

# Primary Care

## Impressions and Observations 2016/17 Quality Improvement Plans



# About Us

Health Quality Ontario is the provincial advisor on the quality of health care. We are motivated by a single-minded purpose: **Better health for all Ontarians.**

## Who We Are.

We are a scientifically rigorous group with diverse areas of expertise. We strive for complete objectivity, and look at things from a vantage point that allows us to see the forest and the trees. We work in partnership with health care providers and organizations across the system, and engage with patients themselves, to help initiate substantial and sustainable change to the province's complex health system.

## What We Do.

We define the meaning of quality as it pertains to health care, and provide strategic advice so all the parts of the system can improve. We also analyze virtually all aspects of Ontario's health care. This includes looking at the overall health of Ontarians, how well different areas of the system are working together, and most importantly, patient experience. We then produce comprehensive, objective reports based on data, facts and the voice of patients, caregivers and those who work each day in the health system. As well, we make recommendations on how to improve care using the best evidence. Finally, we support large scale quality improvements by working with our partners to facilitate ways for health care providers to learn from each other and share innovative approaches.

## Why It Matters.

We recognize that, as a system, we have much to be proud of, but also that we often fall short of being the best we can be. Truth be told, there are instances where it's hard to evaluate the quality of the care and times when we don't know what the best care looks like. Last but not least, certain vulnerable segments of the population are not receiving acceptable levels of attention. Our intent is to continuously improve the quality of health care in this province regardless of who you are or where you live. We are driven by the desire to make the system better, and by the inarguable fact that better... has no limit.

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# Introduction

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## Quality Improvement Plans

**A just, patient-centred health system that is committed to relentless improvement.** This is our vision for Ontario's health system as defined in [Quality Matters](#).

One way that organizations and providers demonstrate this commitment is by sharing their efforts to improve quality in the Quality Improvement Plans (QIPs) that they submit each year. The development of these QIPs and the work that is described within them represent a remarkable effort by health care organizations. In April 2016, more than 1,000 hospitals, long-term care homes, community care access centres, and interprofessional team-based primary care organizations across Ontario developed and submitted QIPs.

The QIPs include three components: the Progress Report, the Narrative, and the Workplan. In the Progress Report, organizations reflect on their quality improvement activities and achievements over the previous year. In the Narrative, organizations provide context about themselves and elaborate on key themes such as the collaborations they are forming and how they are working to engage patients and their families/caregivers in their quality improvement work. Finally, in the Workplan, organizations identify the issues that are important to them and describe their plans to address these issues over the coming year. All submitted QIPs are [publicly available](#) on Health Quality Ontario's website, representing a public commitment to quality improvement.

## Setting priorities for improvement

Each year, Health Quality Ontario works with multiple stakeholders to identify a handful of key quality issues to prioritize across the province, and defines specific priority indicators that organizations can use to track their performance on these key issues in their QIPs. These may reflect sector-specific priorities or system-wide, transformational priorities for which improvement depends on collaboration among sectors. In addition to these key issues, organizations are encouraged to identify issues that are important within their own organization or in a local context, and use the QIP as a tool to improve on these issues as well.

The priority issues/indicators correspond to the six dimensions of a quality health care system (*safe, effective, patient-centred, efficient, timely, and equitable*).<sup>1,2</sup> They also align with Health Quality Ontario's work in monitoring health system performance in the province, which is summarized in the [Common Quality Agenda](#) and our yearly report, [Measuring Up](#).

## About this report

The purpose of this report is to share what organizations across the province are working on and how; to highlight a few inspiring initiatives; and to share where there is room for improvement in the province. These examples are drawn from the careful review of each QIP to evaluate the data and change ideas described within.

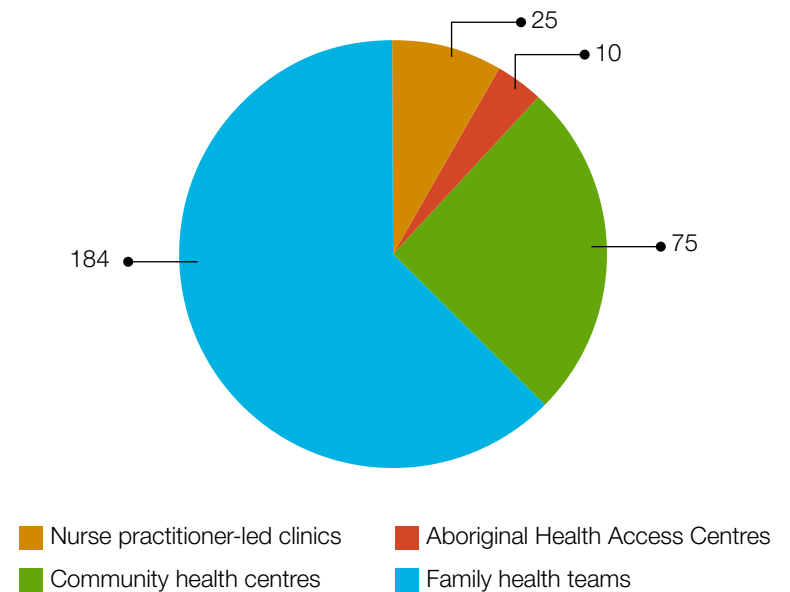
Our analysis of the 2016/17 QIPs is presented in three chapters:

