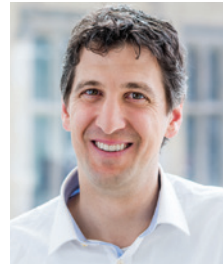# Quality Matters:
Realizing Excellent
Care for All

A Report by Health Quality Ontario's System
Quality Advisory Committee

Contents

Foreword

A health system in Ontario that is safe; effective; patient-centred; timely; efficient; and equitable.

It's been a little more than a year since Health Quality Ontario introduced a common framework for quality health care with the goal of improving population health, delivering high-value health care and enhancing both patient and provider experience. This framework was based on the advice of Health Quality Ontario's System Quality Advisory Committee - a group of experts with a demonstrated commitment to quality. We asked the committee to address a fundamental challenge for many involved with bringing quality to health care: Everyone felt quality was important, but what it meant and how to get there was much more elusive – especially at the system level. The committee's first report has served as a call to action for health system quality improvement for all those living in Ontario. And it has served as a foundation for all we do at Health Quality Ontario.

But alongside this common playbook, an argument: That it's not acceptable to simply acknowledge the importance of a quality health care system, nor to simply identify gaps.

The second phase of the committee's work proposes the tangible, mindful, pragmatic and feasible actions toward this common understanding. Their considerations and recommendations are presented here, for Health Quality Ontario to share with all those with an interest in improving the quality of Ontario's health system.

I thank those on the Committee and its working groups, who have ably responded to the challenge we set before them. They have created for us an important and enduring set of recommendations and an inspiring message for improvement. As we did with the framework for quality health care, Health Quality Ontario welcomes this call to action. You will see us link many of our activities to the recommendations, and we will work actively with our partners to realize the vision for health system improvement set out in Quality Matters. I strongly urge us all to reflect on it, to consider how we might contribute to the shared goals, to share it among our peers, and to revisit it in order to maintain the worthy conversations that will help us in realizing excellent care for all.

Dr. Joshua Tepper
President and Chief Executive Officer
Health Quality Ontario

The Path to a Better Health System

In October of 2015, the System Quality Advisory Committee released its vision for health care in Ontario. We offered a common definition, and set of principles to understand what a culture of quality would look like. And we identified the enablers that will help us to get there. Our work was built on a foundation of previous reports published here in Ontario and abroad. We sought to bring the best of this work forward so that we can understand our progress over time and compared to other health systems.

WHERE HAVE WE COME SINCE THEN?

The Ontario health system is undergoing fundamental reforms. These changes are motivated by the same goals articulated in this report—improved population health, high-value health care services, and enhanced patient and provider experiences. But the success of this undertaking will depend on how well we manage to align the many moving parts in our system towards these goals. We would all say we want a system that puts patients first—how can we make it a reality for all Ontarians?

The challenges facing us are significant. Our system is still organized in ways that do not address the needs of patients. The sustainability of our health system faces mounting pressures—both long-recognized forces like changing demographics as well as emerging issues like the opioid epidemic. We continue to under invest in the tools needed to improve the system. We face persistent unwillingness to resolve accountabilities and to address the lack of trust between key players in our system.

It is precisely because of these challenges that we began this work. As a committee, we encountered a profound tension between celebrating the tremendous work that is already happening in our system and acknowledging that, in spite of the heroic efforts of many, quality is still not where it should be. In light of the many complex challenges we face, we must be able to articulate clearly what we expect from our health care system and establish a shared set of priorities. Without common goals and a road map to guide us, we will never get there.

This report provides a framework and possible next steps to guide our thinking and actions. It is clear-eyed about the barriers to quality health care, but it is also optimistic. We hope it will start a conversation. Once begun, it is up to all of us to continue it.

Adalsteinn Brown
Director, Institute of Health Policy, Management and Evaluation
Dalla Lana Chair in Public Health Policy

Executive Summary

- **It is responsive to the needs of the patient**. It is re-imagined in partnership with patients, working towards common goals.
- **It achieves a balance among competing priorities**, recognizing the need to address both quick wins and longer-term goals that are harder to achieve.
- **It does not depend on the infusion of new funds**, but focuses resources for greatest impact.
- **It requires fundamental change**, and supports transformational leaders by removing barriers to innovation and improvement.

The barriers to building a health system that lives up to these principles are not insignificant but they can be overcome.

For this to happen, **alignment** is imperative. Previous reports have already noted potentially dangerous gaps in care between settings, providers, and sectors. To deliver quality outcomes consistently, health system leaders must collaborate and focus on shared priorities, proven practices, and evidence-based standards.

And how should these leaders identify best practices or determine where to focus their energies? Here, the Quadruple Aim shows great promise. It calls for improving experiences and outcomes for patients, the value of care provided, the health of the population (focusing on the overall wellbeing of specific groups of individuals with similar health care needs), and the experience of providing care. The Quadruple Aim can drive strategic planning efforts for all delivery and funding organizations, inform service-level agreements, and form the basis of senior executive performance assessments.

Two important tools for alignment with the Quadruple Aim are funding models and technology. At present, funding is not tied to the difficulty of the task or the benefits to the system as a whole. If Ontario wants a health system in which patients move with ease between providers, how can funding models be designed to promote collaboration and improve transitions?

Similarly, health information technology and systems – electronic medical records, secure online patient portals, and virtual care, to name a few – have vast potential. Yet too often such initiatives are seen as IT projects rather than quality improvement initiatives. Proprietary systems and platforms and the lack of standards conspire to blunt the full potential of these innovations.

Likewise, the health system's **accountability structures** are in need of re-orientation, moving from a sectoral view (oriented to hospitals, long-term-care, or primary care) to the patient's view. It has been said that the most dangerous procedure in health care is the patient handoff. Can there be a clear line of accountability for patients at every point of care as well as in the spaces between these points?

And finally, if we expect healthcare providers to deliver quality care, then standards for that care (including those reflecting the patient experience), targets against which performance is measured, and consequences for falling short have to be far clearer than they are today.

To enable these transformations, a solid foundation of measurement and transparency is needed. A rich provincial data-collection ecosystem has evolved to support health system measure-

Despite its many assets, Ontario's health system has yet to find a way to translate pockets of excellence into a system-wide culture of quality synonymous with continuous improvement. But that is what it will take to bridge the gaps and reduce the variations in health care that stubbornly persist.

To press the agenda, Health Quality Ontario, the provincial advisor on quality in health care, brought together a group of committed Ontario health system experts. This System Quality Advisory Committee developed a definition of system-wide quality, a vision for the health care system, and a set of principles to guide it – essentially, a common understanding of what quality-first health care could look like. These framework documents were released in October 2015. The Committee then struck three working groups (Understanding Quality Health Care, Delivering Quality Care, and Fostering a Culture of Quality) to delve deeper into these topics and carried out a consultation with patients and caregivers.. Their work forms the basis of three additional reports.

What is a high-quality health system? Using the definition advanced by the Institute of Medicine and informed by consultation with patients and caregivers, the Committee articulates six dimensions: safe, effective, patient-centred, timely, efficient, and equitable. The definition reflects a shift from viewing quality of care as the responsibility of individual providers and institutions to the responsibility of the system itself.

From this comes a vision for health system quality:

Ontario's health system is world-leading in delivering the best outcomes across all six dimensions of quality. Our health care system is just, engages patients and families, and is relentlessly committed to improvement.

In translating this vision to reality, each step will need to be tested against a set of guiding principles. A health system with a culture of quality is many things:

- **It is focused on improving quality** – across quality dimensions, for all sectors, and in a way that reflects the patient journey.
- **It is about health, not just health care**. It is concerned with preventing illness just as much as with treating illness.
- **It is accessible to all**, regardless of who you are or where you live.

ment. Providers expend a huge amount of resources generating data. The challenge is to get better at measuring quality in a way that is relevant, useful, and actionable to improve care for patients.

Accountability and system planning require measures that allow for fair comparisons. It sounds simple yet is hard to achieve. Across provider networks, multiple measurement instruments are used. Questions are not standardized and subtly varying indicators make it difficult to generate a true picture of how the system as a whole is operating.

A number of other measurement gaps merit our immediate attention.

Transitions in care: Safer and more efficient transitions for patients require appropriate accountabilities and hard data rather than anecdotes.

Patient experience: Patient-reported data are collected inconsistently and with minimal standardization. Rapid developments in technology can enable sharing and learning from this data, but only if health care organizations and agencies keep pace.

Staff experience: *Ontario's Excellent Care for All Act* requires health care providers to conduct staff surveys, but much more can be done to understand how clinicians and health care staff perceive their work and to address impacts on quality of care.

Equity: Current measures fall short of assessing the impacts of social determinants of health on outcomes. System planners require linkable and shared data to address the needs of populations.

> It has been said that the most dangerous procedure in health care is the patient handoff.

While new measures may be needed, it also must be acknowledged that too much measurement can place a burden on organizations and agencies, and can generate so much "noise" that efforts to improve become confused. Mitigating these potential pitfalls should involve a review of existing measures to ensure they are still providing useful and actionable information.

And measurement alone is insufficient – linking measurement to improvement initiatives is integral. The pathway from raw data to better quality processes and outcomes is not entirely clear. What is known is that good intentions are not enough. Supporting senior leaders and governors as well as frontline clinicians and staff with both the necessary time and skills to work with data would make a difference. Beyond that, what can be done to create a culture of quality and thereby prepare the ground for organization- and system-wide learning?

We focus on four critical factors that drive the behaviours found in quality-focused health care cultures:

One, **develop leadership skills**. Relying on the lone, heroic leader is not the way to nurture a culture of quality. A properly resourced strategy that targets potential leaders at various career stages is needed. The focus should be on the development of collective leadership among clinicians, frontline staff, and, increasingly, patients and caregivers.

Mid-career providers and administrators should have opportunities to attend leadership programs that expose them to like-minded leaders in other health care sectors. Leaders should have access to proven management practices that support quality improvement as well as advice on how others have successfully implemented these best practices. And they should be rewarded for their transformational thinking and the actions they take towards achieving

the goals of the Quadruple Aim, in addition to incremental quality improvements.

Two, **invest in the capacity to support improvement**. Capacity-building takes many forms. It can be investments to give health care professionals, including nurses and doctors, the knowledge to plan and implement quality improvement initiatives. It can involve redoubling efforts to get local performance data into the hands of clinicians looking to improve their practice, or supporting frontline managers by giving them the time and skills development to lead improvement projects. It can include a wider development of instruments to measure organizational culture and track improvements and areas needing attention. Or it can target the next generation by boosting the quality improvement curriculum for clinicians in training and peer leaders.

Three, **enhance professional cultures and engage clinicians**. Professionals and organizations can find common purpose in better patient outcomes and streamlined operations. A culture of service can be cultivated within practices so that patients are treated with courtesy and compassion. A "just" culture ensures flawed processes are identified and fixed before they cause harm.

> There is neither a common understanding of what defines high quality health care nor a road map.

Four, **engage patients, caregivers, and the members of the public**. There are ways that system and organizational leaders can boost patient engagement at multiple touch points. At the level of care, patients can be asked their preferences on treatment plans and provide feedback on their experiences. At the level of governance, patients can co-lead quality improvement committees and provide input on strategic directions.

The patient voice remains a key motivator for all these changes. Unless senior leaders are committed to patient-centred care and partnering with patients, however, it will not happen. Unless governance structures are redesigned to give patients a seat at the table, the patient voice will not be clearly heard in the development of programs and strategies.

• • • •

In Ontario, there is neither a common understanding of what defines high quality health care nor a road map to get from the status quo to the desired future. Yet we know there is a tremendous opportunity to build the quality health system patients deserve.

The following recommendations from the System Quality Advisory Committee's three working groups (Delivering Quality Care, Understanding Quality Health Care and Fostering a Culture of Quality) have the potential to improve the quality of care, reduce the inequity in our health system, and enhance the experience of both patients and providers. These recommendations are actionable, measureable, and achievable and they do not require a significant influx of funding into the system. There is no reason they could not be achieved within the next five years. Work towards them should start today.

While each of the following recommendations are addressed in detail later in this document, the goals they support are summarized here:

DELIVERING QUALITY CARE

1. **System-wide alignment with the Quality Matters framework improves population health, delivers high-value health care and enhances both patient and provider experience.**
   - Health care organizations and agencies adopt the Quality Matters framework as the basis for strategic planning and accountability efforts. Improved delivery of health care services means achieving better value, better patient outcomes, and better patient and provider experience.
   - Local Health Integration Networks provide a leadership role to ensure all patients have timely access to well-coordinated care.
   - Health Quality Ontario measures and reports system-wide progress towards achieving the goals of the Quality Matters framework.

2. **Clear articulation of who is responsible for what in the delivery of health services ensures patients fully benefit from high quality care as defined by the Quality Matters framework.**
   - The Ministry of Health and Long-Term Care delegates greater flexibility to the Local Health Integration Networks for allocating funding to improve service delivery in alignment with the Quality Matters framework and the Quadruple Aim goals.
   - Funders ensure the Quality Matters framework is reflected in the language and letter of all contracts and funding relationships regardless of payment model, including physician compensation.
   - The Ministry of Health and Long-Term Care, Local Health Integration Networks, other agencies, and municipalities align current and future accountability metrics against health system performance measures that reflect the Quality Matters framework.
   - The governing boards of health care organizations review executive compensation structures to ensure the focus is on rewarding the provision of high-quality care as defined by the Quality Matters framework.
   - Funders of health information systems require organizations to use the data in those systems to advance quality improvement.

3. **Resolute leadership is focused on improving everyone's quality of care.**
   - The Ministry of Health and Long-Term Care, professional colleges and associations, health care organizations, agencies, and their boards ensure quality improvement is clearly understood as a critical component of the role of all care providers.
   - Health Quality Ontario and its partners produce standards for priority areas to support consistent quality improvement efforts at a local level.
   - Health care organizations engage with agencies and others to proactively identify and adopt resources and supports for quality improvement within their organizations, rather than developing new tools.

UNDERSTANDING QUALITY HEALTH CARE

4. **Measurement efforts support a relentless commitment to improvement.**
   - Health Quality Ontario ensures provincial measurement initiatives support health care organizations in setting quality improvement goals based on local performance and needs.
   - Health Quality Ontario measures and reports on the extent to which the health care workforce is trained and engaged in quality improvement activities.
   - Health care organizations ensure people working within their institutions are capable of understanding data and using it for improvement.

5. **Strategic measurement and reporting enhance transparency and promote quality.**
   - Organizations with data collection and reporting responsibilities work together to develop criteria to evaluate the appropriateness and importance of indicators, with the goal of ensuring that the purpose of collecting each measure is clear.
   - Health Quality Ontario convenes its partners to develop a method for using data to identify and monitor emerging health system issues for future inclusion in the Common Quality Agenda.
   - Organizations that hold and share data ensure providers have access to information needed to benchmark the quality of care, design improvement projects, and support patient engagement.
   - Funders of health information systems require those systems to work together within and across organizational boundaries in order to advance the effective delivery of evidence-based, high-quality health care for individuals and communities.

6. **Indicators reflecting shared responsibility for care are widely used across the health system.**
   - Health Quality Ontario, in collaboration with partners, sets standards and indicators for care that reflect a patient's whole journey of care rather than a series of encounters with individual providers.
   - Funders include indicators of effective patient care and transitions in recipients' accountability agreements.
   - Health care organizations include standardized measures of integrated patient care in their Quality Improvement Plans.

7. **Equity is central to every quality measurement and reporting exercise.**
   - The Ministry of Health and Long-Term Care supports the collection of data to enable routine measurement, analysis, and reporting of factors related to equity (e.g. ethnicity, language, income).
   - Funders require recipients to undertake health equity impact assessments for major projects and organizational strategies.

- Local Health Integration Networks evaluate and support providers' abilities to appropriately refer patients to services that address the social determinants of health.
- Health care organizations foster timely collection of patient-reported experience measures at the point of care and in the patient's language of choice.
- Health Quality Ontario and others ensure health system measurement and reporting reflect both overall performance and performance across the province's different populations.

8. **Quality measures meaningful to patients are consistently collected and widely shared.**
   - Health care organizations measure staff experience in a standardized way and report results at provincial and local levels to help improve both provider and patient care experiences.
   - All health care providers collect patient-reported experience and outcome data in a timely, standardized manner and ensure that information is used to improve patient care and experience.
   - Health care providers explore the use of social media and other innovative tools and tactics to capture point-of-care patient-reported experience data.
   - Health care organizations that publicly report on health system performance regularly engage with patients and the public to ensure their reporting is meaningful to that audience.

FOSTERING A CULTURE OF QUALITY

9. **Patients, caregivers, and providers are committed to a culture of quality that is fuelled by continuous learning from experiences of those who provide and receive care.**
   - Boards of health care organizations fully engage patients and caregivers in the selection and use of relevant and meaningful organizational performance measures and reports.
   - Health Quality Ontario and others educate and engage health care leaders – from governing boards to patients – to advance a culture of quality.
   - Health care organizations contribute to transparent reporting and resolution of patient complaints and concerns.
   - Health Quality Ontario ensures health care providers are involved in a productive process to learn from their own and each other's success and failures.

10. **A system-wide culture of quality with an unyielding commitment to improvement.**
    - Funders, agencies and health care organizations invest in additional quality improvement training, with a target of 50% of staff completing basic improvement science training.

- Health professionals' regulatory colleges and professional associations include leadership for quality improvement activities as a core competency and a key element of ongoing certification or licensure.
- Universities and colleges ensure clinical curricula include quality improvement as a competency taught to all students.
- Health care providers and other frontline leaders share both successes and failures as part of an overall commitment to improving the quality of patient care and experience.
- Through awards, public recognition, and social media, health care organizations recognize frontline quality champions and share their achievements widely throughout the health care system.

