Primary Care Quality Improvement Plans: Frequently Asked Questions

The questions below were drawn from *Quality Improvement Plans in Primary Care: Moving Forward on a Common Quality Agenda*, a webcast hosted by Health Quality Ontario and the Ministry of Health & Long-Term Care, which aired on February 7, 2013.

Requirements/Accountability

Q. What are the various health care provider roles in the QI process? For example, if the FHT as a whole is to submit a QIP, how are the individual roles of primary health care providers (NPs/MDs) measured with this process?

A. QIPs are a shared responsibility within an organization. Development and successful implementation of the priorities and quality initiatives in the QIP depend on the involvement and engagement of the organization's Board, senior leadership, clinicians, and staff. QIPs are meant to be developed at the "organizational" level. Although in some situations (such as when working on targeted initiatives) it is recommended that the focus be on a clinician's own practice (like *Advanced Access and Efficiency Learning Community Waves*), the QIP is meant to be developed by and for the organization as a *whole*. This means, for example, in the case of a FHT or other group-based model with more than one practice, all of the practices (and their associated patients/clients) in that model should be reflected in the QIP. The benefits of shared learnings and a team-based approach can be operationalized and formalized by focusing on quality from the perspective of the entire organization.

All health care providers and staff should be involved and accountable to the QIP in some way and the QIP should reflect the organization's priorities in terms of meeting needs of their patients/clients.

Q. What happens if an organization fails to submit a QIP? What if the organization cannot meet the April 1 deadline?

A. The quality improvement program for primary care includes a requirement for Ontario's inter-professional primary care organizations to develop and submit a Quality Improvement Plan (QIP) by April 1, 2013 for review and feedback by Health Quality Ontario (HQO). This requirement is pursuant to the "Other Reports" section of their Funding Agreements.

It is important to note that perfection is not the goal. The goal is to begin the process of aligning your activities within a quality framework and to build the processes, data capacity and structures to embed quality in every aspect of your operations. Although each organization is required to submit a QIP within the specified timeframe, the content of QIPs will not be used to determine or adjust funding levels.

While the formal requirement is in place for AHACs, CHCs, FHTs and NPLCs, other primary health care providers are encouraged to undertake quality improvement planning, using the guidance provided, on a voluntary basis.

Q. Does the QIP template and narrative need to be published for the public to see?

A. At this time, the primary care QIP does not need to be posted publicly. However, it is encouraged that the community be involved in the identification of priorities and possibly in the development of the QIP itself. Transparency in quality improvement processes helps engage the community and provide a level of accountability for high quality care that ensures Ontario's patients and clients are at the front-and-centre of care delivery. Visually displaying data in the QIP in a format useful for public consumption (i.e., charts and graphs) can promote understanding of local initiatives and goals for improvement and facilitate decision making with the local community. Visually displaying data and progress updates will help to 'sustain the gains' within the organization by keeping the improvement efforts and progress achieved prominent.

Measurement

Q. Many of the access metrics (advanced access T3N,) are usually physician-oriented. In general, physicians do not fall under the governance of FHT Boards. This seems like a basic disconnect. How is this reconciled?

A. Although physicians are not always directly accountable to the Boards of the organization in which they work, they share a common responsibility with the Board - ensuring that patients receive quality care.

Your QIP will likely consist of a combination of metrics that are dependent on physician/clinical care and others that are dependent on the management of the organization. The combined efforts of the administration, health care providers and other staff, complimented by strong board oversight and linkages with the community, will help support the delivery of quality care.

Q. How much emphasis should be put on standardizing the data in the EMR vs. other quality improvement activities (e.g. surveying, safety, increasing access, etc.)?

A. Standardization of data collection and tracking is important to improving quality within the organization. Organizations can consider working with their EMR providers and other primary care organizations to develop standardized queries for shared priority quality improvement initiatives. EMRs can also be used in change concepts such as enabling automated triggers for evidence based practices, or patient/client reminder systems.

The EMR can support data collection, but this can also be achieved without the EMR in place. Ongoing data collection and data monitoring can be used to identify opportunities for performance improvement. Every organization will be at a different stage in their quality improvement journey, and will have different challenges and priorities. For those that are at the appropriate stage, using the EMR can be an effective means to support quality and standardizing data in the EMR can add tremendous value.

Q. During the webcast it was mentioned that ALC rate and re-admission rate are metrics of integration between primary care and hospitals. Are there any other similar metrics?

