, Provincial Network Activities

Multi-Level Indicator Framework

System-level

Provincial/ LHIN-level indicators of change
Outcomes focused, some process, balancing
Fewest numbers of indicators
Longest duration before evidence of change visible

Mid-level

Regional/ LHIN/team level indicators of change
Outcome and process focused
Direct and/or indirect alignment with system-level and quality improvement-level indicators
Moderate number of indicators
Early to mid-range duration before evidence of change visible

Quality Improvement-level

Individual provider/facility/ team level indicators of change
Outcome, process and balancing
Some indicators common to all providers, some unique
Direct and/or indirect alignment with mid-level indicators
Largest number of indicators
Earliest evidence of change

bestPATH Program Benefits

Ontarians

- Access to health care professionals will be more equitable
- Chronic illness management will be proactive, engaging the person in care planning to achieve meaningful person-centred goals

All Health Sectors

- Seamless communication at transition points (e.g., discharges)
- Access to information reducing duplication and/or omission of key care processes

Primary Care Practitioners

- Valued as central partners in effective chronic disease prevention and management
- Collaboration with specialists will be streamlined

Community Care Access Centres

- Optimized interdisciplinary outreach to high risk clients, including access to early medication reconciliation post hospitalization

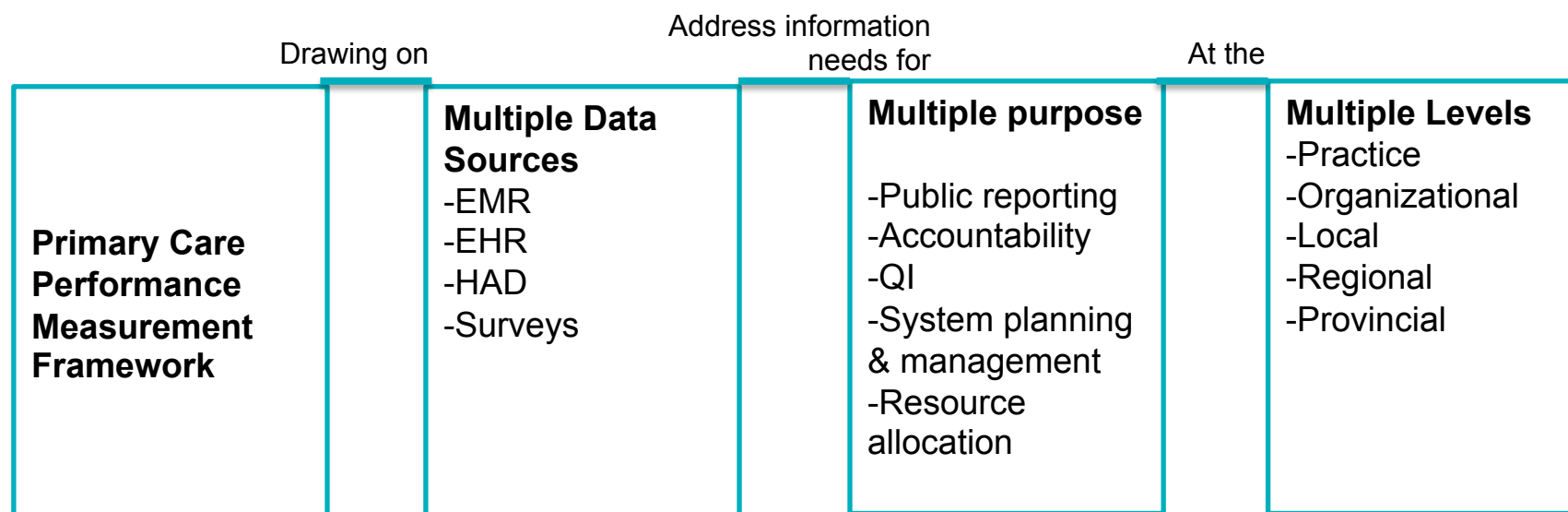
Hospitals

- Reduction in index admissions and reduction in readmissions
- Reduction in CTAS 4-5 emergency department visits

Primary Care Performance Measurement Project

Laying the foundation for performance measurement in primary care in Ontario

Project Purpose



Intended Results

- Enhanced capability to align primary care performance measures across Ontario and Canada
- Alignment of key stakeholders initiatives for the development of primary care performance measures;
- Enhanced performance and quality monitoring of primary care in Ontario;
- Adoption of EMR functionality that support quality monitoring and improvement, including standardized chronic disease management flowsheets; and,
- Increased opportunity for primary care providers to participate in voluntary pooling of de-identified EMR data for purposes of performance monitoring (including comparisons with peers) and quality improvement.