---

[1] Adapted from the Quadruple Aim.
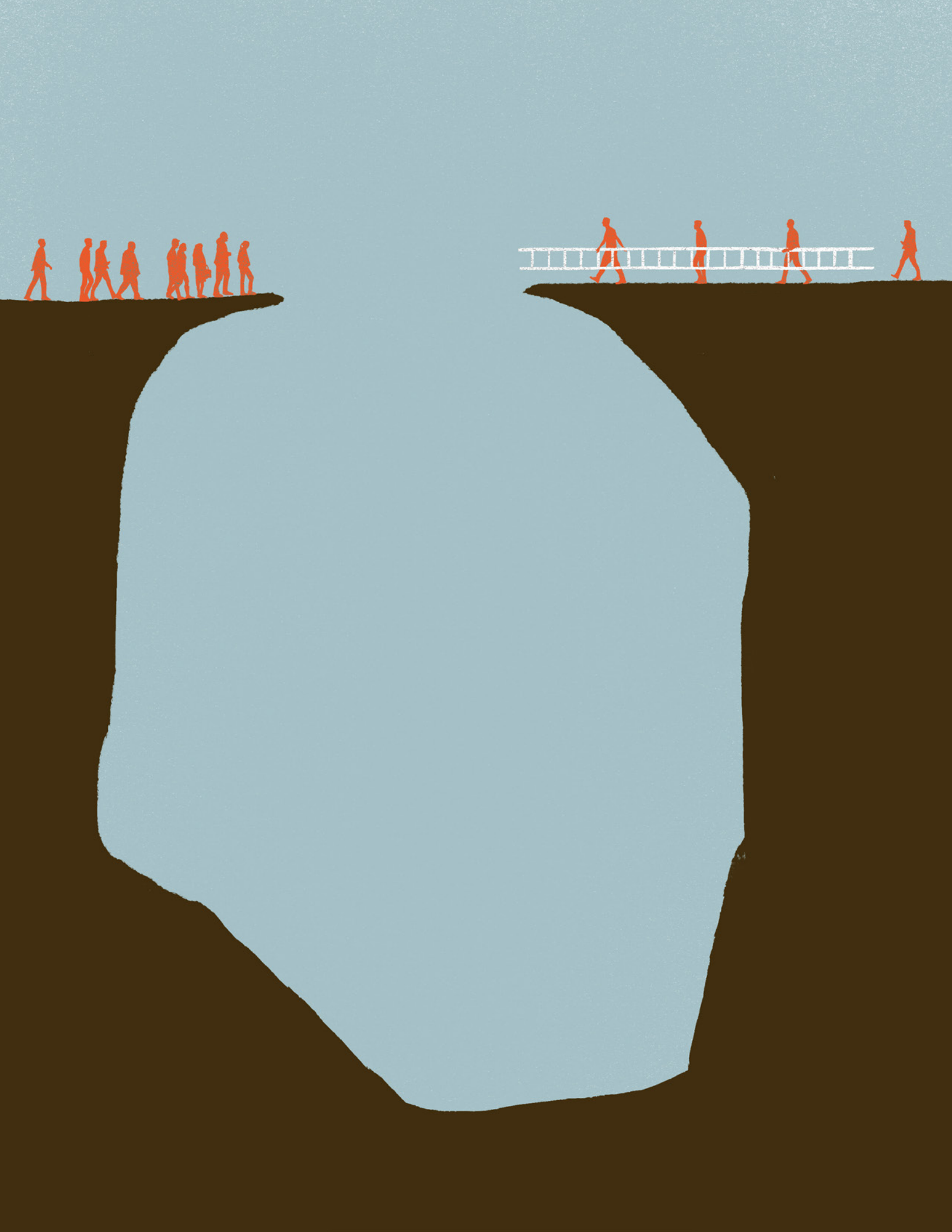
The Case For System-Wide Quality
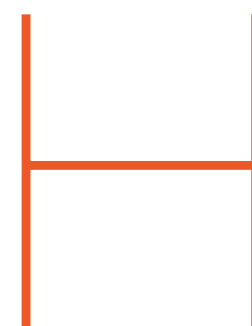
Health care quality is a challenging concept that is hard to put into words. But when quality is experienced, it is unmistakeable. When a patient receives the right treatment at the right time in the right setting, that is health care quality. When a primary care physician and a specialist are able to work in concert in the best interest of a patient, that is health care quality. When system funders and institutions have the timely information they need to craft evidence-based policies and procedures, that too is health care quality.

How well do these aspirations stack up against reality? Various surveys have shown that roughly three-quarters of Ontarians give the health system high marks, which mostly reflects their positive interactions with their own care provider. Indeed, there are legions of health care professionals who deliver excellent care, who develop and deliver new ways to treat patients, and who reach out to vulnerable populations underserved by the health system. Ontario has no shortage of committed champions making a difference.

From higher ground, a different view appears. Recently, a number of thoughtful studies were published on the state of the Ontario health system and the options for improvement: the Price-Baker report on patient care groups, the Donner report on home and community care, the Baker-Axler report on high-performing health systems, Auditor General assessments of Community Care Access Centres and Local Health Integration Networks, and numerous reports from Health Quality Ontario, notably *Measuring Up*.

From these reports emerges a health system that is not as equitable as we expect. There is a pattern of gaps in health care, gaps that carry significant negative consequences for patients:

difficulty accessing primary care[2,3]; long waits for speciality care; critical safety events in health care institutions; poor access to medically necessary prescription[4] medicine. Variations in care that, by any measure, are frightening to contemplate and that have tragic consequences for patients.

Given this evidence, the unmistakeable conclusion is that the Ontario health system works well for some people, with some conditions, treated in some institutions, at some points in time. That's situational quality, not systemic quality.

Situational quality has been the rule ever since quality management processes – similar to those that re-cast the auto industry, among others – were applied to the Ontario health system beginning in the 1980s. Initially, quality was seen through the lens of structure, process, or outcome. The issue at first was appropriateness – appropriateness of both a service and the setting in which care was provided. In response, institutions began reengineering processes of care and undertook Continuous Quality Improvement programs.

In time, a broader case for quality, encompassing additional dimensions of quality, started to coalesce. The safety dimension arose in reaction to challenging situations such as *C. difficile* outbreaks and an epidemic of adverse events. Patient experience – particularly how easily people move through the health system and have access to information – and equity – why certain patient populations are chronically underserved,[5] for example – were now acknowledged as important elements of health system quality.

Yet small-scale, incremental change to existing health processes – which marked the first wave of quality health care initiatives – simply will not get us to where we need to be. This realization has compelled governments to create agencies that would advance quality improvement in a more strategic, system-wide fashion. In Ontario, the *Excellent Care for All Act*, passed in 2010, created what is now Health Quality Ontario. As a result of the Act, each year hundreds of health care institutions submit quality improvement plans to Health Quality Ontario, identifying how they intend to achieve their long-term improvement goals.

Still, it has been tough to move from situational quality to systemic quality. Attitudes have been changing, but they have been changing for the past 20 years. The fact that there is not more to show for all the good intentions is understandable: a health system encompasses not only the "moving parts" such as hospitals and long-term care homes or patients, providers, and funders, but also the spaces between these parts – how they fit together and support one another. In those spaces live behaviours, habits, professional affiliations. Incentives and disincentives. Knowledge flows. Accountabilities.

Undeniably, these are significant challenges. Today, they represent the basis for the updated case for quality. This is a case for an integrated health system, one in which patients do not have to repeat their health history or undergo multiple tests that are unnecessary. It is a case for a health system in which:

- health care providers and leaders see a relentless commitment to quality as part of their roles and, in doing so, identify new ways of delivering their services, even

The fact that there is not more to show for all the good intentions is understandable: a health system encompasses not only the moving parts, but also the spaces between these parts.

if that means acknowledging their own shortcomings;
- health care organizations are oriented to the patient journey rather the structure of the current system;[6]
- policymakers, funders, and providers consider new models that challenge the status quo, and spread and scale up all of the innovative work and successful models being tested at local levels; and
- patients and their caregivers can navigate safely, respectfully, and efficiently through the health care system.

These aspirations will only be realized by taking a holistic approach to quality health care. G. Ross Baker and Renata Axler of the University of Toronto Institute of Health Policy Management and Evaluation, in their 2015 report *Creating a High Performing Healthcare System in Ontario*, said the first of 12 key attributes of high-performing health systems is a focus on quality and system improvement as the core strategy.

> *"Systems approaches are necessary for sustained improvement because they consider clinical workflows, care processes, and the overall environment clinicians practice in, as opposed to simply adding another task to a clinician's already heavy workload. Indeed, such approaches have become more essential as healthcare has become more complex, with larger teams needed to deliver care, increasingly complicated diagnostics and treatments, many settings where care is delivered (hospitals, out-patient clinics, in their home and community), and new services aimed at addressing the many factors[7] outside healthcare that impact health."*

In our explorations of system-wide quality care, we interviewed a number of thinkers in North America, Australia, and the United Kingdom. From these discussions, the new case for quality emerged in sharper focus. Previous cases have measured the gap between appropriate care in different settings and what is actually being delivered. This does not reflect the joined-up system that we now require. What is the best version of the Ontario health system, and how do we get there?

The new case for system-wide quality comes packaged with a number of knotty issues. These issues will be explored in greater detail elsewhere in this report; we provide a high-level view here.

HOW DO YOU CHART HEALTH SYSTEM PERFORMANCE WITHOUT LOSING YOUR BEARINGS?

Quality improvement experts all agree: Measures are essential to provide a system-level assessment of variations and gaps in performance. This is based on the well-travelled idea that if a process or outcome cannot be measured, it cannot be improved.

Yet it is a challenge to come up with a set of appropriate measures of health quality. Some, such as hospital mortality rates, are compelling yet difficult to use as means of comparison. Process measures, such as the percentage of patients treated according to clinical guidelines, can invite criticism because guidelines change as the evidence changes. It is also all too tempting to collect performance data on what is easy to measure rather than on what matters most to people using the system.

Data cannot tell the entire story of health system quality: they often fail to capture the lived experience of patients, providers, or health care workers. Yet the narratives in the numbers can spark engagement and drive change or be used as diagnostic tools. Transparency is key. "A plane crashes and everyone who flies wants to know why," says Michael Decter, a former Deputy Minister of Health for Ontario. "The National Transport Safety Board might spend $100 million figuring out why a plane crashed to see if it's preventable. Yet we have 20,000 people die each year due to avoidable errors in the health system and you don't see a public groundswell. The public needs more granular information and they need to hear from providers what metrics they're using."

What do we really know about the processes of care that produce higher quality?

And what should those metrics be? For people who rely on the health system, measures relating to patients' touch points with providers and institutions can build engagement in quality improvement; examples would be continuity of care,[8] medication errors, adverse events[9] (preventable patient safety incidents that result in serious harm[10] or death), or the responsiveness of a family practitioner.

Cathy Fooks, President and CEO of The Change Foundation, argues for measures that capture patients' experiences at each step of their journey through the health system: How smooth were the transitions between care providers?[11] How easy was it to access the care facility? Did the physician or staff deal with the patient's anxiety with empathy? Experience-based measures are on the rise as well: David Blumenthal, President of The Commonwealth Fund, points out that consumer ratings of physicians on social media platforms (such as Yelp for health care) are growing in popularity in the U.S. These measures have greater or lesser ability to speak to issues of quality; unfortunately, they are not really set up to help patients make decisions about their care.

By contrast, clinicians and administrators require a set of more comprehensive indicators that allow for greater depth of understanding of the gaps in processes, provision of care according to guidelines, or re-admission rates. And they need the information to be timely and well-packaged. Blumenthal describes it as "measurement and feedback of valid, reliable data to providers in real time," supported by widespread electronic health information systems that harvest relevant information and format it for feedback in consumable ways.

And for funders, indicators that reveal how efficiently the system is operating and how well payments and incentives are aligned with system functioning are key proof points.

There are plenty of data to sort through. The point is that purposeful and evidence-based choices need to be made around system-wide quality measures, and that data must be deployed to engage the right people in the right conversations.

Despite the lack of consensus on the ideal set of quality measures – or perhaps *because*

of it – there is a tremendous amount of performance measurement of Ontario's health system. And therein lies the dark side. For one, collecting all that data imposes a heavy administrative burden on providers and health organizations, and there can be pushback if the data being collected are not considered clinically significant. For another, it becomes increasingly difficult to separate signal from noise.

The challenge of transforming data into actionable information – trusted by patients, providers, and funders alike – is as pressing as deciding on the best performance indicators. How can measurement information be tied to quality improvement on the frontlines, to close the gap between what we learn from the data and what changes we actually make?

HOW DO WE GET OUR HEALTH SYSTEM FIT FOR QUALITY?

Health system improvement projects have a mixed record of success; a great many fail to take root after the first blush of excitement wears off. This is hardly surprising considering the typical demands of health care work environments. Research by Westyn Branch-Elliman, published in the journal *BMJ Quality and Safety*, quantified the resources involved in implementing one patient safety intervention aimed at reducing infections from the use of ventilators. In a study at a U.S. medical centre, he found that nurses spend an extra 115 minutes a day per patient to administer a ventilator prevention strategy. Almost one-third of the nurses reported that other patient care tasks were sometimes delayed because time was allocated to these potentially life-saving activities.

To replace existing behaviours with new behaviours, the "right" thing to do must also be the "simple" and "valuable" thing to do: we have learned that from psychology, behavioural economics, and change management.

That's not easy to achieve: a hospital ward or long-term care home is a complex environment. Integrating new processes and procedures into already stressed health care contexts requires sophisticated thinking and trial and error. Yet it can be a problem system leaders fail to see. Are frontline teams able to fully integrate the growing number of patient safety interventions? What do we really know about the processes of care that produce higher quality or how to create reliable care that does not consume a huge amount of resources? We do not even have good grounding on how to implement the innovations that have been scientifically proven to work. A classic case in point: hand hygiene rates are still disappointing even though proven best practices exist.

"We're stumbling in the investment in the science of improvement," says Eric Schneider, Senior Vice President for Policy and Research at The Commonwealth Fund. "How to do organizational management better, change them to be nimble and responsive, how to spread pilots, and professional training related to how to change processes and implement new ones. There's a resistance among professionals – it has to do with how they're trained and accountability."

Alongside greater research is the value of more broad-based education of frontline per-

sonnel and wider knowledge transfer. That requires system-level decisions to commit training resources and leaders to say, We know what we need to accomplish and how to get there. This is important for all of us. With greater capacity in quality measurement, health care teams can see for themselves how well they are doing rather than just measuring what they are compelled to, based on system requirements. That is when quality improvement becomes less about compliance and more about commitment.

A health system that has quality "fitness" also carefully aligns the funding streams and resource allocations to the quality outcomes that everyone desires. This may be the toughest challenge of all.

On the provider level, the fee-for-service payment model for medical doctors is very often seen as an impediment to quality improvement because it drives volume without necessarily driving the quality – particularly the appropriateness – of care. On the system level, payment models and incentives could have unintended consequences. A hospital, for example, can invest in Lean methods to redesign one of its units in order to reduce wait times and improve patient outcomes. The positive result could be that they perform fewer high-cost (and high-funded) procedures and a greater number of low-cost (and low-funded) physical therapy and telephone consultations. The negative result from this new mix of procedures could be reduced funding for that hospital.

These issues are not only financial in nature. They touch on the cultural dynamics of our health care institutions and must be managed with great care.

IF PATIENTS ARE TO BE TRUE PARTNERS IN QUALITY IMPROVEMENT OF THE HEALTH SYSTEM, WHAT SUPPORT WILL THEY NEED?

Management theorist Peter Drucker once wrote that quality in a service or product is not what you put into it but what the client or customer gets out of it.

So it stands to reason that a quality-first health system puts people – those delivering and receiving care – first. And, indeed, the dominant themes in Ontario health circles are patient engagement and patient-centred care. At the practice level, patients have important insights on what clinical interactions are working or not working, particularly in the area of doctor-patient communications.[12] On the system level, patient experiences can say a lot about poor hand-offs as they transition from, say, a hospital to long-term care home. The challenge is to make patient engagement more than just a check mark on a quality improvement plan.

As Cathy Fooks says, "Systems don't engage people, people engage people. Systems support engagement." A first step is for health organizations and providers to see patients as decision-making partners. That means bringing patients into the governance of institutions, particularly at the Local Health Integration Network level where system decisions are made.

Eric Schneider notes that a growing number of hospitals invite patients to serve as advi-

sors and are given important roles in the redesign process and policy development. "It changes the conversation and allows hospitals to accomplish changes that would be difficult otherwise," he says. This may require creating incentives for organizational leaders to embrace the vision and take the necessary tactical steps to bring patients and caregivers into the governance and care redesign process.

Many patient engagement efforts assume that patients and caregivers are motivated to share their experiences and are knowledgeable about how the health system operates. But this is not always the case. Many patients are uncomfortable sharing their experiences or speaking out against their physicians – David Naylor, physician and medical researcher, says "there's a lot of fuzzy thinking out there about fear of losing my doctor, and professional groups play into this to create alarm" – and patients may have little knowledge about funding, the management of long-term care homes, or how health care delivery is measured. The temptation for quality improvement administrators or system leaders is to continually turn to the same patient advocates who are comfortable in this environment rather than seek out a range of patient experiences.

The answer, many have said, is to give patients the tools to become active participants in care. "Quality improvement will be determined, to a great extent, by the capacity of people to engage meaningfully in their clinical interactions, to challenge doctors or support doctors with their capacity to understand what is it that they're supposed to gain from that clinical encounter," says Jean-Frederic Levesque, chief executive of Australia's Bureau of Health Information. "It does require an effort towards health literacy and more meaningful engagement in care. It's not just a delivery issue."

As with many issues in system quality, greater patient involvement faces cultural hurdles within the system itself. "We need a total culture shift where providers of care realize that they're doing it for patients and that it's actually paid for and provided for patients," says Deb Matthews, Ontario's Deputy Premier and former Minister of Health and Long-Term Care. "The patients are the bosses. That's the direction we need to go."

WHAT TYPES OF LEADERS ARE NEEDED TO DELIVER ON THE PROMISE OF BETTER QUALITY IN THE HEALTH CARE SYSTEM?

It is hard to wrap your arms around a health system. It is perhaps one of the most complex workplace social systems we have: highly decentralized, with dispersed powers and loose accountabilities, strong cultures occasionally in conflict, invested in matters of life and death. In such systems, change does not come easily or quickly, if at all. When change is needed, what sorts of leaders can make it happen?

Many different kinds of leaders, operating in clinical, administrative, and policy capacities. Certainly people for whom performance improvement and innovation are instinctual,

> **The challenge is to make patient engagement more than just a check mark on a quality improvement plan.**

strong communicators with an appetite for change and the ability to feed that appetite in others. Immensely important is the ability to see the big picture beyond their own organizations and to translate the values and expectations of the health system. They are the ones with the responsibility to educate patients and taxpayers on the reasonable expectations of quality within the system.

Unfortunately, system planners cannot truly direct large parts of the system, and many of those in leadership positions do not necessarily have the levers to impose new quality improvement processes or other initiatives themselves. "As leaders in the health system, we think we can change people just because it's important to us, and that just ain't happening," Chris Power, Chief Executive Officer of the Canadian Patient Safety Institute, told us. "The best way I found to help people to change their behaviour is tap into their feelings."

As leaders in the health system, we think we can change people just because it's important to us, and that just ain't happening.

For many, it begins with clarity of vision: the ability to communicate that clarity in an ever-shifting hospital or long-term care environment is a valuable asset. Helen Bevan, Chief of Service Transformation at the National Health Service (NHS) Institute for Innovation and Improvement in the UK, says this can be one of the most significant barriers to successful quality improvement initiatives, a barrier that can only be dealt with by an unwavering and relentless pursuit of "what's in front in us" – the pursuit of quality care. "When you're at the top of an organization it's very clear," she says, "but at the frontline there are 50 or 60 strategies, and politicians or leaders continue to institute new plans or priorities. It can be hard to determine how they fit together, where to focus your energies. In a crowdsourcing exercise with 1,400 clinicians, this was what they reported as the biggest problem."