A. A number of metrics exist that can support measuring integration between primary care and hospitals. A short list of these metrics is provided below:

- Percent of patients who visited the ED for conditions best managed elsewhere
- Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions
- Hospitalizations for ambulatory care sensitive conditions (ACSC)
- Hospital Readmission within 30 days for select Case Mix Groups
- Patient admissions (all causes)
- ED visits (all causes)

Data for groups with rostered patients will be available on the Health Data Branch portal in February, 2013. Please go to https://hsimi.on.ca/hdbportal/user/register to register for access to the primary care site.

Q. How do the QIP PHC indicators line up with the work that took place at the Ontario Primary Care Performance Measurement Summit on November 21, 2012?

A. The organizers of the Ontario Primary Care Performance Measurement Summit and Health Quality Ontario are committed to moving forward on the recommendations related to the measurement priorities identified by participants to inform a range of future primary care performance measurement activities, including QIPs. The Summit proceedings were broadly circulated in an effort to inform and synchronize measurement efforts in Ontario. For more information about the Summit or the work of the Primary Care Performance Measurement Steering Committee, please feel free to email PCPMSummit@hqontario.ca.

Surveys

Q. Could HQO or the MOHLTC support us by providing and analyzing a primary care Patient/Client Survey focusing on the three dimensions?

A. Patient/client experience is increasingly recognized as an important indicator of quality in primary care. In recognition of this, many practices across the province are now using patient/client experience surveys to collect information on how their patients/clients feel about the services provided by their primary care organization.

The long-term vision for Ontario is a standardized, organization-based survey that is consistent with surveys for other sectors but sensitive to the unique elements of primary care. In the absence of a standardized, practice-based primary care patient/client experience survey, many organizations are creating their own surveys, sharing surveys with other practices, or using survey questions found in relevant literature. Whatever your organization's approach, four core questions have been identified. Please see Appendix 2 of the Primary Care QIP Guidance materials: (http://www.health.gov.on.ca/en/pro/programs/ecfa/docs/qi_pri_app2.pdf).

This year may be the first time some organizations collect experience information from their patients/clients. Other organizations may be routinely collecting this type of information. For those new to the process, this should not be an arduous task. Please see Appendix 2 of the Primary Care QIP Guidance materials for some recommendations for implementing primary care patient/client experience surveys: (http://www.health.gov.on.ca/en/pro/programs/ecfa/docs/qi_pri_app2.pdf).

QIP Development Process

Q. How have the Registered Nurses' Association of Ontario (RNAO) and the Nurse Practitioners' Association of Ontario (NPAO) been involved in the QIP development process?

A. These associations have been important participants in the development of QIP materials. Both associations participated in the Primary Care Roundtable in August, and have been part of the discussions leading up to the development and release of the materials.

Governance Training

Q. Because of the high demand for the Governance Training sessions, is there any discussion of having more sessions open up?

A. The high level of interest in primary care governance training is an indication of the level of commitment and enthusiasm of this sector. Unfortunately this means that the sessions are at full capacity. However, one of the goals is to ensure good representation from across the province and among all models of primary care. If organizations have not been able to sign up, we encourage them to get onto the wait list as there may still be a chance that they will be placed in one of the upcoming sessions. Moreover, we are trying to accommodate additional sessions in the future and we will be using the wait list to identify the need for these sessions. To access the wait list, please see: https://events.r20.constantcontact.com/register/eventReg?oeidk=a07e6y7uiac83d1f49a&oseq=&c=&ch.

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Q. Should a QIP not meet the standards of expectation in the first submission, will there be immediate and direct support/guidance to review and revise, specifically noting areas that need to be enhanced/enriched/etc.?

A. For year 1, HQO anticipates a high degree of variation in the interpretation of QIP expectations and direction provided via guidance materials. HQO will provide support and guidance to primary care organizations about improving the content of the QIP, aligning the QIP with strategic priorities for the organization, as well as implementing QIPs in practice.

HQO is preparing a multi-modal approach to providing this support and guidance, including webinars, workshops and in person sessions. Importantly many of these topics will be included in the Analysis for Improvement Report which is expected to be released in the fall of 2013. This report aims to highlight key themes for improving quality of care and services in primary care as shared in the QIPs, success stories, challenges facing primary care organizations, as well as opportunities for improvement. The document will also provide guidance on how primary care organizations can strengthen their QIP as a means of communicating their goals and accomplishments to each other and the public.

Q. Will there be a process of reporting outcomes of this year's goals?

A. Yes. Health Quality Ontario will report on measures and outcomes as reported in QIPs via the annual Analysis for Improvement Report. Please see above.