Ontario Primary Care Performance Measurement Summit

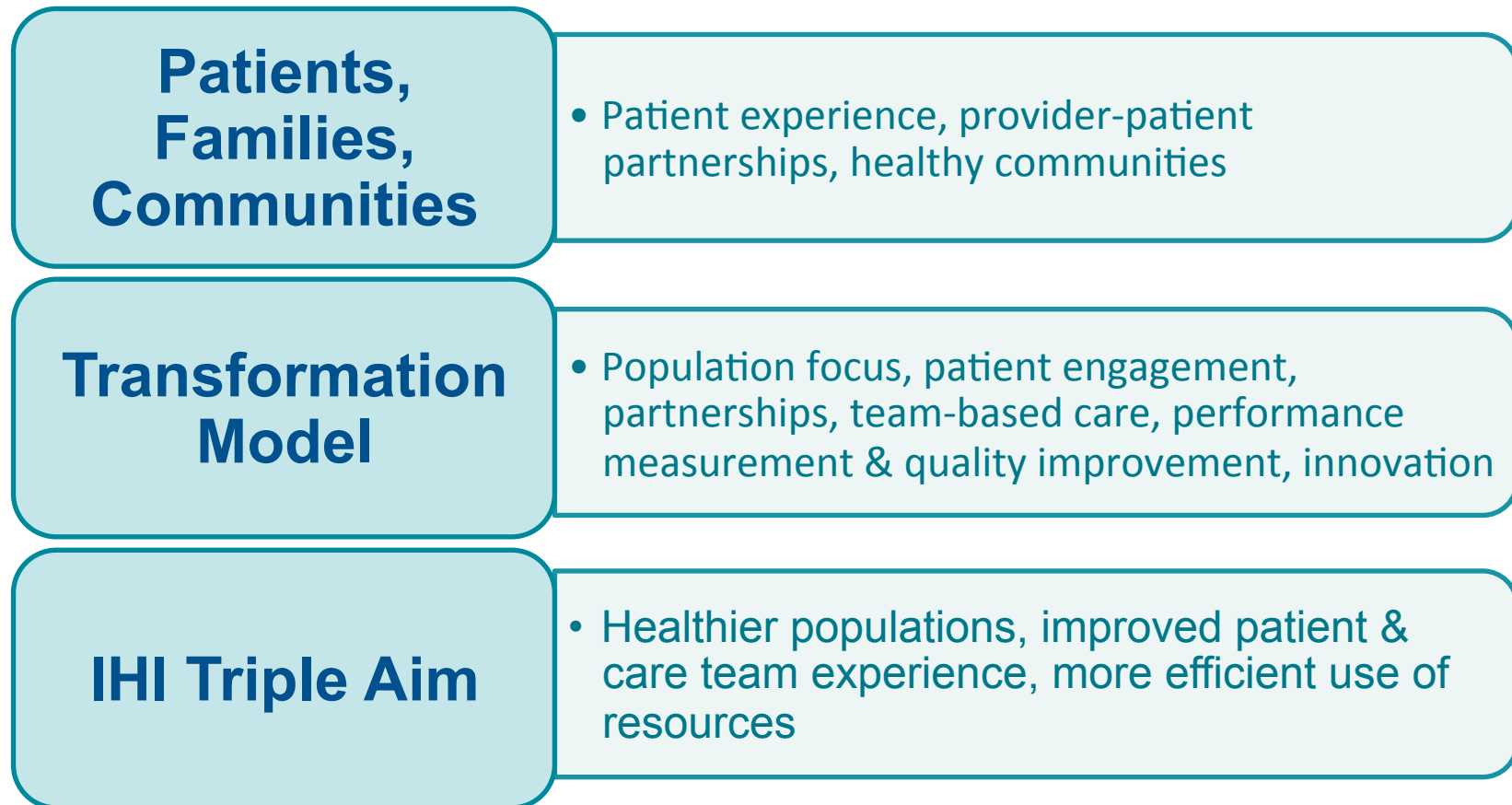
November 21, Sheraton Center Hotel



- Agreement on what to measure
- Infrastructure & tools to support measurement
- A coordinated approach to measurement & uptake

In Summary

HQO Programs Support a Framework for Improvement in Primary Care



Kates, N et al. Framework for Advancing Improvement in Primary Care. Healthcare Papers Vol. 12, No. 2, July 2012



www.hqontario.ca