Institutional and organizational leaders will also have to cast their vision outwards, using their systems thinking and relationship management skills to make connections with other parts of the health system. Breaking down barriers between primary care and specialist care holds great potential for quality improvements. A system leadership "SWAT team" that includes community and patient advocacy leaders is one way to pool resources and knowhow for shared outcomes. Linking leadership in new ways can midwife creative approaches to building a quality health system in Ontario.

MAKING THE CASE STICK

The new case for health system quality means different things to different audiences.

If you are a patient, why should you care about system-wide quality? The terms "quality" and "system" may not have meaning to you; you put your health in the hands of your family practitioner, the local specialist, or the community health care facility and assume you will be treated properly.

"Quality" may not be an easily relatable term for patients. "The only times I've heard people actually talk about quality in the way we traditionally define it is when they get an infection during a hospital stay," says Deb Matthews. "Then they know that that's poor quality. It's kind of sobering."

In fact, patients should care deeply about system-wide quality. If you are a victim of a traumatic event while travelling elsewhere in Ontario, you want to receive the same high-quality care as you would if you were at home. When you transition from your family practitioner to a specialist, you want to do so with confidence that your medical information will flow seamlessly between the two. When you are discharged from hospital and require follow up, you want aftercare to be available without having to chase it down. You want the "system" to just work efficiently so that you don't have to wait so long[13] for appointments.

This case can be driven home with proof points that have meaning for patients, at the level of the health system with which they can identify. Examples may be: patients' reports on the timeliness of care and service they received from their primary care providers or the provision of care instructions upon hospital discharge for certain conditions. When this evidence is combined with comparable data from other communities in the province, patients would either see the need for change or be reassured that they are receiving quality care.

System-level data certainly do play a role in patient understanding; the commitment to transparency builds engagement and confidence that quality is a priority. But the aggregate measures of system quality "are mathematical constructs that average local variations and it's the local variation that is the reality, not the average of those experiences," says Diane Watson, Chief Executive Officer of New South Wales Bureau of Health Information in Australia.

The case for system-wide quality should be easier to make to providers and health care organizations and funders; they live with the issues of quality improvement, measurement, and gaps every day. For them, system quality means being able to offer their patients better care and better experiences and being reassured that public funds are being used wisely. It means being empowered to have a hand in designing a practice or process that leads to better outcomes all around. It means more efficient practices, with more resources devoted to quality care. And it means greater trust in our institutions and governments that the data being collected have real meaning in a clinical setting.

All this may be true but the message does not always hit home. Professional or "guild" mentalities and a focus on hitting local targets or benchmarks can inhibit providers and organizations from paying attention to the implications of their actions on the entire health system. Leadership plays an important role here in helping change the horizon and nature of planning.

● ● ● ●

One of the unfortunate features of the discussions around system-wide quality care is that the issues traditionally tend to be framed in negative terms. Ontario's health system does not perform[14] as it should. There are gaps in care that can have serious consequences for patients. We must collect more and more data to shame providers, if necessary, into complying with standards of care.

The real shame is that quality care isn't more often seen as an exciting opportunity to push and pull the health system to an even higher level, especially in light of the respectable investments currently being made[15]. It's an opportunity to work together – patients alongside

providers and funders – with enthusiasm and confidence that we'll get it right, one way or the other. "A killer of change is losing the aspirations [for excellence]," says Deb Matthews. "That can happen in many ways so you've got to bring people into quality improvement and [share the] the joy that comes with seeing these measurable improvements."

Helen Bevan's observation that health systems have tended to replace shared purpose with de facto purpose is critical to understanding how to rebalance our system. You could understand how it can happen quite innocently. Leaders send out signals about what matters – that they have to hit a certain target, such as ensuring that 95 percent of patients should be in and out of Emergency within eight hours – and they communicate these priorities to frontline staff and providers. *You have to hit this target or else.* The danger in making it all about the target is that you risk losing the larger point: that all Ontarians want a health system that deals with every patient effectively and quickly. "This is toxic because it stops us from connecting with the values that drive our colleagues to do their best," Bevan says. "We're taking the meaning out of the change."

Somehow, we must find a way to capture and channel that sense of shared purpose and affiliation – the responsibility that we have for one another – that will resonate with patients, providers, and funders. This shared purpose can help patients get over the discomfort of being full partners in improving health care and providers get over the discomfort of possibly losing some control or status.

We have everything we need to make it happen. The reports have been written that have clearly identified the challenges. We have data – more data than we know what to do with. There's no shortage of pilot projects that prove the concept in a hundred different ways. It's that last mile of change – past situational quality and towards systemic quality – which we must travel.

We hope this report will show the way.

––––––––––

[2]   Canadians and Ontarians report the worst access to same-day and next-day appointments with their primary care providers among 11 countries surveyed:
Canada 30%
Ontario 40%
United States 33%
Germany 72%
(Commonwealth Fund International Health Policy Survey of Primary Care Doctors (2015)

[3]   94% of Ontarians have a primary care provider
44.3% of adults report they are able to see their primary care provider on the same day or next day if they are sick,
52.4% report it is very or somewhat difficult for them to get evening or weekend access to primary care without going to a hospital emergency department *(Measuring Up, 2015).*

[4]   Roughly 1 in 10 Canadians do not fill prescriptions because of the cost.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3281154/

[5]   A 2007 Street Health survey in Toronto found that 59% of the 368 homeless adults interviewed did not have a family doctor. Barriers include not having health insurance, difficulty making appointments, fear of discrimination from health care providers, lack of transportation, long wait times, and choosing other priorities (such as food and shelter needs) over health care.

[6]   In 2014, the Ministry of Health and Long-Term Care mandated that all Ontario hospitals involve patients when creating quality improvement plans" Health Debate http://healthydebate.ca/2016/02/topic/hospitals-patient-engagement However, of those hospitals that include patient satisfaction in their Quality Improvement Plans, there is still significant variation: http://www.hqontario.ca/Portals/0/documents/qi/qip-hospital-analysis-2015-2016-en.pdf

[7]   The poorest people in Ontario are nearly twice as likely to report having multiple chronic conditions as the richest people–23.5% compared with 12.4% and 16.2% for Ontario overall. http://www.hqontario.ca/Portals/0/documents/system-performance/health-equity-report-en.pdf

[8]   In Ontario, 45% to 60% of patients with chronic conditions receive a high continuity of care. Patients are rated as having received a high continuity of care when at least 75% of patient visits are with the same care provider. OHIP 2011/2012

[9]   In 2000, the overall rate of adverse events was 7.5 per 100 patients admitted, not including pediatric, obstetric, and psychiatric admissions. Approximately 185,000 of the 2.5 million similar medical and surgical admissions in Canadian hospitals in 2000 were associated with an adverse event; 65% of adverse events resulted in no physical impairment or disability, or minimal and moderate impairment, with recovery in under a year's time. Forty-six adverse events were associated with the death of 40 patients, suggesting that 1.6% of people hospitalized in Canada died following an adverse event in 2000.
Baker, G. R., P. G. Norton, et al. 2004. "The Canadian Adverse Events Study: The incidence of adverse events among hospital patients in Canada". CMAJ 170 (11): 1678-86.

[10]   The rate at which a foreign body is left inside the body during a procedure per 100,000 medical and surgical discharges (age 15+) in Ontario is 6.7, lower than the Canadian rate of 8.6 but higher than the OECD average. International Comparisons: A focus on the quality of care CIHI DAD, 2010 to 2012, CIHI; MED-ÉCHO, 2011, MSSS. OECD Health Data 2013.

[11]   36% of Ontario family doctors say it's easy or very easy to coordinate patients' care with social services or other community providers, very low in comparison with other countries/provinces.
http://www.hqontario.ca/Portals/0/documents/system-performance/connecting-the-dots-report-en.pdf

[12]   66% of Ontario primary care physicians report using an electronic medical record compared with:
97% of UK physicians
97% of New Zealand physicians
98% of Netherlands physicians
92% of Australia physicians

Source: Institute for Competitiveness & Prosperity analysis based on Commonwealth Fund International Health Policy Survey of Primary Care Physicians (2012) and eHealth Ontario

[13]   Proportion of patients in Ontario receiving care within the determined Waiting Time benchmarks (2015):
Hip replacement – 87%
Knee replacement – 86%
Hip fracture repair – 88%
Radiation therapy – 99%

Source: Canadian Institute for Health Information (2012) and Wait times in Canada – A summary (2015)

[14]   Canada's health system efficiency is estimated to be between 0.65 and 0.82; if all regions were perfectly efficient, between 12,600 and 24,500 premature deaths could possibly be prevented in Canada.
Source: Canadian Institute for Health Information

[15]   Canada and Ontario are among the top spenders on total per capita health care spending in the OECD with spending 36 and 33 above the OECD average, respectively, ranking 6th and 9th out of 34 countries. (Institute for Competitiveness and Prosperity Analysis of OECD Health Data (2013)

Quality Matters:
A Health System
Quality Framework

What does it mean to "improve the quality of health care"? It means achieving better health outcomes and better patient experiences in a sustainable manner. This involves refining processes with an eye towards greater efficiency, easier navigation, faster and smoother adoption of innovation, and smarter resource allocation. It also means paying attention to all of the patients in our province, regardless of ethnicity, income, or place of residence, and making sure that health care is organized according to their needs, not the habits and history of our health care system.

By this definition, we know Ontario's health care system is capable of better performance. We are already seeing it. Local innovations are evidence of ingenuity and a changing culture that values quality. These improvements make our system more responsive to patients' needs and have led to better outcomes. Yet they also expose a key weakness in the Ontario health care system: without a common operational framework for defining and focusing on quality across the board, quality initiatives remain uncoordinated with limited impact. The Health Council of Canada put its finger on the challenge:

"Many leaders said that at the start of their efforts, quality improvement was typically a collection of piecemeal work in the province, often driven by well-intentioned

champions. These efforts typically led to "islands of innovation" and "pockets of leadership" but lacked a coherent, coordinated approach."
– Health Council of Canada, in *Which way to quality? Key perspectives on quality improvement in Canadian health care systems (2013)*

Imagine what could be accomplished by adopting a more coordinated and systematic approach to improving quality across all life stages, all diseases and conditions, along the entire continuum of care – from prevention, treatment of acute illness, management of chronic conditions, to end-of-life care – and across the province. If we could transform the parts of our health care system into a true system, all Ontarians would benefit from a consistent level of high quality care. Islands of innovation would come together into consistent excellence.

Building a pervasive culture of quality in our health care system does not happen without a coherent and widely accepted framework. This framework must:

- Act as a touchstone for policy-makers and funders as they set priorities and plan for the system;
- Serve as a guide for clinicians, managers, and system leaders in the planning and delivery of care and services; and
- Resonate with patients and their families, building their confidence in the health care system's commitment to improvement.

The Health System Quality Framework is made up of a number of elements: a definition of quality grounded in the core dimensions that focus on improvement; a vision that guides the setting of goals; and principles to help with decision-making. The following section presents these elements in greater detail.

PUTTING THE PIECES IN PLACE

Ontarians rely on the support of the health system to get a strong start on life, to stay healthy by preventing chronic illnesses or detecting disease early, to recover after an acute illness or injury, to live well with a chronic condition, and to receive individualized and appropriate end-of-life care.

Health services should be provided, to the greatest extent possible, when and where the patient needs them. This includes the individual's home when appropriate, in the community (for instance, in a primary care setting or community clinic), or in an institution such as a hospital, nursing home, hospice, or rehabilitation centre. No matter where health services are provided or who provides them, these services are part of the health care system. Ontarians should expect and be able to rely on high standards of quality care.

Defining Quality

Currently there is no widely accepted singular definition of a quality Ontario health care system. The preamble of the *Excellent Care for All Act*, enacted in 2010, moves us closer to a common definition by articulating these areas of focus: *"A high quality health care system is one that is accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focussed, and safe"*.

Health Quality Ontario has, in the past, employed a definition that includes nine slightly different dimensions of quality. Although these dimensions are important, driving towards a pervasive culture of quality requires a more streamlined operational definition of quality. In order to focus on key areas, the definition used by the Institute of Medicine (IOM) serves us better. The IOM defines six aims of quality care: safe, effective, patient-centred, timely, efficient, and equitable. This definition reflects the shift from viewing quality of care as the responsibility of individual providers and institutions to a system responsibility. It is a definition that focuses foursquare on improvement.

> ### Definition of a High-Quality Health System
> A health system that delivers world-leading safe, effective, patient-centred services, efficiently and in a timely fashion, resulting in optimal health status for all communities.

The IOM definition offers a number of advantages. It widely overlaps with definitions used by other groups in Ontario and in other jurisdictions, thus ensuring the ability to benchmark and set targets against these jurisdictions. Indicators are available to measure quality in these dimensions, and these indicators are affected directly by health service provider activities. The six dimensions offer a focused way to engage clinicians, administrators, providers, and patients in our health care system. And they allow for nuanced meanings that speak to patients and providers, as Table 1 shows.

Table 1: Defining elements of quality care		
Element	**Patient meaning**	**Provider meaning**
Safe	I will not be harmed by the health system – physically, emotionally or otherwise.	The care my patient receives does not cause the patient to be harmed.
Effective	I receive the right treatment for my condition, and it contributes to improving my health.	The care I provide is based on best evidence and produces the desired outcome.

Patient-centred	My goals and preferences are respected. My family and I are treated with respect and dignity.	Decisions about my patient's care reflect the goals and preferences of the patient and his or her family or caregivers.
Efficient	The care I receive from all practitioners is well coordinated and efforts are not duplicated. The value of my time is respected.	I deliver care to my patients using available human, physical, and financial resources efficiently, with no waste to the system.
Timely	I know how long I have to wait to see a doctor or for tests or treatments I need and why. I am confident this wait time is safe and appropriate.	My patient can receive care within an acceptable time after the need is identified.
Equitable	No matter who I am or where I live, I can access services that benefit me. I am fairly treated by the health care system.	Every individual receives high quality care that is fair and appropriate to them, no matter where they live, what they have, or who they are.

SETTING A VISION FOR QUALITY

When building a culture of quality in health, a coherent vision acts as the North Star. The vision below references the six defining elements of quality discussed in the previous section. While the defining elements lay out the working parts of a high-quality health care system, the vision is an aspirational statement about the health care system we want.

> **Vision for Quality**
>
> Ontario's health system is world-leading in delivering the best outcomes across all six dimensions of quality. Our health care system is just, engages patients and families, and is relentlessly committed to improvement.

ESTABLISHING PRINCIPLES TO SUPPORT A CULTURE OF QUALITY

On the journey to building a culture of quality in Ontario's health care system, each step will need to be tested against a set of guiding principles. Here are seven guiding principles to keep front and centre.

1. It is focused on improving quality.

The proposed framework for a high-quality health care system is about more than improving discrete services or outcomes. In order to have system-wide impact, efforts to improve quality must have a broad focus, both in terms of the full range of quality dimensions and across sectors, to reflect the patient journey. Outside of the *Excellent Care for All Act*, the idea that the health care system is focused on continuous improvement is not usually reflected in public policy. Quality improvement has been seen as an issue of culture or structure relating to organizational dynamics; public policy, by contrast, has focused on processes that do not often translate into changes on the ground. System-wide change will require public policy to reflect the quality agenda.

2. It is about health, not just health care.

When we talk about the health care system, too often the focus is on taking care of people after they become ill. A health care system focused on quality must be concerned with preventing illness – through health promotion and illness prevention – just as much as with treating illness. It must acknowledge the importance of the many factors that shape an individual's health, and of adopting a "health in all policies" approach that takes into account health implications across sectors. Although the system remains focused on health care and population health interventions, it should look for opportunities to engage the broader social services system. Socioeconomic status, early childhood experiences, social support, and people's physical environment among other factors are important influences on individual well-being and health status. A health care system with quality as its focus will build alliances with other sectors in order to best serve the needs of patients.

3. It is accessible to everyone.

Our health care system must strive to meet the health needs of each resident of Ontario. Currently, the focus is on improving care for patients accessing the system. Meeting the health needs of those who cannot access the health care system as easily is often neglected. If we are to commit to continuous quality improvement, we must provide access for all, regardless of how far patients live from where the services are provided, what language they speak, their health status, or other socio-demographic factors. Programs and initiatives must take into account issues of equity, address them where possible, and avoid contributing to barriers to access for marginalized populations.

4. It is responsive to the needs of the patient.

As we build a culture of quality, we need to re-imagine our health care system in partnership with patients and families. Patients and providers alike feel the effects of the disjointed nature of the system. Communication between hospitals and primary care, for instance, continues to be a challenge to the detriment of patients and the frustration of their providers. We know that fewer than half of patients who need to see a primary care provider after leaving the hospital do so within seven days. Rates are particularly poor for mental health patients. True system

integration, so long talked about, remains an elusive goal. At a mature state, our system should facilitate patient and provider roles so they could achieve common goals.

5.   It achieves a balance among competing priorities.

Strategies for improving our health care system must consider safety and effectiveness, accessibility, and patient experience while also maximizing efficiency and equity. Although these priorities may appear to be in competition, it is not always the case. There are many examples in our system that demonstrate how delivering higher quality care can actually contribute to more efficient operations or more equitable outcomes. Although some goals may take longer to realize than others, improvement efforts need not neglect one dimension at the expense of those that are harder to change or take longer to show improvement.

6.   It does not depend on the infusion of new funding.

Neither the public nor elected officials are interested in allowing the health care budget to compromise the ability to deliver other public services. Indeed, the high per capita spending in Canada relative to other developed nations does not appear to have resulted in superior health status. With little or no new money invested, a re-allocation of existing resources is called for. Scarce financial and human resources need to be directed to the areas of greatest impact on patient outcomes according to the best evidence. Reducing medical errors, strengthening supports for health promotion, prevention, and screening, and improving care coordination are investments that can lead to better patient experiences and health outcomes and bigger system savings.

7.   It requires fundamental change.

Making the leap to a system that puts quality first will require fundamental changes in how services are delivered and funded. Stimulating system-wide quality improvement will lead to challenges in the areas of governance, infrastructure, and funding among others. Policy initiatives such as Patients First: Action Plan for Health Care have created an opportunity for the system to pursue a quality agenda by ensuring that, as the system evolves, it puts patients first, focuses on better outcomes, and is based on the best available evidence. Yet, where quality has been made the main focus, it has often been due to the extraordinary efforts of health professionals who go beyond their day-to-day responsibilities to advocate for a specific improvement. A health care system focused on quality should support these visionaries by removing the barriers that prevent improvements and innovations from spreading across the province.

BUILDING A QUALITY SYSTEM: WHAT MUST WE DO TO MAKE IT HAPPEN?

The delivery of high-quality health services depends not only upon operationalizing the definition of "high quality" and the principles of a quality system but on harnessing key social and material assets. Here are a number of key factors that go into the building of a culture of quality.

Engage patients and the public

If our health care system had been designed with patients front of mind, we would not have the system we have today. Patient perspectives can be powerful enablers of change. For patients, being heard can influence their levels of satisfaction with the health care system and may affect their health outcomes (Baker, CFHI August 2014). What is meaningful engagement? How can patients best be kept at the forefront of decision-making and system design? How can we effectively share health system information with patients in easy-to-understand formats? What do patients value? How do we reach those who are the most difficult to reach, ensuring no perspective is marginalized?

Evolve into the right structure

We have long wait times for consultations and treatments. Patients use crowded emergency departments for non-emergency care. These are signals that the design of our system does not support high-quality care. Setting a new path will involve changing the way the system is organized, accepting that resources will need to be realigned and investments prioritized differently than in the past. In what ways does the design of our health care system have an adverse effect on quality? Is accountability for quality built into all health care organizations? Do we have the right mix of services in the right place to serve the needs of different communities? Are the strategic priorities of health services providers aligned? This is where the quality framework can be a useful diagnostic to help identify areas where the design of the system is getting in the way of better quality. Although attention to quality does not include all health policy questions, we can make quality a critical lens that can identify health policy issues that need to be addressed.

Enable people to deliver the best care

At its core, health care is about people caring for people. Building a culture of quality will involve supporting the innate drive of health care providers to do the best they can for patients. It requires us to ask: Do all frontline staff have the knowledge, skills, and support to improve the care they provide to their patients? Is executive-level capacity being developed to provide effective leadership in all areas of the province? Are all health professionals working to their optimal scope of practice? Is the scope of practice comparable to other jurisdictions that are leaders in patient access, satisfaction, and health outcomes? Are we breaking down organizational silos and designing workplace environments that support the delivery of effective care? Are we helping our health professionals to work in inter-professional teams?

Ensure technology works for us

Information technology is one critical enabler to better and more coordinated care. But that involves placing quality first as we enable patients and clinicians to connect virtually, and use technology to support a better patient experience and better health outcomes. Quality also needs to be the key consideration as health information systems are leveraged to plan and deliver health services. How will the wealth of information be organized and shared to support

our quality goals? Electronic health records provide a complete medical and personal history of the patient that can be shared securely with all health service providers and with patients. How do we ensure these records are designed to help deliver the best quality outcomes? What tools can be introduced to support better service provision and decision-making for health service providers? How do we know which tools provide the best quality returns on investment?

Support innovation and improvement

Innovation keeps us ahead of the curve and can support high quality in any aspect of the health care system. It can touch clinical practice, how care is organized, where care is delivered, and how care is purchased (such as when it is appropriate to pay for outcomes rather than services). A high-performing health care system encourages and nurtures research and innovation and learns from other jurisdictions and even industries. Many of Ontario's areas of excellence within the health care system are the direct result of the creative and dedicated efforts of a small number of individuals with a passion for improving the system. How is innovation currently supporting quality in Ontario? Are there dynamics discouraging innovation or the system-wide spread of promising innovations? Do we have the right model in place to assess new innovations and to know which ones offer the most promise? Are there areas where a strong and coordinated provincial effort is needed to drive improvements?

Monitor performance

To know whether or not our health care system is moving in the right direction and to drive further improvement, we need to ask foundational questions: What is "good quality"? How do we choose the right goals and targets? Do we need to develop new indicators? Monitoring the performance of the system through the lens of quality demands attention on at least five fronts: one, articulating best practices that define a high-quality health care system; two, identifying the most meaningful quality indicators and attaching clear performance expectations; three, collecting and analyzing data to measure performance against the indicators; four, reporting results in timely and transparent fashion in a way that stimulates improvement; and five, comparing results within Ontario to other jurisdictions and over time. That way, we can show both what is possible and the progress we are making.

Nurture cultural change

Achieving a "quality first" health system will require a significant shift in the culture of health care in Ontario to become a more patient-centred system in which patients are co-designers. The broader adoption of inter-professional teams, so important in developing quality health services, will compel clinicians to learn to work in different ways. Accountability in Ontario's health care institutions is already moving to focus on outcomes relating to quality rather than just financial obligations, thanks to provisions of the *Excellent Care for All Act*. But there should be no illusion: successfully introducing solutions that require collaboration and trigger change across traditional organizational and professional boundaries is always challenging. The system

can manage the tensions by agreeing on common quality priorities and recognizing professional and personal needs of service providers. Going forward, key questions will be: What are promising models, tools, or strategies for embedding quality into the culture of our health care organizations? How do we balance accountability for quality with building a culture of quality? And how will we know we are succeeding?

Delivering Quality Care

The quality of a health system is most keenly felt at the point of delivery. What is the experience of a distressed father waiting in Emergency for his child's cut to be stitched? Or a patient from a First Nations community receiving cancer treatment far from home? Or a daughter arranging for home care for her mother who suffers from dementia? These interactions appear to have a beginning, middle, and an end; surely it would not be so difficult to say what is quality health care and what isn't.

In truth, there is so much else at play behind these episodes. They can point to successful outcomes – timely attention to a medical problem, sensitive care by an empathetic doctor, access to the right treatment – yet they would still not provide a meaningful picture of a health system that delivers on its quality promise. We have to go deeper: Does the system deliver quality consistently, no matter where we live or the medical challenge we face? Do we receive treatment based on the best available evidence rather than on a conventional approach shown to be outdated? Are all providers oriented to our needs as patients or do we feel our provider's time and interests are more important than our own?

Elsewhere in the *Quality Matters* report, we have shown that Ontario's health system, from the perspective of quality, falls short of our aspirations. These findings are not random; they are the result of a system designed to deliver care to a younger and less populated province, during a time when resources were seemingly more plentiful and technologies not as pervasive and expensive. It has evolved by following the path of least resistance. Predictably,

the result is a health system in which quality and a focus on patients are not fully embedded but inconsistently added after the fact.

Delivering the level of quality care to which we all aspire is within reach, but there are significant barriers. Some are historical: a system resistant to change, set up for acute care yet needing to pivot to chronic disease prevention and management and the requirements of an aging population. Some are political: finding the appetite to change and the willingness to have fierce conversations with important groups. Some are systemic: institutions acting as a collection of silos and inhibiting coordination and cooperation. And some are organizational: units following conflicting priorities and having underdeveloped leadership teams.

The barriers to better delivery of quality care are not insignificant. But they can be overcome. The challenge is to move from the static to the dynamic, introducing fluidity so that all parts of the health system can support the flow of the patient journey, so that medical information and feedback can be mobilized and accessed by the right people at the right time.

> **For a health system, the goal of alignment is to deliver quality outcomes consistently.**

How can this be achieved? Partly by focusing energies on three key dimensions often cited as points of vulnerability for Ontario's health system: alignment, accountability, and leadership. These are the three foundational pieces that support the delivery of quality health care.

- Without better alignment among providers, patients will continue to fall into gaps in the system and providers will waste precious energy and resources.
- Without stronger accountability to creating value, we'll only talk the language of quality care but not realize any gains.
- Without resolute leadership within enabled governance, we will lose our focus and miss opportunities to improve care for our citizens.

A truly integrated system, supported by effective incentives and performance measures that are respected and clear-eyed leaders committed to a culture of continuous improvement – together, these goals offer the richest payoff for delivering higher quality care in Ontario.

ALIGNMENT: MENDING THE GAPS

The next time you notice geese or other birds flying in V-formation, consider the lesson they offer in alignment and design. For them, energy efficiency during flight is paramount; to reduce wind resistance and conserve energy, each bird flies above the one in front, taking advantage of the vortex of air that is generated. Typically, the birds take turns leading the way and doing the heavy flapping. Flying in V-formation also boosts communication and coordination and makes it easier to keep track of all members of the flock.

Fighter pilots have learned this lesson well. So have many organizations that have successfully followed the winds of change. These are organizations that are flexible and able to stay one step ahead of others: their strategy and goals provide a shared purpose and focus and are widely understood by employees, suppliers, and partners.

A health system is a more complex environment than a single organization, and not only because of scale. Actually, it is less of a "system" than a constellation of institutions and professional groups that may overlap or compete with one another, motivated by differing incentives and delivering disparate outcomes.

For a health system, the goal of alignment is to deliver quality outcomes consistently. All key groups in a health system – funders, providers, institutions – need to work with consistent focus on shared priorities, proven practices, and evidence-based standards. Impossible to imagine? Not really. Ontario's Wait Time Strategy is successful alignment in action. Originally developed to improve access to five key health services by reducing wait times for cancer surgery, cardiac procedures, cataract surgery, hip and knee replacement, and MRI and CT scans, it has since expanded to include all surgeries and time spent in emergency rooms. Wait times have generally improved for medical services, though some areas, such as the time it takes for a patient to have an initial consultation with a specialist, need further improvement.

What lessons can be drawn from this experience? The Wait Time Strategy clearly laid out quantifiable quality goals, marshalled considerable funding and information technology to support the strategy, tweaked governance structures to bring together various parts of the system, and created a system of accountability through transparent reporting of wait time information and targeted funding. The strategy directed all these efforts towards addressing a compelling quality care need of a specific population of Ontario patients. In words and deeds, it carried a sense of urgency.

What if the same sense of urgency were to be summoned for the goals of the health system as a whole? To bring the elements of the system into better alignment, where would we start?

BETTER INTEGRATION

An obvious place to start would be to introduce the connective tissue that would close the many gaps that now exist within the health system. The gaps are self-evident and well-documented in previous reports: between primary care physicians and specialists, between hospitals and

community care, between social support organizations and community care. Municipal and provincial roles in health care can benefit from stronger connective tissue as well.

This is clearly the direction in which Ontario is headed. Many studies, most recently the Price-Baker report, and the *Patients First* legislation, passed in December 2016, call for bringing primary health care providers, hospitals, and home and community care together under the umbrella of Local Health Integration Networks.

Integrating health care providers is only half the alignment story; the other side is orienting the system around patient needs. There are already innovative ideas that have been tested in Ontario that address the lack of communication with patients or the need to work together as a team with a focus on patients.

A more integrated health system offers multiple benefits to patients and providers alike. With better communication among primary care providers and specialists, the plan of care and patient and caregiver roles are better understood and supported. Practitioners working together – from physicians and nurses to pharmacists and case managers – can pre-emptively identify care issues. And inevitably, providers develop a deeper appreciation for how they fit into the larger system. They can see that other providers or institutions are equally committed to delivering quality care in their own ways, and may even have lessons to offer.

ALIGN WITH POPULATION HEALTH AND QUADRUPLE AIM IN MIND

Increasingly, health systems are moving toward a population health approach to delivering health care. The approach is similar to how marketing strategists segment their audiences. Population health focuses on designing care for specific groups of individuals with similar health care needs and attends to their overall well-being. It involves taking proactive measures to help keep individuals living well and avoiding crises that rely upon care at emergency departments.

A population health approach is sound policy from an equity perspective. It is also sound management from a quality or value perspective. Delivering health care with population health in mind drives resources from across the spectrum of services to high-need patients who are most vulnerable. Some 90 percent of Ontarians require few medical interventions; for them, virtual care models and more convenient community-based health care are convenient options. Other groups of patients – say, diabetics in Northern Ontario or homeless people in Ottawa – have more intensive needs and would benefit by more targeted approaches.

Population health is one dimension of the Quadruple Aim view of health system alignment. Drawing from the important work of the U.S.-based Institute for Healthcare Improvement on the Triple Aim, Quadruple Aim calls for simultaneously enhancing the experience and outcomes of patients, reducing per capita cost of care for the benefit of communities, improving the health of the population, and improving the experience of those providing care. These interdependent goals require continual improvement in all four dimensions, which requires ongoing calibration. Ideally, Quadruple Aim also requires what American health care leader Donald Berwick describes as an integrator, an entity that accepts responsibility for all four dimensions of the Quadruple Aim for a specified population. The integrator's role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro-system integration (bringing a multifunctional group of providers together to serve a specific subpopulation).

Quadruple Aim provides the template for Ontario's health care providers and funders to transition to a patient-centred approach. It can drive the strategic planning for all delivery and system funding organizations, inform service-level agreements, and be the basis of senior executive performance assessments. Yet it also poses the challenging question: Are all levels of the system willing to take on different roles and shift resources to support new processes and system designs?

WHAT ARE WE PAYING FOR?

Funding is probably the clearest way for a system to communicate what is most important and what is secondary. It is one of the few available levers that can be used to better integrate a health care system and support population health. The funding lever, though, is also among the most delicate of instruments; it is too easy for funders to set out with clear objectives yet have gains undone by unintended consequences. All payment models offer advantages and disadvantages and all must be tailored to the desired outcome.

In Ontario, much of health care delivery is funded through payments that go directly to organizations and individuals. Funding is not tied to the difficulty of the task or the benefits to the system of treating patient populations with complex needs. The fee-for-service model, for example, has the perverse effect of discouraging providers or institutions from spending the time to find innovative solutions or taking on more challenging patient populations. Similarly, the quality-based procedures model being implemented in Ontario grants hospitals a predetermined fee for providing an "episode of care" to a patient, regardless of length of stay. This model may encourage hospitals to code patients so they appear as sick as possible in order to maximize their fees.

A number of well-researched reports have suggested that the only way to encourage effectiveness rather than mere activity is to fund for outcomes rather than for services. Not just any outcomes but those that have greatest meaning for patients – overall experience, the effectiveness and efficiency of their care, safety, accessibility – regardless of who they are.

Quality-Based Procedures, designed to improve the funding for outcomes, is a step in the right direction. The QBP model reimburses health care providers for the types and quantities of patients they treat, with the support of handbooks and pathways to help guide appropriate care.

If we as a province want a truly integrated health care system in which patients move seamlessly between providers, how would the funding model be designed to encourage providers to work together to ensure collaboration and better handoffs? Would it be a funding model that integrates, for example, both the primary care physician and the specialist, or hospital and community care?

If we want a truly integrated health care system in which patients move seamlessly between providers, how would the funding model be designed?

Promising innovations hint at how funding can be used to encourage integration and support population health. In 2011, St. Joseph's Health System in Hamilton, the Ministry of Health and Long-Term Care, and the region's Local Health Integration Network developed a bundled care model for select chronic diseases and a specific group of surgical patients transitioning out of hospital. The Ministry provided a single envelope of funding to support integrated care for the hospital and home care. This model of integrated funding shows great promise and is being piloted elsewhere in Ontario.

Part of any conversation must be a realistic view of how to factor in the intangibles of funding models. Funding models that appeal to the already strong, intrinsic motivations of providers stand a better chance of encouraging all health care system players to translate words into action.

EXPLOIT TECHNOLOGY AS AN ALIGNMENT LEVER

Funding models or legislation are not the only ways to bring the health system into alignment. Technology, for example, is like a handy tool capable of making the system more cohesive. So how do we support the delivery of better quality care through enhanced information systems, data collection, and data sharing?

Here are a few ways: Electronic medical records that capture all of a patient's interactions with the health system and are accessible by providers streamline the patient experience and boost efficiency. Secure online patient portals allow patients to schedule appointments and exchange information with health care teams, request prescription refills, and download and complete forms. Virtual care, via online video links and other remote communication technologies, eases the transition from hospitals to the community or home.

Technology can make a difference. For example, early warning and response systems that monitor patient vital signs and alert medical teams to potential problems have been shown to speed patient transfer to intensive care units and reduce mortality risk from sepsis.

We have also learned what can go wrong. When electronic health initiatives are seen as IT projects rather than quality health projects, they can end up delivering product features that are at odds with what is actually needed and rarely get the uptake from providers or patients that is critical to realizing the benefits of technology.

When new systems offer real-time information to providers without standards for what is to be measured, there is little value in the exercise. The need for standards is particularly acute in the fast-evolving world of patient portals.

When health data are held captive in proprietary systems and platforms, there is no chance for connections to be made with other systems.

And when there is a lack of discipline in how health delivery organizations are managed, the impact of new technology on clinical outcomes or cost is blunted. Arming all clinicians with iPads will not translate into better quality care if it is cumbersome for information to be entered at the right time and place. Similarly, if organizations do not use the information to monitor and improve care, there is little incentive to carefully enter data.

Many of the disappointments associated with health care technology can be mitigated by making patients and providers co-designers of systems such as portals and IT products for clinical processes, improving the odds that the technology will actually be used and have the desired impact.

ACCOUNTABILITY: MOVING THE YARDSTICKS

The management thinker Stephen Covey once noted that, "Accountability breeds response-ability."

Accountability can be an elastic term that triggers multiple associations: control of behaviour, close oversight, finger pointing. It too often carries a loaded meaning associated with the negative view of enforcement. Although enforcement is part of a robust system of accountability, accountability can actually take stress out of a system. Done right, it means greater clarity around roles, responsibilities, and priorities and fewer overlapping efforts. A universal approach that features openness and transparency may not be loved at first but it would be respected and would support better care.

We can see an effective approach to accountability in the system of Cancer Care Ontario, the provincial cancer agency. There, clinical and administrative accountability are aligned, supported by three advisory bodies. Participants understand their own accountabilities and are equipped to deliver on them. Standardized measurements across organizations allow for relevant peer comparisons and benchmarking. Accountability is backed up by a performance management system that helps Cancer Care Ontario tie funding to health care quality. As for public accountability, a quasi-independent advisory body, the Cancer Quality Council of Ontario, monitors and publicly reports on overall cancer system performance.

CASE STUDY IN QUALITY

Integrating Care: Nurses and Telemedicine Offer Streamlined Experience

The Toronto Central Local Health Integration Network and the community Health Links created an innovative model of care called Telemedicine IMPACT Plus (TIP). The model relies on the use of telemedicine for case conferences, in which the patient meets with a group of inter-professional care providers and his or her family physician by video call. Nurses take a lead role facilitating the TIP sessions. They interact with the patient on behalf of the team and keep all members of the care team up-to-date on the patient's care plan. They also build trust to ensure the patient experience is seamless and free of hassles. Initiatives such as TIP offer patients a streamlined and less stressful medical experience, and help them avoid disruptive and potentially costly trips to clinics.

If quality is the paramount goal for Ontario's health system, then for what purpose do we want "response-ability"?

RESPONSE-ABILITY FOR THE PATIENT JOURNEY

It has been said that the most dangerous procedure in health care is the patient handoff. Transitions are indeed a challenge: a patient can be under the care of a provider who, in essence, disappears before someone else assumes responsibility. Patients get lost in the shuffle. They can be unsure of whom to call when they need information about their medical condition. In other critical high-risk industries, accountabilities are in place so that workers cannot walk away when their jobs are done until the file is handed off. Air traffic controllers do not leave an airplane unwatched when their shift is over.

Accountability for the patient journey was not a pressing issue 30 years ago. Family doctors used to be more tied into hospitals and visit their patients there, and patient hospital stays were longer. Today, the average episodes of care are very brief, with fleeting points of contact; it takes much more time to work with a patient than with a specific problem. The handoff is also harder than ever because of the growing number of patients leaving hospitals with more complicated needs.

Today accountability in health care is oriented within sectors rather than across the patient journey. People may be accountable within their organization, but their actions may not be aligned with the service that is actually required.

Far better would be a clear line of accountability for patients at every point of care as well as the spaces between these points. This can be handled in number of ways. In the UK, family doctors are accountable for the entire continuum of care. Closer to home, the health system navigator role is showing promise within some hospitals and the cancer care system; these are people from the same community, culture, or health population who help patients and caregivers move between unconnected health delivery providers. Similarly, case management, possibly delivered by nurses or patient advocates, can be an effective coordinating service in any sector.

Yet another approach is to assign accountability for an episode of care; a patient requiring cardiac treatment, for example, would see a primary care provider and a specialist and require an admission to a hospital. Can there be one point of accountability to cover all these touch points?

Clearly this is an area desperate for improvement and innovation. By sharpening the accountability for the patient journey, the health system will see less service duplication and greater continuity of care and patient satisfaction.

CASE STUDY IN QUALITY

Population Health: Offering Health Care Access to the Homeless

Ottawa Inner City Health, created by community organizations and senior leaders at The Ottawa Hospital, provides access to health care for a particularly vulnerable population. The team coordinates and integrates health care services to give homeless individuals the opportunity to receive quality care. OICH's units are located within local homeless shelters, creating a safe environment where care can be provided. These special units are staffed by personal support workers and backed up by visiting nurses and doctors.

HOW DO WE MAKE THIS REAL?

Response-ability requires measurability and enforceability. If we expect health care providers to deliver quality care, then the standards of care, the targets against which performance is measured, and the consequences for falling short have to be clear. Moreover, providers need to be able to see their data and how it compares against others. This stimulates improvement and taps into the best incentives in providers.

A service agreement is one way that accountability can be formalized. Home care or telemedicine providers, for example, sign agreements that stipulate not only the service they are expected to deliver but also the manner in which the service is delivered.

In a clinical setting, standards of care exist but they can be confusing and not necessarily widely understood by providers. And in the realm of quality care, there are no standards that reflect the patient experience, such as standards guiding referrals or follow-up.

Developing consensus on a health care standard is a considerable challenge and takes time; it is a job being undertaken by Health Quality Ontario in collaboration with clinical leaders, experts and patients. For accountability to become real, measures need to be available to determine whether or not outcomes are improving as a result of standards being met. This would stimulate improvement among providers and potentially support patient choices.

Those who are accountable for performance require the authority to follow through. While it is an uncomfortable topic in health care circles, enforcement is a necessary dimension in an effective system of accountability. Understandably, this is a sensitive area that is all too tempting to avoid.

There is certainly more that Ontario can do to make it easier for health care professionals and organizations to self-correct the way they deliver care based on evidence. Audit and feedback tools based upon health information technology, if they are not burdensome for providers to administer, can provide them with metrics and feedback to improve.

If quality health care is seen as something nice to have, a carrot-based approach to accountability would likely yield noticeable gains. If quality is seen as something essential, that will require challenging conversations on how to fully realize the health system's intentions using both carrot and stick approaches.

CASE STUDY IN QUALITY

Quality-Based Procedures: Driving Continuous Improvement

Mount Sinai Hospital used the Quality-Based Procedures model and engaged staff and clinicians at all levels to make changes that improved prospects for both patients and the hospital's budget. Using hip and knee surgery was a test area, hospital leaders set out to cut in half the time patients spent in hospital, from four days to two. They examined every cost associated with hip and knee surgery and identified ways of improving all aspects of procedures, from how soon patients started physiotherapy to earlier planning for how they would be supported once they return home. The earlier discharge goal was achieved in six months without any increases in readmission rates. The resulting cost reduction: 12 percent over one year.

LEADING AND GOVERNING:
PUSHING THE QUALITY AGENDA FORWARD

Leadership – including the governance structures in which leaders operate – is the animating force that brings alignment and accountability to life.

If we in Ontario are to realize the delivery of quality health care, leaders at all levels of the health system will have to play multiple roles, and play them well. What are those roles?

Health leaders help focus priorities

Given the competing pressures of the health care environment, leaders play an essential role in setting the agenda and helping define priorities. Which are the most important quality-producing actions or measures, and which must be de-prioritized? What can be accomplished with existing processes or resources to avoid re-inventing the wheel? These are difficult questions to answer, since all providers in the health system passionately believe in the value of the work they do.

Health leaders strengthen business processes and build capabilities

Effective leaders develop a compelling business case for the technology – in what way will new health IT address patient needs – and make an equally strong case within their own institutions that health IT will make a positive difference and not introduce more burden or complexity. And leaders drive hard to streamline and standardize business processes using proven models such as Lean, so that when a new IT system arrives, it doesn't make a chaotic environment even more so.

Beyond technology, leaders build the capabilities of their workforce for quality improvement. They motivate teams and individuals to work collaboratively and model the learning, improvement, and innovation behaviours that are so necessary for health organizations to continually improve their care.

Health leaders help us think big

To achieve the system-wide transformation that is called for requires more than reform around the edges. Effective leaders push providers and patients out of their comfort zones to fundamentally reshape how providers work with one another and how patients can move from the periphery to the core of health care delivery. They help providers see the relative value of their services within the health system and involve different parts of the community using a variety of engagement models.

> **CASE STUDY IN QUALITY**
>
> **Patient Journey: System Navigators Show Their Value**
>
> The Tweed-based Gateway Community Health Centre – lead organization in the Rural Hastings Health Link – has made great use of System Navigators. These are registered nurses who act as single points of contact and advocates for patients as they transition from one sector of the health system to another. In a follow-up study, Gateway found that patients who were supported by a System Navigator demonstrated an 87 percent reduction in emergency department visits, an 85 percent reduction in hospital admissions, a 71 percent reduction in length of stay, and 100 percent implementation of a medicine reconciliation" post-care plan.

Health leaders are relentless and courageous

Transformation does not happen quickly. It takes continuity and consistency, which are difficult to sustain. And quality improvement may mean new relationships among providers or different use of human and financial resources. Effective leaders do not lose sight of the big picture; by marshalling the evidence, they relentlessly reinforce the need to stay the course. Neither do they back down from fierce conversations that are unavoidable.

These types of leaders will not just appear out of the mist. Such individuals must be identified, developed, and supported throughout the system. Providers and administrators should have opportunities to attend a province-wide leadership program that exposes them to people in various sectors of health care. Leaders should have access to proven management practices that support quality improvement as well as advice on how others have successfully implemented these best practices. And they will need to be rewarded for their transformational thinking and actions toward achieving the goals of the Quadruple Aim in addition to their incremental quality improvements.

BUILDING GOVERNANCE STRUCTURES
FOR QUALITY OUTCOMES

While leadership can be and is on display at all levels of the health system, governance refers to formal structures that define the system's goals and frameworks of accountability within which leaders work. Governance determines the "what" – what the system does now and what it should become in the future – while leaders and managers determine the "how" – how the system will reach those goals. Leaders do not necessarily have the levers of authority to compel change that governance bodies possess.

There are multiple governance levels in Ontario's health system. The Ministry of Health and Long-Term Care provides overall direction and leadership, focusing on planning and guiding resources to bring value to the health system. Local Health Integration Networks fund health care institutions in their regions and integrate services. Organizations such as academic health science centres and community hospitals provide patients with timely access to advanced patient care services; train the next generation of health care professionals; and conduct leading-edge research. Long-term care and community and home care providers focus on the needs of particularly vulnerable populations.

Beyond these levels, leadership and governance are mixed. In the primary care area, some providers are organized with contracts and others fall under fee-for-service arrangements.

> **CASE STUDY IN QUALITY**
>
> **Technology Edge: Patient Portal Paying Off**
>
> Sunnybrook Health Sciences Centre's eHealth service, MyChart.ca, streamlines the way health record information is accessed and shared. MyChart is a secure web-based tool that allows patients to create and manage their personal health information and share it as they choose with their family caregivers, hospital clinicians, primary care physicians, Community Care Access Centres, and pharmacists. Mychart.ca includes personal and family health details, appointment requests, patient questionnaires, test results, clinic visit notes, and links to relevant disease-specific information. As of June 2015, there were 75,000 MyChart users, and an average of 29,000 logins a month.

There is limited public reporting at the provincial level. Clinical leads fall under Local Health Integration Networks or agencies such as Cancer Care Ontario or Health Quality Ontario. Health regulatory colleges set standards of practice for doctors and nurses.

This map of health system governance does not provide the entire picture. In practice, governance can be both a barrier and enabler of change. Too much governance can lead to a proliferation of silos. Funding that goes to various organizations for the same result is wasteful. Even though there may be many levels of governance, it doesn't necessarily translate into greater accountability.

Governance can also be seen as an enabler of quality health care – with shared goals, there is less likelihood of duplicating work, which means greater value. They can accelerate the use of evidence and quality improvement, and be a means by which patients help shape the health system.

Different forms of shared governance can also help break barriers by enabling partnerships. The fact is that to achieve true transformation, we can no longer afford to tightly limit the circle of potential partners. Patient-centred care is holistic care, and this requires the support of social service providers and local communities. In what ways can re-imagined governance structures at the community level help bring about these new partnerships? How can they ensure a population health approach is taken, patient transitions are smooth, and providers are engaged in meeting standards and constantly improving care?

• • • •

DELIVERING QUALITY CARE: GOALS AND POINTS OF ACTION

The success or failure of health care delivery hinges on how well alignment, accountability, and leadership are executed in pursuit of the Quadruple Aim—namely, improved population health, high-value health care services, and enhanced patient and provider experiences. With this in mind, the following goals and points of action have been developed to advance:

- effective alignment to the Quality Matters framework to achieve the Quadruple Aim;
- transparent accountability to enhance clarity and build trust in the system for patients and providers; and
- resolute leadership in driving towards better quality care for everyone in Ontario.

1. **System-wide alignment with the Quality Matters framework improves population health, delivers high-value health care and enhances both patient and provider experience.**
   - Health care organizations and agencies adopt the Quality Matters framework as the basis for strategic planning and accountability efforts. Improved delivery of health care services means achieving better value, better patient outcomes, and better patient and provider experience.

- Local Health Integration Networks provide a leadership role to ensure all patients have timely access to well-coordinated care.
- Health Quality Ontario measures and reports system-wide progress towards achieving the goals of the Quality Matters framework.

2. **Clear articulation of who is responsible for what in the delivery of health services ensures patients fully benefit from high quality care as defined by the Quality Matters framework.**
   - The Ministry of Health and Long-Term Care delegates greater flexibility to the Local Health Integration Networks for allocating funding to improve service delivery in alignment with the Quality Matters framework and the Quadruple Aim goals.
   - Funders ensure the Quality Matters framework is reflected in the language and letter of all contracts and funding relationships regardless of payment model, including physician compensation.
   - The Ministry of Health and Long-Term Care, Local Health Integration Networks, other agencies, and municipalities align current and future accountability metrics against health system performance measures that reflect the Quality Matters framework.
   - The governing boards of health care organizations review executive compensation structures to ensure the focus is on rewarding the provision of high-quality care as defined by the Quality Matters framework.
   - Funders of health information systems require organizations to use the data in those systems to advance quality improvement.

3. **Resolute leadership is focused on improving everyone's quality of care.**
   - The Ministry of Health and Long-Term Care, professional colleges and associations, health care organizations, agencies, and their boards ensure quality improvement is clearly understood as a critical component of the role of all care providers.
   - Health Quality Ontario and its partners produce standards for priority areas to support consistent quality improvement efforts at a local level.
   - Health care organizations engage with agencies and others to proactively identify and adopt resources and supports for quality improvement within their organizations, rather than developing new tools.

---

[16] For more information about this study and other ideas for improvement, visit the Minister's Medal website: http://www.health.gov.on.ca/en/pro/programs/transformation/minister_medal.aspx

Understanding Quality Health Care

The English social reformer Florence Nightingale is rightly hailed as the founder of modern nursing yet less well known is her significant role as a trailblazer in health outcomes measurement. Inspired by her experience on the frontlines during the Crimean War in 1854-55, Nightingale produced reports based on mortality rates that linked basic sanitation and hygiene standards to decreased mortality when caring for wounded soldiers. It was a novel approach in marshalling health care evidence.

Some 70 years later, Ernest Amory Codman, an orthopaedic surgeon at the Massachusetts General Hospital, pioneered the use of "End Result Cards;" essentially, index cards that kept track of patient demographics, diagnoses, treatments, and outcomes. There is a direct line from Codman's insight to today's outcomes management approach to quality improvement in health care.

And a little more than a century after Nightingale's mortality reports, Avedis Donabedian, an Armenian physician working in the United States, developed a framework for measurement – based on structures, processes, and outcomes – that became a cornerstone of quality measurement.

These historical markers continue to resonate. They remind us that, at its root, health system measurement is essentially about caring for patients, and that continual improvement rests on the best available data and evidence. They also reveal just how long it has taken for the link between measurement and quality to be widely accepted and adopted.

Today no one doubts the value of measurement and reporting or questions whether health care quality can be measured. Providers expend a huge amount of resources generating

data. The challenge has been to get better at measuring quality in a way that is relevant, useful, and actionable to improve care for patients.

Certainly, the methods of measurement have become more sophisticated, though there remain limitations. Structural measures, such as the number of hospital beds or level of certification, can tell what is in place to support care delivery but very little about the quality of that care. Process measures that indicate how care is delivered can be easy to manipulate, and the link between a patient's treatment and their outcome is not always clear. Outcome measures, such as improvements in a patient's quality of life following surgery, are labour intensive to generate, may relate to factors outside a provider's control, and do not yet reflect the entire continuum of care.

A rich provincial data-collection ecosystem has evolved to fuel the quality measurement movement. In Ontario, a range of institutions such as Health Quality Ontario, the Institute for Clinical Evaluative Sciences, the Cancer Quality Council of Ontario, and University of Toronto, generate high-value information that helps improve many dimensions of quality. Health Quality Ontario's annual *Measuring Up* report provides increasingly sophisticated measurements of health system performance for the entire province. A web-based Insight tool developed by the Canadian Institute for Health Information offers access to data that help users compare trends across organizations. The Cancer System Quality Index integrates Ontario's system-wide performance measures and supports monitoring of fairness and equity targets. Registries for cancer, heart disease, stroke, organ replacement patients, and for other types of patients capture detailed data on health status, treatment patterns, and outcomes, and support quality improvement.

At its root, health system measurement is essentially about caring for patients.

WHY MEASURE? AND FOR WHOM?

While the measurement movement has evolved, it is still difficult to determine whether or not the quality of the health system has kept pace. For this, two foundational questions are worth asking: For what purposes are we measuring and reporting? And for whom?

Why do we measure and report? We do so to hold people and institutions accountable, drive improvement, and provide information with which to make informed decisions. But this inevitably creates tensions in terms of measures, reporting format, the culture of information use and other key issues in our system.

For whom? For patients, providers, and funders.

Patients and their families want trusted information to inform choices of facilities and providers. They deserve a say in how the system is measured and to have their experience of care reflected in the data, based on measures that have meaning for them. They also deserve to know that the system is operating well, making smart choices with public funds, and that it will be there for them when they need it.

Providers need to identify important areas for improvement in their own practices, to benchmark their performance against others, to understand risks related to care, and to make a case for greater investment when needed. They require support in interpreting metrics for quality improvement and to monitor performance.

Funders need data to direct resources where they are most needed; to monitor changes or variations in quality, to assess the health needs of populations, to reward and disseminate best practices, and to demonstrate value and equity to taxpayers. They struggle to fill gaps in what organizations report on, particularly to capture transitions in care.

Everyone has a stake in developing an effective measurement and reporting system that leads to accountabilities that shape the right behaviours, learning insights to improve care delivery, and information that leads to smart decisions.

Measuring for Accountability

As discussed elsewhere in this report, accountability in the realm of health care is often associated with a negative view of enforcement but, executed well, can also be a means to greater clarity around roles, responsibilities, and priorities and fewer overlapping efforts. Accountability is most valuable when it reflects the intrinsic motivations of providers.

Smart accountability relies on standardized and risk-adjusted measures that allow for fair apples-to-apples comparisons. With standardized metrics relating to processes and outcomes and derived from best practices and scientific evidence, variations in medical practice across the province can be identified. It sounds simple yet it is hard to achieve. Across provider networks, the use of multiple measurement instruments that ask non-standardized questions and subtly varying indicators make it difficult to generate reports that provide a true picture of how the system as a whole is operating in the service of higher quality patient care.

There are areas of the health system where standard measures are missing altogether. Measures relating to the coordination of care and outcomes across the continuum of care – encompassing the full range of care providers – are primed for greater standardization and better defined accountability. As well, patient-centric measures need to be further developed and standardized to be used in performance measurement and accountability reporting. Generally, measures need to move beyond individual processes that individual providers can change to outcomes that teams and organizations can influence.

While standard measures are essential, it is also true that sometimes standardization can get in the way of understanding health system quality. This may be the case, for example, if family doctors in rural regions offer primary care follow-up in hospitals, a service that may not be captured in the standard family practice database, or if measurement for patient access does not include innovations such as virtual access (e.g. telemedicine) to care for patients in remote communities.

Standard measures can also shape behaviour when they are tied to incentives or penalties, much like benchmarks or targets. It has been well noted how some process and even outcome measures can be easily gamed, and how providers can focus on hitting specific targets within practice areas to the detriment of broader goals of health system improvement – goals

that truly reflect improved patient experience and better management of care. System planners and leaders face the difficult task of constantly balancing and adjusting incentives and account-abilities so that they lead to better care and better experience rather than re-enforcing gaming and the status quo.

ASSESSMENT WITH POPULATIONS IN MIND

Increasingly, the Ontario health system is moving towards a population health perspective, in which integrated care is delivered to people based on their needs (patients with multiple chronic diseases, for example) and the whole system pays attention to health promotion and the broader determinants of health. Population health is an important pillar of the Quadruple Aim approach.

How might accountability – based on indicators of quality – be designed to ensure responsibility for this type of integrated care? A recent study by the Institute for Clinical Eval-uative Sciences (ICES) shows a potential approach.

Using information from health administrative databases, ICES linked a selection of Ontario residents to their primary care physician. Each primary care physician was then linked to the hospital where the patients were admitted and to specialist physicians who provided care. In doing so, ICES was able to identify 78 "multi-specialty physician networks" – informal networks sharing care for a common set of patients.

Based on this research, ICES released a chart book in 2016 that reported performance levels for a comprehensive set of quality indicators, across primary and specialty care, acute hospital care, and long-term care, as well as shared care and transitions from one setting to another. The indicators were drawn from multiple domains of care.

As ICES points out, these networks are ideally suited to examine quality health care metrics because "they include all the physicians who contribute to the majority of the care of the patients associated with them. The networks are small enough that meaningful variations in quality indicators and outcome rates may be detected."

One weakness of this model of informal networks is that it does not include all the providers who are responsible for patient care or all the community-based data that truly reflect patients' experiences. The full picture of some urban populations, such as Indigenous patients or people suffering mental health issues, may be missed because data are not being collected where patients are being served. Capturing such information is essential to understanding how well the system is performing in the quality-based domains.

Measuring and Reporting to Drive Improvement

As measurement developed over the years, it was seen more often as a means to ensure com-pliance with practice guidelines than as tool for improvement. Evidence suggests, however, that the learning value of measurement should not be underestimated. Studies in the U.S. and elsewhere have shown that pubic reporting of process and other types of measures can lead to

significant improvements in many dimensions of quality health care.

But linking measurement to learning is a challenge for Ontario and other jurisdictions. The pathway from raw data to the goals of the Quadruple Aim is not entirely clear; what is known is that good intentions are not enough.

Supporting senior leaders and governors as well as frontline clinicians and staff with the time and skills development to contextualize and work with data would help. There is also a place for more empirical research and policy development into how performance measurement and analytics can be translated into better processes, outcomes, and policies. Can new data visu-alization applications be integrated with existing quality improvement tools to bring performance measurement to life? Would targeted reports geared to specific groups of providers rather than one-size-fits-all reports be more effective at engaging those who are in the best position to use data to improve quality?

We are already seeing this play out in promising audit and feedback programs. In audit and feedback, health care providers are given targeted per-formance reports based on quality indicators so they can see how they are doing compared to others in their practice area or region. In Ontario, Health Quality Ontario, Cancer Care Ontario, and the Canadian Primary Care Sentinel Surveil-lance Network, among others, offer practice- and provider-level reports that help identify variations in care, clinical and surgical outcomes, and other patterns.

These reports, offered to providers who request them and not publicly released, are labour intensive to generate; at present, they are typically issued quarterly or annually. An investment in boosting the timeliness of these reports would likely yield even greater engagement.

In the years ahead, closer to real-time reports based on quality indica-tors should take improvement efforts to another level. In particular, applications being developed on mobile technology platforms will allow patients to immediately share infor-mation and feedback on their health care experience. This will put the onus on policy-makers and health system agencies to catch up and develop standardized systems in which these sorts of patient reports are captured, processed, and shared.

Measuring to Inform

Patients and caregivers have had to rely largely on anecdotes and word-of-mouth as sources of health system information, particularly on matters that mean most to them. Clearly, system planners and providers can and must do better in this area and, in fact, there is considerable activity in improving patient-friendly measurement.

Patient reported outcome measures (PROMs) are standardized questionnaires com-pleted by patients to measure their perception of their physical and mental well-being. They are valuable in measuring the effectiveness of care and safety, two important dimensions of quality. Patient-reported experience measures (PREMs) offer a window on what patients and their caregivers think of their care: Were they treated with dignity and given sufficient opportu-

Patients and caregivers have had to rely largely on anecdotes and word-of-mouth as sources of health system information, particularly on matters that mean most to them.

nity to be involved in decisions about their own care? Were they seen in a timely fashion? What was the state of the clinic's cleanliness?

One promising model to harvest patient-generated data, pioneered in the U.S. in 2012 by University of Utah Health Care (UUHC), is to survey all patients on their experience with doctors, nurses, and staff, and to publish the results online, including unedited comments and five-star rankings. From 2009 to 2013, the number of UUHC physicians in the top ten of a national patient ratings database rose from four percent to 46 percent. The National Health Service in England has introduced a friends and family test (would you recommend this provider) at the national level – and although the jury is still out on the overall effectiveness of this effort – it shows that entire countries can move towards measuring and sharing patient-reported data.

Taking the full measure of Ontario's health system is a huge but worthy enterprise.

There is certainly a case in favour of greater use of patient-reported measures reflecting outcomes that matter to patients, such as whether or they were able to return to work following an intervention as well as measures that reflect the patient experience. Reporting on these measures can help patients better understand the quality of local health care and what to expect after a diagnosis or treatment. They can also help guide decision-making around care by providers by helping time certain surgeries, and in the case of Cancer Care Ontario's symptom screening, help identify major issues in patients' well-being.

Measurement also has a role in shining a light on areas of health care delivery in need of improvement that are currently not getting enough attention. We need the information on how different populations in our health system are treated – defined, for example, by gender, ethnicity, education, or income – in order to determine whether they are being treated equitably and enjoying equitable outcomes and, if not, how to reverse such inequities.

For system planners and providers, there remains the question of how best to communicate to patients and families the information they care about when it comes to quality. The Canadian Institute for Health Information has created online tools that allow website visitors to examine and compare the performance of health care providers on multiple levels; these tools could have greater impact if more widely publicized. In addition to reporting on measures of patient experience, Health Quality Ontario's public reporting routinely incorporates patient and caregiver stories to show what the results mean to individual patients and their families.

Worth developing is a web-based platform for a clearly organized and engaging overview report with key indicators reflecting the patient perspective and covering all six dimensions of quality. This report should be at the local provider level to provide patients, caregivers, and providers themselves information they can act upon as well as at the system level to make sure that policy-makers can see overall system performance. Moreover, alignment of accountability efforts around such scorecards – as done by Cancer Care Ontario for cancer care – could help reduce some of the indicator chaos that distracts providers and confuses patients. End user research, such as market research conducted by industry and retailers, would offer insights on how best to present information for maximum impact.

A Strategic Approach

Taking the full measure of Ontario's health system is a huge but worthy enterprise. There are many moving parts, making it easy to lose focus or waste energy. In an attempt to align measurement, quality improvement, and policy and execute the Patients First action plan, the Ministry of Health and Long-Term Care is now working with partners such as Health Quality Ontario, ICES, Cancer Care Ontario, Local Health Integration Networks, The Canadian Institute for Health Information, Public Health Ontario, and the Cardiac Care Network on a provincial data advancement agenda.

Leveraging existing information, building new and linked datasets, and boosting analytic power are all important elements in a comprehensive measurement strategy. So too is acknowledging the need to address a number of gaps in our understanding of the health system, in particular:

- Transitions in care. Many issues arise when patients transfer from hospital to home or from primary care provider to specialist. Making these transfers safer and more efficient for patients and assigning appropriate accountabilities require hard data rather than anecdotes.
- Patient experience. There is a lack of consistency in how providers collect patient-reported experience and outcomes data. Standardization, the linking of PROMs and PREMs, and more information on patients' perceptions of transitions in care would help bridge this gap.
- Staff experience. Physicians and health care staff are prone to burnout and dissatisfaction, which have been associated with lower patient satisfaction and reduced health outcomes. Ontario's *Excellent Care for All Act* requires health care providers to conduct staff surveys but much more can be done to understand the extent of dissatisfaction and its impacts.
- Equity. Current measures fall short in assessing the impacts of socioeconomic factors on health care outcomes. For that, system planners need to take a fit-for-purpose approach using linkable and shared data beyond physical and mental health, such as data elements or sets relating to income, ethnicity, social services, justice, and housing status. As well, how can equity considerations be reflected in health care benchmarks?

Beyond addressing these gaps, a robust strategy would offer guidance on how to make measurement and reporting as efficient and relevant as possible. Too much measurement can be burdensome in time and resources for providers and agencies, and can generate so much "noise" that efforts to improve become confused. There can also be consequences to getting measurement wrong: false conclusions are drawn, safety issues are missed.

Mitigating these potential pitfalls might involve a review of existing measures to ensure they are still providing useful and actionable information. Or it might involve separate reporting streams that better target the needs to inform patients and caregivers and help providers continuously improve their processes and practices.

And finally, a data strategy would look at the larger issue of transparency. Opening the books not only builds confidence in the health system and supports better decision-making. It can also be an engine of innovation. In particular, the "open data" movement – which calls for the release of foundational data such as performance measures, clinical trial results, and population health estimates, packaged for usability by anyone – can spur new approaches and applications. That can mean better quality health care for all.

● ● ● ●

UNDERSTANDING QUALITY HEALTH CARE: GOALS AND POINTS OF ACTION

1. **Measurement efforts support a relentless commitment to improvement.**
    *   Health Quality Ontario ensures provincial measurement initiatives support health care organizations in setting quality improvement goals based on local performance and needs.
    *   Health Quality Ontario measures and reports on the extent to which the health care workforce is trained and engaged in quality improvement activities.
    *   Health care organizations ensure people working within their institutions are capable of understanding data and using it for improvement.

2. **Strategic measurement and reporting enhance transparency and promote quality.**
    *   Organizations with data collection and reporting responsibilities work together to develop criteria to evaluate the appropriateness and importance of indicators, with the goal of ensuring that the purpose of collecting each measure is clear.
    *   Health Quality Ontario convenes its partners to develop a method for using data to identify and monitor emerging health system issues for future inclusion in the Common Quality Agenda.
    *   Organizations that hold and share data ensure providers have access to information needed to benchmark the quality of care, design improvement projects, and support patient engagement.
    *   Funders of health information systems require those systems to work together within and across organizational boundaries in order to advance the effective delivery of evidence-based, high-quality health care for individuals and communities.

3. **Indicators reflecting shared responsibility for care are widely used across the health system.**
    *   Health Quality Ontario, in collaboration with partners, sets standards and indicators for care that reflect a patient's whole journey of care rather than a series of encounters with individual providers.

*   Funders include indicators of effective patient care and transitions in accountability agreements.
*   Health care organizations include standardized measures of integrated patient care in their Quality Improvement Plans.

4. **Equity is central to every quality measurement and reporting exercise.**
    *   Ministry of Health and Long-Term Care supports the collection of data to enable routine measurement, analysis, and reporting of factors related to equity (e.g. ethnicity, language, income).
    *   Funders require recipients to undertake health equity impact assessments for major projects and organizational strategies.
    *   Local Health Integration Networks evaluate and support providers' abilities to appropriately refer patients to services that address the social determinants of health.
    *   Health care organizations foster timely collection of patient-reported experience measures at the point of care and in the patient's language of choice.
    *   Health Quality Ontario and others ensure health system measurement and reporting reflect both overall performance and performance across the province's different populations.

5. **Quality measures meaningful to patients are consistently collected and widely shared.**
    *   Health care organizations measure staff experience in a standardized way and report results at provincial and local levels to help improve both provider and patient care experiences.
    *   All health care providers collect patient-reported experience and outcome data in a timely, standardized manner and ensure that information is used to improve patient care and experience.
    *   Health care providers explore the use of social media and other innovative tools to capture point-of-care patient-reported experience data.
    *   Health care organizations that publicly report on health system performance regularly engage with patients and the public to ensure their reporting is meaningful to that audience.

Fostering A
Culture Of Quality
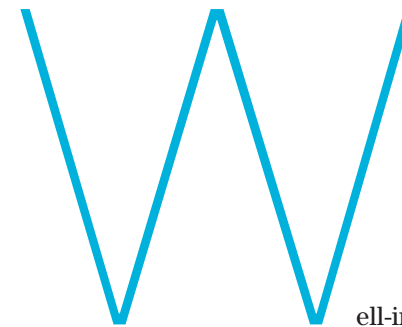
W ell-intentioned quality improvement initiatives rarely hit the mark when they clash with the attitudes and habits – the culture – of the people who must carry them out. This has been shown in countless industries, and is certainly true in health care.

What does a "culture of quality" mean for a health system? Answering this seemingly simple question depends upon the context. A culture of quality can mean a safety culture, in which providers and organizations work to ensure no harm is done. A service culture respects the patient's interests, preferences, and dignity. A just culture allows people the freedom and safe space to speak up. An innovation culture emphasizes continuous learning and relentless improvement.

All these perspectives define a "quality culture." All are associated with views and behaviour patterns that may vary among institutions or services. Each group's "ways of doing things" are shaped by deep-seated attitudes acquired through education and professional affiliations. A system or organizational culture is nothing more or less than the shared attitudes and unconscious assumptions around collaborating or going it alone; speaking up or harbouring resentments; working towards system priorities or pursuing narrower professional goals.

In health care organizations, culture is like a wooden Russian doll: lift the top half and you'll find sub-cultures nested inside. Within a typical hospital or long-term care home, for example, there may be groups that operate like quasi-independent clans or guilds valuing traditions and engendering ferocious loyalty. There may be units organized hierarchically that depend on clear expectations, standardization, and deference to authority. Or staff members

who welcome diversity, creativity, and risk-taking.

A cohesive culture that focuses these multiple groups on a shared vision and goals and that can adapt to changing environments is often hard to nurture. That's particularly true within the hierarchical management and accountability structures of health care institutions. Health care leaders may well ask: how do we bring together these different worldviews or ways of working? How do we seize the opportunities to learn from pockets of excellence and scale up our efforts to build an enduring culture of quality?

PRINCIPLES AND DRIVERS OF A QUALITY-FIRST CULTURE

While there are undeniable challenges in trying to develop strong quality-first health system culture, successes in other health systems and years of research suggest a way forward for Ontario. It starts with embracing a set of principles to foster system-level capacity for cultures of quality. And it involves ensuring that these principles support individual organizations, providers, and patients via training programs, networking, knowledge transfers, and rigorous tracking of quality performance.

In our deliberations, we identified a culture of quality as one that:

- Uses the experiences of patients and what they value as key drivers
- Aligns around a clarity of focus across an organization
- Practices transparency and openness
- Empowers staff at all levels
- Selects leaders based on characteristics that go beyond credentials
- Supports and enables engagement and job satisfaction among health care workers
- Promotes team-based or collective work that focuses on continuous improvement and mutual accountability to speak up for quality and safety
- Models a view that everyone can make a quality contribution within the health care community

Culture is integral to the quality of an organization or health system but, given its organic nature, cannot be created by a policy edict. What is far more realistic is to move upstream and address what drives the behaviours that spring from health care cultures. That may seem like a daunting task; cutting through the inevitable cynicism involves focusing on concrete measures that lead to improved culture.

What drives a culture of health system quality described above? In their report, *Creating a High Performing Healthcare System for Ontario*, Ross Baker and Renata Axler, of the Institute of Health Policy, Management and Evaluation, identified a number of key attributes of high-performing health systems. Four relate to fostering a culture of quality:

- Develop leadership skills
- Invest in capacity to support improvement
- Enhance professional cultures and engage clinicians
- Engage patients, caregivers, and members of the public

These are not the only drivers that foster a culture of quality yet, together, they offer a powerful way to focus the attention of everyone within health care on how to build a higher level of cultural fitness in Ontario's system.

DEVELOP LEADERSHIP SKILLS

Cultural change is never easy. Well-meaning health system leaders who want to make change happen too often face wpowerful countervailing forces within their environments.

- Health care professionals who want to boost quality by comparing their practices with peers face a fragmented system.
- Hospital leaders who want to bring people together under a shared vision must battle against competing cultures.
- Long-term care leaders preoccupied with reducing harm to residents from falls or antipsychotic medications need help to build high-reliability systems in low-resource settings.
- Health system leaders who want to commit to innovation are rewarded for maintaining stability rather than setting stretch targets.

And yet, it is impossible to see how a culture of quality can take root without an effective leadership cadre that is rewarded for enlarging the sense of possibility. Leaders can have a sweeping impact, helping to create the conditions for a culture of continuous improvement of patient care and collaborative work across professional or organizational boundaries.

A quality-minded leadership, starting at the board and management levels, cascades throughout organizations, encouraging and embedding leadership at all levels. The King's Fund in the UK refers to this as "collective leadership," in which everyone takes responsibility for the success of the organization and health system, not just for their areas.

Culture is both incredibly dynamic yet difficult to change from the perimeter. Leaders who are culture change makers know how to use available levers and personal skills to improve

> **CASE STUDY IN QUALITY**
>
> **What Is Collective Leadership?**
>
> "Collective leadership means everyone taking responsibility for the success of the organisation as a whole – not just for their own jobs or work area. This contrasts with traditional approaches to leadership, which have focused on developing individual capability while neglecting the need for developing collective capability or embedding the development of leaders within the context of the organisation they are working in."
> – The King's Fund, UK-based think tank

the quality of care. They help health care communities make sense of outside factors that may undermine their resolve over the long haul of culture change. They align their organizations to a vision using great persuasion skills and adaptive thinking. They set clear expectations based on transparent standards of performance – not the ethical standards of each profession but the standards of a system that has millions of customers. Change-making leaders are encouraged to ask, if these are our standards of performance, what can I do to enable you to meet them?

Relying on the lone, heroic leader is not the answer. Far better for health care providers is to pursue a leadership development strategy that is properly resourced and targets potential leaders at various levels. Such a strategy does not focus solely on individuals; it includes ways to develop collective leadership encompassing clinicians, frontline staff, and, increasingly, patients that are focused on collective goals.

INVEST IN CAPACITY TO SUPPORT IMPROVEMENT

High-performing health care organizations do not leave quality improvement to chance. They do not expect their leaders to do the heavy lifting alone, nor do they see quality improvement as a discretionary activity. Instead, they take a systematic approach to building the capability and capacity for continual improvement in all areas. They know that such investment will pay off in truly scaling up the quality improvement activities already underway.

Capacity building takes many forms. It can be investments to give health care professionals – physicians, nurses, and teams – the knowledge to plan and implement quality improvement initiatives. It can involve redoubling efforts to get local performance data into the hands of clinicians – and helping them understand how to leverage that data to actually improve their practices (discussed elsewhere in this report). It can include a wider development of instruments to measure organizational culture and track improvements and areas needing attention. Or it can target the next generation by boosting the quality improvement curriculum for clinicians in training. Notice the common theme: education.

Some of these supports already exist in Ontario. IDEAS (Improving and Driving Excellence Across Sectors) is a province-wide initiative that offers two accredited quality improvement learning programs, online resources, and an active alumni program to build and sustain a vibrant quality improvement culture. The Canadian Foundation for Healthcare Improvement runs the EXTRA executive training program and improvement collaborative. Health Quality Ontario's Advanced Access and Efficiency in Primary Care Online Curriculum teaches primary care teams how to implement evidence-informed care and improve access to care and patient experiences. As well, there are excellent forums to foster system-level capacity, such as the Health Quality Transformation annual conference and Health Achieve.

These initiatives provide a foundation worth building upon. Developing more educational and data infrastructure, however, is not the only capacity challenge. Outreach – engaging more people who are in the position to most benefit from such resources – must be on the agenda as

well. A case in point are Primary Care Practice Reports. These reports offer family physicians, Community Health Centres, and Family Health Teams access to information on their practice, as well as comparative regional and provincial data. They are designed not only to provide information and context, but also to share change ideas that drive quality improvement. Unfortunately, to date relatively few physicians and practices have signed up for Primary Care Practice reports. The low uptake is consistent with research that has shown physicians ill-prepared and often reluctant to undertake quality improvement initiatives, particularly in small or solo group practices where the infrastructure required to fully participate in quality improvement is limited.

Hospitals and long-term care homes can also step up their commitment to creating a learning environment where team members use the data they produce to prioritize, design, and evaluate improvement efforts (in other words, a learning health system). The heart surgery program at the Hospital for Sick Children, for example, does a complete review of every procedure with all the staff involved, and as a result everyone is engaged in the learning.

Patient and staff concerns and complaints offer another rich source of insights on where operations and services fall short. But, according to a Health Quality Ontario survey, 54 percent of hospitals do not have a dedicated complaints team and fewer than half of hospitals track the number of complaints by underlying reason. Half of the long-term care homes surveyed said they could improve when it comes to collecting complaints data and using the feedback to improve service quality.

What this suggests is that building capacity in quality improvement is an issue of both supply and demand; of not only making available more food for learning but also stimulating the appetite to continually improve. This sort of work on the cultural DNA of the health system is an intensive, boots-on-the-ground project. Recognizing the trail-blazing of individuals, practices, and institutions and encouraging successful organizations to spread their ideas will encourage others to blaze trails of their own.

ENHANCE PROFESSIONAL CULTURES AND ENGAGE CLINICIANS

Imagine a National Hockey League in an alternate universe. On the hockey teams are professional players, all of them proud overachievers who are dedicated to their roles and reputations as sure-handed scorers, dogged checkers, or reliable defenders. And when they're asked with whom they most closely identify, they don't point to the league, the team, or the city in which they play but to all their fellow sure-handed scorers, or dogged checkers, or reliable defenders.

In our health system, the key players can often have similar affinities. Many clinicians identify first with their fellow professionals with whom they share training and cultural worldviews rather than with the programs or health care organizations in which they operate. Given the way the health system is organized and how professionals are regulated, they may even feel

Well-intentioned quality improvement initiatives rarely hit the mark when they clash with the attitudes and habits – the culture – of the people who must carry them out.

like outsiders to the system; an example being physicians who come in briefly to a hospital to deliver a service and then leave. The system, for the most part, is set up to accommodate people working as individuals rather than as teams.

Professional affinities are not problematic – indeed, they explain why clinicians are so engaged in their work and persevere in such challenging environments. They can, however, make the job of building an overarching culture of quality focusing on the patient more challenging to achieve for organizations and the system at large. The system has traditionally valued an independent physician "culture" rather than an integrated commitment to professional practice. As a result, the work to ensure alignment and engagement of physicians in organization goals falls onto the individual clinicians themselves, often without any real organizational support. And health care delivery organizations are often hard-pressed to support, facilitate, and encourage the participation of clinicians in quality improvement projects or in positions of leadership. The reasons are varied: too little available time; comfort with existing procedures or processes; or perceptions that system leadership roles conflict with core professional values.

The growing role of patients and caregivers is perhaps the most significant disruptor in the culture of health care delivery organizations in decades.

Enhancing professional cultures is not about reinforcing existing silos or making it easier for health care professionals to resist the needs of the health system.

It is about:

- building on existing affiliations and creating a stronger bond between professional roles and organizational and health system goals related to quality and performance;
- cultivating a culture of service among professionals and within their practices so that patients are treated with courtesy, empathy, and compassion;
- enhancing the "just" culture in which people can challenge their organizations and system leaders, in which accountability is not based on shame and blame but seen as an opportunity to help the patient and fix a flawed system;
- finding the better tradeoff between empowerment and accountability so that serving patients is a joy for professionals and staff and individual practitioners are not dissuaded from innovating; and
- identifying ways to introduce more inter-professional teams, largely focused on patient populations.

How do we bridge these cultures? One way is to have clinicians partner with quality improvement leads and find common purpose in better patient outcomes and streamlined operations. That means full transparency and clear on-boarding communications to make clinicians aware of the expectations when they begin working at a health care delivery organization. Engagement efforts should extend to professional associations as well.

Quality improvement leaders would certainly improve their chances of success by making the right thing to do the easy thing for clinicians to try. These leaders could also take the opportunity in their interactions with clinicians to broaden discussions and analyze the system issues behind adverse events.

We have made headway in encouraging and supporting physicians to take leadership roles – on governing bodies and in executive positions and inter-professional teams – that offer them a big-picture view. The CanMEDS framework developed by the Royal College of Physicians and Surgeons of Canada reflects the importance of leadership in the suite of competencies that physicians require. Leadership development opportunities, inter-professional education, and compensation for time spent in leadership roles all have roles to play in this strategy.

Many of these new opportunities and expectations can be formalized in physician compacts, which are used by a number of hospitals in the U.S. Compacts are created by physicians in collaboration with hospitals or other practice organizations. They outline the commitments of physicians to how they run their practices and operate within organizations as well as spelling out the commitments of hospitals to the physicians. By clearly articulating the terms of acceptable behaviour and accountabilities, these documents have the potential to reframe the relationship between provider and organization and signal the importance of quality improvement, with physicians as partners.

Boards have a role to play as well. They can establish a clinical governance model for quality within their organizations that clearly sets out who is accountable for quality and supports local improvement with relevant resources. This requires a culture driven by the board through the chief executive and practice leaders.

ENGAGE PATIENTS, CAREGIVERS, AND THE PUBLIC

The growing role of patients and caregivers is perhaps the most significant disruptor in the culture of health care delivery organizations in decades.

The idea that the patient voice and interest be central to quality improvement is both perfectly logical and radical. Logical because serving patients and improving their outcomes are where health care begins and ends. Radical because the assumption until fairly recently has been that individual patients did not have

---

CASE STUDY IN QUALITY

Share Care Council

Mississauga Halton Community Care Access Centre's Share Care Council is meant to ensure patients and families have a direct opportunity to shape the development of programs and services. So far, the 15-member council has worked with improvement teams to improve care and has developed several products, including a patient and caregiver bill of rights and information sheets to help patients get the most value before and after a visit with a family doctor. As well, the Council provided important advice to help shape the Seamless Transitions: Hospital to Home initiative. This initiative, led by the Mississauga Halton CCAC and Trillium Health Partners in Mississauga, tested an approach to improving hospital to home transitions, including an integrated, mobile care team, early transition planning, enhanced care coordination, post-discharge phone calls or visits, and the timely and accurate flow of information between team members. "Patient-centred care is an ideal that should be at the forefront," says Pamela Read, a Share Care Council member. "Unfortunately it isn't but we have a group of people that have experienced all aspects of that patient-centred care."aspects of that patient-centred care."

much to say or contribute to health care delivery, besides showing up for often lengthy waits for appointments and following through on the plan of care.

That is no longer the view. Particularly among the system's policy-makers, the patient perspective is being given a central place as new forms of patient engagement are being developed. For health care delivery organizations, though, patient engagement is more challenging to execute. There are varying communication preferences, uncertainty among clinicians and staff about how best to proceed, and structuring processes to support such engagement. The episodic nature of patient involvement with the health system is another challenge.

Unless senior leaders are committed to patient-centred care and patient co-design, it will not happen. And unless governance structures are re-imagined to give patients a seat at the table, the patient voice will not be clearly heard in the design of programs and strategies. To date, only 45 percent of Ontario hospitals and 39 percent of Community Care Access Centres ensure that patients inform their quality improvement plans; this figure is much lower in the primary care sphere.

Clearly, cultural change needs to happen before patients and caregivers are meaningfully engaged. On the other hand, once patients are allowed to have a role, the culture of organizations is inevitably affected for the better. "The challenge of working against the authority gradient is still there," says one experienced health care leader, "but the conversation changes when there's a patient in the room. Patients aren't interested in credentials; they're interested in the kind of care they receive."

The Thunder Bay Regional Health Sciences Centre's Patient Family Advisory Council and Patient Family Advisors, for example, have a major role in shaping the organization's culture and delivery of services. Patient Family Advisors are active on Senior Management Council, Board Quality, and all care and system teams, giving them a say on strategic planning, executive hirings and spending, policy development, and clinical practice. "Patient and family-centred care is not something that just happens," Dr. Rhonda Crocker Ellacott, Executive Vice-President of Patient Services and Chief Nursing Executive has said. "It is about making an intentional effort to begin a journey with a richer appreciation of what it means to work in collaborative partnership with patients and families. It changes the way you do business to shape a better organization. It transforms the culture and the care."

There are measures that system and organizational leaders can take to boost patient engagement at multiple touch points. At the level of care, patients can be asked their preferences on treatment plans and provide immediate feedback on their experience of care via apps. At the

level of governance, patients can co-lead quality improvement committees. And at the level of policy, educating patients and caregivers on issues such as accountability, measurement, and population health would be empowering and enrich their contributions.

While there is a growing body of knowledge on how best to engage patients and caregivers, all the efforts are focused on single organizations or practices. The reality, however, is that many patients interact with multiple providers on a typical journey through the health system. In this case, the notion of an organizational culture is a massive challenge to a system-wide culture of quality. With the primacy of patient-centred care, one expert asks, how do we deal with transitions between cultures?

TRUST IS THE GLUE

If leadership development, capacity building, the enhancement of professional cultures, and the engagement of patients are key drivers for fostering a culture of quality, then trust is the glue that solidifies a quality-first culture.

As the earth shifts beneath the health system, trust – interpersonal and institutional – takes on new meaning. It used to mean simply that doctors were trusted to know the best treatment plan to follow, without questioning about alternatives; that health care institutions were trusted to carry on their business with limited public accountability; and that health care professionals were trusted even though they worked with little collaboration.

Today, the health system operates on very different principles. Patients expect a greater hand in their own treatment plans and in shaping the system; they need to trust that they are being given the right information to make informed decisions. Institutions are adapting to a new world of accountability; they want communities to trust that resources are being used wisely and employees to trust that smart strategic decisions are being made that will lead to quality outcomes. Health care professionals are now expected to work more collaboratively across professions; trust is essential for decision-making to be shared. And system funders need taxpayers to trust that public funds are being used efficiently and wisely.

Trust is a fragile commodity. It is hard to gain and easy to lose, particularly in an age of media reports on system flaws and shortcomings. Perversely, measures to promote transparency and trust – such as releasing ever more system performance data – can also increase the distrust that clinicians and patients feel towards the system itself when they feel the data do not accurately reflect reality.

It can feel like a struggle to trust the system and to protect the trust that others have in you. But for anyone committed to supporting a culture of quality, it is a struggle worth confronting, because without trust, organizational and system learning is severely degraded. In an environment of distrust, providers and managers are loath to admit failure, and without admitting failure, there is limited opportunity for continual improvement.

Unless senior leaders are committed to patient-centred care and patient co-design, it will not happen.

"We hide our failures in service delivery innovation, even from ourselves," says Merrick Zwarenstein, Director of the Centre for Studies in Family Medicine at Western University, who has written about what is known as high-reliability culture. He has called for a process of "systematically identified failure" in which planned innovations are identified, including goals, criteria for success, and methods of evaluation.

What kind of culture does the health system need so that groups can collaborate with one another with confidence and candor, and learn from clinical missteps and innovations that fall short?

It starts with trust. And trust starts with the willingness to share relevant information, open communication, meaningful culture metrics, and respect for diverse views. From there, building a strong leadership cadre, increasing the capacity to continually improve, enhancing professional cultures, and engaging patients will get Ontario to a health system where quality truly matters.

• • • •

FOSTERING A CULTURE OF QUALITY: GOALS AND POINTS OF ACTION

To advance a strong quality-first culture, the following goals have been set:
- Patients, caregivers, providers, and citizens engaged in and committed to championing a culture of quality
- A system-wide capacity to relentlessly improve the quality of care in a culture of quality and safety

1. Patients, caregivers, and providers are committed to a culture of quality that is fuelled by continuous learning from experiences of those who provide and receive care.
- Boards of health care organizations fully engage patients and caregivers in the selection and use of relevant and meaningful organizational performance measures and reports.
- Health Quality Ontario and others educate and engage health care leaders – from governing boards to patients – to advance a culture of quality.
- Health care organizations contribute to transparent reporting and resolution of patient complaints and concerns.
- Health Quality Ontario ensures health care providers are involved in a productive process to learn from their own and each other's success and failures.
- Health Quality Ontario ensure health care providers are involved in a productive process to learn from their own and each other's success and failures.

2. A system-wide culture of quality with an unyielding commitment to improvement.
- Funders, agencies and health care organizations invest in additional quality improvement training, with a target of 50% of staff completing basic improvement science training.

- Health professionals' regulatory colleges and professional associations include leadership for quality improvement activities as a core competency and a key element of ongoing certification or licensure.
- Universities and colleges ensure clinical curricula include quality improvement as a competency taught to all students.
- Health care providers and other frontline leaders share both successes and failures as part of an overall commitment to improving the quality of patient care and experience.
- Through awards, public recognition, and social media, health care organizations recognize frontline quality champions and share their achievements widely throughout the health care system.

It Is Within Our Grasp

This report offers several concrete recommendations to advance the quality agenda in Ontario. But a report alone can only take us so far.

If the goal is a system where patients come first, each of us must take responsibility for moving this work forward. One of the greatest challenges we face is not a lack of passion, intellect, or even resources. Our greatest challenge remains a lack of alignment and accountability in the system.

For each of the goals presented here, several principal groups are called upon to take action. But quality is up to all of us, and to see progress we must all be willing to take responsibility for making it happen. We see no reason why all of the actions here could not be accomplished within the next five years. But we hope that the vision advanced in this report has a life far beyond that.

It is not acceptable to simply acknowledge the importance of a quality health system or identify gaps that need to be closed. Action is required to address our shortcomings. Fortunately, many of the pieces are already in place. Successful initiatives in various parts of the system show the way.

If we could see only one recommendation proposed here move forward, it would be to measure our progress each year against the aspirational statements and opportunities identified in this report—an annual review of our forward momentum toward a health care system that has quality at its core. This would serve as a reminder to constantly refocus our efforts on our shared commitments.

This report provides a framework and a series of next steps that can guide our planning, investment and evaluation as a system. It is a foundational document against which we hope to measure our progress. We must continue to move this conversation forward with a structure and sense of urgency. It is within our grasp. Together and in time, we will realize the promise of excellent care for all.

REFERENCES AND FURTHER READING

1) Arah, O.A., Westert, G.P., Hurst, J., Klazinga, N.S. (2006). *A conceptual framework for the OECD health care quality indicators project*. Journal for Quality in Health.

2) Baker, G.R., Denis, J.L., (2011). *A Comparative Study of Three Transformative Healthcare Systems: Lessons for Canada.* Canadian Health Services Research Foundation. Retrieved from http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/Baker-Denis-EN.pdf?sfvrsn=0

3) Baker, G.R., MacIntosh-Murray, A., Porcellato, C., Dionne, L., Stelmacovich, K., Born, K. (2008). "Learning from High-Performing Systems: Quality by Design." High Performing Healthcare Systems: Delivering Quality by Design.

4) Berwick, D.M., Calkins, D.R., McCannon, C., Hackbarth, A.D. (2006). *The 100,000 Lives Campaign: Setting a Goal and a Deadline for Improving Health Care Quality*. JAMA.

5) Brown, A., Baker, G.R., Closson, T, Sullivan, T. (2012). *The Journey Toward High Performance and Excellent Quality*. Healthcare Quarterly 15 (Special Issue).

6) Donabedian, A. (1980). *Explorations in quality assessment and monitoring*, *Vol. 1: The definition of quality and approaches to its assessment*. Ann Arbor: Health Administration Press.

7) Lewis, S., Sullivan, T. (2013). "How to bend the cost curve in health care." Institute for Research on Public Policy Insight No. 1.

8) Perlin, J.B., Kolodner, R.M., Roswell, R.H. (2004). *The Veterans Health Administration: quality, value, accountability, and information as transforming strategies for patient-centered care.*

9) Romanow, R.J. (2002). *The Future of Health Care in Canada. Commission on the Future of Health Care in Canada*. Retrieved from http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf

10) *Charting a path to sustainable health care in Ontario: 10 proposals to restrain cost growth without compromising quality of care* (2010). TD Economics Special Reports.

11) *Four Pillars: Recommendations for Achieving a High Performing Health System. Ontario Hospital Association*. Retrieved from http://www.oha.com/KnowledgeCentre/Library/Documents/Four%20Pillars%20-%20FINAL%20FULL.pdf

12) *Better health*, *Better care*, *Better value for all: Refocusing health care reform in Canada* (2013). Health Council of Canada. Retrieved from https://www.cahspr.ca/web/uploads/conference/201414_Better_Health_Better_Care_Better_Value_For_All.pdf

13) *High Quality Care for All: NHS Next Stage Review Final Report* (2008). Department of Health (London).

14) *Closing the Quality Gap: Revisiting the State of the Science* (2012). Public Reporting as a Quality Improvement Strategy, Agency for Healthcare Research and Quality. Evidence Report No. 208.

15) *The Mid Staffordshire NHS Foundation Trust Public Inquiry*, Chairman's Statement (2013). Retrieved from: http://www.midstaffspublicinquiry.com/sites/default/files/report/Chairman%27s%20statement.pdf

16) *The Path to a High Performance U.S. Health System* (2009). The Commonwealth Fund Commission on a High Performance Health System. Retrieved from http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Feb/The%20Path%20to%20a%20High%20Performance%20US%20Health%20System/1237_Commission_path_high_perform_US_hlt_sys_WEB_rev_03052009.pdf

17) Strengthening Health Systems to Improve Health Outcomes (2007). World Health Organization Framework for Action. Retrieved from http://www.who.int/healthsystems/strategy/everybodys_business.pdf?ua=1

18) *Which way to quality? Key perspectives on quality improvement in Canadian health care systems* (2013). Health Council of Canada. Retrieved from http://www.healthcouncilcanada.ca/rpt_det.php?id=455#sthash.kMhYWaRf.dpuf

Delivering Quality Care References

1) Advisory Panel on Healthcare Innovation (2015). *Unleashing Innovation: Excellent Healthcare for Canada*. Retrieved from: http://www.healthycanadians.gc.ca/publications/health-system-systeme-sante/report-healthcare-innovation-rapport-soins/alt/report-healthcare-innovation-rapport-soins-eng.pdf

2) Atluri, V., Cordina, J., Mango, P., Velamoor, S. (2016). *How tech-enabled consumers are reordering the healthcare landscape*. McKinsey & Company. Retrieved from: http://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/how-tech-enabled-consumers-are-reordering-the-healthcare-landscape

3) Brinkerhoff, D.W. (2004). "Accountability and health systems: toward conceptual clarity and policy relevance." Health Policy Plan., 19 (6), 371-379.

4) Brown, A.D., Barnsley, J., Porcellato, C. (2006). "Accountability: unpacking the suitcase." Health Care Quarterly 9.

5) Bytautas, J., Dobrow, M., Sullivan, T., Brown, A. (2014). "Accountability in the Ontario Cancer Services System: A Qualitative Study of System Leaders' Perspectives." Healthcare Policy, Vol. 10.

6) Conference Board of Canada (2015). *Financial Models and Fiscal Incentives: Proceedings from the Healthy Canada Conference*. Retrieved from: http://www.conferenceboard.ca/e-library/abstract.aspx?did=8039

7) Deber, R.S. (2014). "Thinking about Accountability." Healthcare Policy, Vol. 10 (Special Issue), 12-24.

8) Dubnick, M. (2005). "Accountability and the Promise of Performance: In Search of the Mechanisms." Public Performance and Management Review, 28(3), 376-417.

9) Dubnick, M., Frederickson, H.G. (2010). "Accountable Agents: Federal Performance Measurement and Third-Party Government." Journal of Public Administration Research Theory, 20, i143-i159.

10) Expert Group on Home and Community Care (2015). *Bringing Care Home*. Retrieved from: http://health.gov.on.ca/en/public/programs/ccac/docs/hcc_report.pdf

11) Institute of Public Administration of Canada (2013). *Healthcare Governance Models in Canada: A Provincial Perspective*. Retrieved from: http://www.ipac.ca/documents/ALL-COMBINED.pdf

12) Ministry of Health and Long-Term Care (2015). *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. Retrieved from: http://www.health.gov.on.ca/en/news/bulletin/2015/docs/discussion_paper_20151217.pdf

13) Price, D., Baker, E., Golden, B., Hannam, R. (2015). *Patient Care Groups: A new model of population based primary health care for Ontario*. Retrieved from: http://health.gov.on.ca/en/common/ministry/publications/reports/primary_care/primary_care_price_report.pdf

14) Sullivan, T., Ashbury, F.D., Pun, J., Pitt, B.M., Stipich, N., Neeson, J. (2011). "Responsibility for Canada's Healthcare Quality Agenda: Interviews with Canadian Health Leaders." Healthcare Papers, 11(3), 10-21.

15) Zwarenstein, M. (2015). "Systematically identified failure is the route to a successful health system." Healthcare Pap., 15 (2), 8-14.

Understanding Health Care Quality References

1) Berensen, R.A., Pronovost, P.J., Krumholz, H.M. (2013). *Achieving the Potential of Health Care Performance Measures: Timely Analysis of Immediate Health Policy issues*. Robert Wood Johnson Foundation. Retrieved from: http://www.rwjf.org/en/library/research/2013/05/achieving-the-potential-of-health-care-performance-measures.html

2) Blumenthal, D., McGinnis, J.M. (2015). *Measuring Vital Signs: An IOM Report on Core Metrics for Health and Health Care Progress*. JAMA, 313(19), 1901-1902

3) Canadian Institute for Health Information (2016). *Canada's International Health System Performance Over 50 Years: Examining Potential Years of Life Lost*. Retrieved from: https://secure.cihi.ca/free_products/International_PYLL_EN.pdf

4) Carinci, F., Van Gool, K., Mainz, J., Veillard, J., Pichora, E.C., Januel, J.M., Arispe, I., Kim, S.M., Klazinga, N.S., OECD Health Care Quality Indicators Expert Group. "Towards actionable international comparisons of health system performance: expert revision of the OECD framework and quality indicators." Int J Qual Health Care, 27(2), 137-46.

5) Donabedian, A. (2005). "Evaluating the quality of medical care." Milbank Quarterly, 83(4): 691–729.

6) Ham, C., Raleigh, V., Foot, C., Robertson, R., Alderwick, H. (2015). *Measuring the performance of local health systems: A review for the Department of Health*. The King's Fund. Retrieved from: https://www.kingsfund.org.uk/publications/commissioned/measuring-performance-local-health-systems

7) Health Council of Canada (2011). *A Citizen's Guide to Health Indicators: A Reference Guide for Canadians*. Retrieved from: http://healthcouncilcanada.ca/tree/2.10-HCC_Indicators_Bookmark_Accessible.pdf

8) Health Quality Ontario (2014). *Monitoring What Matters: Health Quality Ontario's Approach to Performance Monitoring and Public Reporting*. Retrieved from: http://www.hqontario.ca/Portals/0/documents/pr/monitoring-what-matters-en-1410.pdf

9) Health Quality Ontario (2015). *Connecting the Dots for Patients: Family Doctors' Views on Coordinating Patient Care in Ontario's Health System*. Results from the 2015 Commonwealth Fund International Health Policy Survey of Primary Care Doctors. Retrieved from: http://www.hqontario.ca/Portals/0/documents/system-performance/connecting-the-dots-report-en.pdf

10) Health Quality Ontario (2015). *Quality in Primary Care: Setting a foundation for monitoring and reporting in Ontario*. Retrieved from: http://www.hqontario.ca/Portals/0/Documents/pr/theme-report-quality-in-primary-care-en.pdf

11) Health Quality Ontario (2015). *Taking Stock: A Report on the Quality of Mental Health and Addictions Services in Ontario*. Retrieved from: http://www.hqontario.ca/Portals/0/Documents/pr/theme-report-taking-stock-en.pdf

12) Hibbard, J., Sofaer, S. (2010). *Best Practices in Public Reporting No. 1: How To Effectively Present Health Care Performance Data To Consumers*. Agency for Healthcare Research and Quality. Retrieved from: https://archive.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/pubrptguide1/pubrptguide1.pdf

13) Ketelaar, N.A., Faber, M.J., Flottorp, S., Rygh, L.H., Deane, K.H., Eccles, M.P. (2011). "Public release of performance data in changing the behaviour of healthcare consumers, professionals or organisations." Cochrane Database Syst Rev., 11.

14) McGlynn, E.A., Kerr, E.A. (2016). *Creating Safe Harbors for Quality Measurement Innovation and Improvement*. JAMA, 315(2), 129-130.

Fostering a Culture of Quality References

1) Baker, G.R., Axler, R. (2015). Creating a High Performing Healthcare System for Ontario: Evidence Supporting Strategic Changes in Ontario. Ontario Hospital Association. Retrieved from: https://www.oha.com/News/Documents/OHA%20High%20Performing%20Healthcare%20System%20Paper.pdf

2) Baker, G.R., Judd, M., Maika, C. (Eds.). (2016). *Patient Engagement: Catalyzing Improvement and Innovation in Healthcare*. Longwoods Publishing Corp.

3) Canadian Health Services Research Foundation (2011). *National Health Leadership Survey on Performance and Quality Improvement*. Retrieved from: http://www.cfhi-fcass.ca/sf-docs/default-source/ceo-forum-files/National_Health_Leadership_Survey_on_Performance_and_Quality_Improvement_-_English_-_Feb_17_2011.pdf?sfvrsn=0

4)   Denis, J.L., Baker, G.R., Black, C., Langley, A., Lawless, B., Leblanc, D., Lusiani, M., Hepburn, C.M., Pomey, M.P., Tré, G. (2013). *Exploring the Dynamics of Physician Engagement and Leadership for Health System Improvement: Prospects for Canadian Healthcare Systems*. Canadian Foundation for Healthcare Improvement. Retrieved from: http://www.cfhi-fcass.ca/sf-docs/default-source/reports/Exploring-Dynamics-Physician-Engagement-Denis-E.pdf?sfvrsn=0

5)   Fooks, C., Obarski, G., Hale, L., Hylmar, S. (2015). "The Patient Experience in Ontario 2020: What Is Possible?" Healthcare Pap., 14(4), 8-18.

6)   Frank, J.R., Snell, L., Sherbino, J. (2015). *CanMEDS 2015: Physician Competency Framework*. Royal College of Physicians and Surgeons of Canada. Retrieved from: http://canmeds.royalcollege.ca/uploads/en/framework/CanMEDS%202015%20Framework_EN_Reduced.pdf

7)   Health Quality Ontario (2016). *Engaging with Patients: Stories and Successes from the 2015/2016 Quality Improvement Plans.* Retrieved from: http://www.hqontario.ca/portals/0/documents/qi/qip/engaging-with-patients-en.pdf

8)   Health Quality Ontario (2016). *Primary Care: Impressions and Observations 2015/2016* Quality Improvement Plans. Retrieved from: http://www.hqontario.ca/Portals/0/documents/qi/qip/qip-analysis-pc-2015-16-en.pdf

9)   Lavis, J. N., Moat, K.A., Rizvi, Z. (2014). *Issue Brief: Fostering Leadership for Health-System Redesign in Canada.* McMaster Health Forum. Retrieved from: https://www.mcmasterhealthforum.org/docs/default-source/Product-Documents/issue-briefs/fostering-leadership-health-system-redesign-canada-ib.pdf?sfvrsn=2

10)   Marx, D. (2001). Patient Safety and the "*Just Culture:" A Primer for Health Care Executives.* Columbia University and University of Texas Southwestern Medical Center at Dallas.

11)   McTavish, A., Phillips, C. (2014). "Transforming the patient experience: Bringing to life a patient- and family-centred interprofessional collaborative practice model of care at Kingston General Hospital. Patient Experience Journal, 1(1).

12)   Mery, G., Dobrow, M.J., Baker, G.R., Brown, A. (2015). *Evaluating Investment in Quality Improvement Capacity Building: A Synthesis of the Literature.* Working Paper. Institute of Health Policy, Management and Evaluation. Retrieved from: http://ihpme.utoronto.ca/wp-content/uploads/2015/08/Mery-et-al_Evaluating-QI-Capacity-Building_Working-Paper_Aug-2015.pdf

13)   National Patient Safety Foundation (2015). *Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human.* Retrieved from: http://www.npsf.org/?page=freefromharm

14)   Parmelli, E., Flodgren, G., Beyer, F., Baillie, N., Schaafsma, M.E., Eccles, M.P. (2011). "The effectiveness of strategies to change organisational culture to improve healthcare performance: a systematic review." Implementation Science, 6, 33.

15)   Swensen, S., Pugh, M., McMullan, C., Kabcenell, A. (2013). *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs.* Institute for Healthcare Improvement White Paper. Retrieved from: http://www.ihi.org/resources/pages/ihiwhitepapers/highimpactleadership.aspx

16)   Tepper, J., Martin, D. (2015). "Failure is the new success." Healthcare Pap., 15(2), 4-6.

17)   West, M., Eckert, R., Steward, K., Pasmore, B. (2014). *Developing Collective Leadership for Health Care.* The King's Fund. Retrieved from: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/developing-collective-leadership-kingsfund-may14.pdf

18)   West, M., Amrit, K., Loewenthal, L., Eckert, R., West, T., Lee, M. (2015). *Leadership and Leadership Development in Health Care: The Evidence Base*. The King's Fund. Retrieved from: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf

APPENDIX 1
SYSTEM QUALITY ADVISORY COMMITTEE
TERMS OF REFERENCE

I.   Background:

To assist in fulfilling its mandate as the provincial advisor on quality, Health Quality Ontario has established a System Quality Advisory Committee, led by Dr. Adalsteinn Brown, to guide the development of a provincial plan for health system quality. The System Quality Advisory Committee is made up of experts who have demonstrated a commitment to keeping quality at the core of their professional activities and who have knowledge of what it takes to build a quality health care system and experience in making it happen.

Over the coming months, the System Quality Advisory Committee and its three working groups will prepare reports on creating, supporting, and refining key enablers for a high quality health care system in Ontario. Health Quality Ontario will seek feedback on the committee's findings with the goal of developing a widely supported plan of action.

A strong foundation for this plan already exists through a number of thoughtful and excellent contributions to the field of quality. Such resources include the Ministry of Health

and Long-Term Care-sponsored report *Quality by Design (2008)*, which lays out a number of important characteristics of high performing systems. Reports from expert committees, advisory bodies and councils, and researchers have provided further guidance on how to consider the highest quality care across clinical areas, different health professions, and various sectors within our healthcare system.

The System Quality Advisory Committee's goal is to draw on this body of knowledge to present a concise definition and vision for quality in the province, and to clearly articulate the areas where collective action and focus are required to advance a quality agenda. This work will enable HQO and health system leaders to collectively embed quality as a core value in the health care system. At the same time, Health Quality Ontario will be communicating how and why health care quality matters to Ontarians.

The Committee has already set out a system framework for quality and identified three major areas for further examination by working groups. These terms of reference will guide the role and work of the Committee and its working groups.

II.   Role:

Reporting to the CEO of Health Quality Ontario, the System Quality Advisory Committee will designate three working groups to consider the following areas of focus:

- Understanding Quality
- Building a Culture of Quality
- Delivering Quality Care

Working in close collaboration, the Health Quality Ontario Policy and Strategy team and the Committee will guide the inquiries of each of the Working Groups and will receive and review their reports. The Committee will share its overall recommendations in report form on what is required to advance the quality of health care in Ontario to the President and CEO of Health Quality Ontario.

The three key themes are:

1.   Delivering Quality Care
- Supporting innovation and improvement
- Improving structural capacity
- Ensuring information technology and communications initiatives lead to better and more coordinated care

2.   Understanding Quality Health Care
- Engaging patients and the public
- Measuring and monitoring heath system performance

3.   Fostering a Culture of Quality
- Leading and managing a quality-focused workforce
- Nurturing cultural change

III.   Responsibilities:

The Working Groups will begin meeting in May 2015. Each Working Group is composed of individuals with specific knowledge and expertise to advise on the designated area of focus. Each Working Group has been tasked with examining their respective topics and clearly articulating, in the form of short reports, what is required to accelerate improved quality of care across our health care system.

Throughout this stage of its work, the committee and working groups will adhere to the previously agreed-upon principles of:

- Drawing on reports, tools, and reviews that are already available and giving preference to Ontario reports that are evidence-based;
- Ensuring that its conclusions can be translated into practical recommendations for the health care system;
- Demonstrating transparency by collecting and making available all source material;
- Providing open platforms for engagement; and
- Communicating clearly the vision and values behind its recommendations

Decision-making: Members will strive to make decisions by the Chair, Adalsteinn Brown.

Frequency of meetings and manner of call:
The System Quality Advisory Committee will meet regularly or as needed. The Chair reserves the right to call or cancel meetings, as appropriate. Meetings may be held in-person or via tele/video conference.

IV.   Communications:

Agendas are to be distributed approximately one week prior to meetings. Members may add agenda items through the chair. Deliberations of the Committee will occur under the Chatham House Rule.

Official discussion of the System Quality Advisory Committee with members of the media or at conferences or at other external events will only be done with the permission and coordination of Health Quality Ontario.

V.   Review of Terms of Reference:

The Committee has, per its original mandate, reviewed and agreed upon its terms of Reference, mandate, activities, and relevance of the Committee. Health Quality Ontario will publish the work of the Committee in late 2016.

The members of the Committee are:

- Adalsteinn Brown, Chair, Director, Institute of Health Policy, Management, and Evaluation, University of Toronto
- Ross Baker, Professor, Institute of Health Policy, Management, and Evaluation, University of Toronto
- Tom Closson, former Chief Executive Officer of the University Health Network and the Ontario Hospital Association
- Terry O'Driscoll, Chief of Staff, Sioux Lookout Meno Ya Win Health Centre (participated until December, 2015)
- Rheta Fanizza, Senior Vice President, St. Elizabeth Health Care
- Jack Kitts, President and Chief Executive Officer, The Ottawa Hospital
- Kirsten Krull, Vice President, Quality and Performance; Chief Nursing Executive, Hamilton Health Sciences
- Dorian Lo, former Executive Vice President, Pharmacy and Healthcare, Shoppers Drug Mart
- Mark MacLeod, orthopaedic surgeon, former President of the Ontario Medical Association
- Camille Orridge, Senior Fellow, The Wellesley Institute
- Kaveh Shojania, Scientist, Sunnybrook Research Institute; Director, Centre for Quality Improvement & Patient Safety, University of Toronto
- Moira Stewart, Professor, Department of Family Medicine, Western University (participated until December, 2015)
- Charles-Antoine St. Jean, National Partner, Ernst & Young, University of Ottawa Board
- Terry Sullivan, Chair of the Canadian Agency for Drugs and Technologies in Health; Senior Fellow, Institute of Health Policy, Management, and Evaluation
- Sarita Verma, Deputy Dean, Faculty of Medicine, University of Toronto (participated until December, 2015)

Delivering Quality Care Working Group Membership
- Jack Kitts, Chair
- Kim Baker, Chief Executive Officer, Central Local Health Integration Network)
- Ed Brown, Founder and Chief Executive Officer, Ontario Telemedicine Network
- Dafna Carr, Chief Information Officer, Ministry of Children, Youth and Social Services
- Mark Dobrow, Associate Professor, Institute of Health Policy, Management, and Evaluation
- Alan Forster, general internist and Chief Quality and Performance Officer, Ottawa Hospital

- Pam Goldsilver, Patient, Caregiver, and Public Representative
- Kristin Krull
- Mark MacLeod

Understanding Quality Health Care Working Group Membership
- Kaveh Shojania, Chair
- Anna Greenberg, Vice President of Health System Performance, Health Quality Ontario
- Lianne Jeffs, Director, Nursing/Clinical Research, Nursing Administration, St. Michael's Hospital
- Annette McKinnon, Patient, Caregiver, and Public Representative
- Camille Orridge
- Charles-Antoine St. Jean

Fostering a Culture of Quality Working Group Membership
- Terry Sullivan, Chair
- Ross Baker
- Connie Clerici, Chief Executive Officer, Closing the Gap Healthcare Group
- Tom Closson
- Peter Donnelly, Chief Executive Officer, Public Health Ontario
- Lee Fairclough, Vice President of Quality Improvement, Health Quality Ontario
- Rhetta Fanizza
- Henry Lowi, Patient, Caregiver, and Public Representative
- Donna McRitchie, Medical Director Critical Care and Division Chief Surgery, North York General Hospital
- Jennie Pickard, Director, Strategic Partnerships
- Bruce Squires, Vice President of People, Strategy and Performance, the Children's Hospital of Eastern Ontario
- Margo Twohig, Patient, Caregiver, and Public Representative

Health Quality Ontario Support
- Alan Morantz, Senior Writer
- Michelle Rossi, Director, Policy and Strategy
- Claire Tallarico, Senior Editorial Advisor
- Kate Wilkinson, Policy Analyst, Policy and Strategy

The following individuals were consulted as part of this work:

- Helen Bevan, Chief of Service Transformation, National Health Service, England
- David Blumenthal, President of the Commonwealth Fund
- Trey Coffey, Staff Paediatrician and Medical Officer for Patient Safety, The Hospital for Sick Children
- Michael Decter, former Deputy Minister of Health for Ontario and Cabinet Secretary in the Government of Manitoba
- Cathy Fooks, President and Chief Executive Officer, The Change Foundation
- Jean-Frederique Levesque, Chief Executive Officer at Bureau of Health Information, New South Wales
- Deb Matthews, Deputy Premier and former Minister of Health and Long-Term Care
- David Naylor, Canadian physician, medical researcher and former president of the University of Toronto
- Chris Power, Chief Executive Officer, Canadian Patient Safety Institute
- Eric Schneider, Senior Vice President for Policy and Research, The Commonwealth Fund
- Diane Watson, Chief Executive Officer, National Health Performance Authority, Australia