- **Chapter 1: Overarching Observations**, which describes our broad observations from the analysis and touches on key themes and issues for each sector
- **Chapter 2: Priority Issues/Indicators: Highlights from the 2016/17 QIPs**, which briefly summarizes performance on the priority indicators, key change ideas that organizations are using to improve on these indicators, and spotlight examples of innovative change ideas
- **Chapter 3: Moving Forward**, which summarizes our key observations, provides guidance on how organizations can improve the quality of care they provide as they move forward, and links to a few key sources for readers who are looking for more information on the 2016/17 QIPs

## The primary care sector

The 2016/17 submissions mark the fourth year that interprofessional team-based primary care organizations in Ontario have submitted QIPs. Together, these organizations – which include family health teams (FHTs), community health centres (CHCs), nurse practitioner-led clinics (NPLCs) and Aboriginal Health Access Centres (AHACs) – employ over 3,000 physicians and more than 4,700 interdisciplinary health care providers who provide care to nearly 4 million Ontarians (Figure 1).<sup>3</sup>

**Figure 1. Number of primary care organizations that submitted QIPs.**



*All primary care organizations that were required to submit a QIP did so.*

# Chapter 1: Overarching Observations

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Our analysis of the 2016/17 QIPs has highlighted the considerable efforts primary care organizations in Ontario are taking to improve the care that they provide. There are many successes to celebrate, but as always, there remains room for further improvement in some areas. This section presents the overarching observations from our analysis of the 2016/17 QIPs.

## **Primary care organizations are applying the lessons they've learned to new projects**

Organizations have made considerable progress on improving colorectal and cervical cancer screening rates among their patient populations (Figure 2). Those that chose to work on these population health indicators described techniques such as electronic flagging of patients who are overdue for screening and following up with these patients to book appointments. Many organizations have adapted these successful techniques for the new population health indicator measuring glycated hemoglobin (HbA1c) testing among patients with diabetes.

## **Organizations are working to develop partnerships to support integration of care**

Partnerships among organizations in different sectors of the health care system are key to providing integrated care to patients in Ontario. In the QIPs, partnerships with hospitals are especially important for primary care organizations as they work to improve effective transitions, as measured by the seven-day post-discharge follow-up rate for selected conditions

indicator. Primary care organizations also demonstrated their commitment to improving transitions of care between hospital and home through the work that they described on two additional indicators: emergency department visits for conditions best managed elsewhere (selected by 63% of organizations) and hospital readmission rate for primary care patient population (selected by 54% of organizations).

The number of partnerships described in the 2016/17 QIPs increased compared with the 2015/16 QIPs. Primary care organizations' most commonly described partnerships were with hospitals (80%) and Health Links (60%), followed by community care access centres (47%) and other primary care organizations (43%). Some primary care organizations also reported partnerships with long-term care homes (9%).

## **There are both successes and opportunities for improvement on the patient experience indicators**

Primary care organizations have increased the numbers of patients surveyed by ~30% over the 2015/16 QIPs, with more than 93,000 patients being surveyed on the patient experience questions this year. However, there is still considerable variation in the survey sample size among organizations (ranging from one respondent to 4102 respondents), and some organizations need to increase the number of patients they are surveying to ensure a representative sample size.

While organizations may need to work on improving their survey sample size, they should also remember that the main goal of working on the patient experience indicators is to improve patient experience. In the 2016/17 QIPs, the most commonly cited change ideas for the three patient experience indicators were related to improving survey methodology, rather than improving patient experience.

As primary care organizations work on surveying their patients, they should consider using the [Primary Care Patient Experience Survey](#) produced by Health Quality Ontario, which includes the survey questions that are included as priority indicators for the 2016/17 QIPs. This survey is available in multiple languages, and the questions are validated and reliable. Organizations can also adapt the survey to add questions that are relevant to their local context.

### **Organizations are increasing their efforts to engage patients**

Engaging with patients, family members, caregivers, and the public in efforts to improve the health care system is essential to promoting person-centred care. We are pleased to observe that the percent of primary care organizations that described use of Patient and Family Advisory Councils in their 2016/17 QIPs has increased compared with the 2015/16 QIPs (11% in 2015/16 vs 20% in 2016/17). In addition, the percent of organizations that reported engaging with patients and families in the development of their QIPs has also increased (9% in 2015/16 vs 19% in 2016/17).

### **The primary care sector is relatively advanced when it comes to promoting health equity**

In the 2016/17 QIPs, primary care organizations entered more custom indicators focused on health equity than any other sector that submitted QIPs. These indicators were most commonly related to:

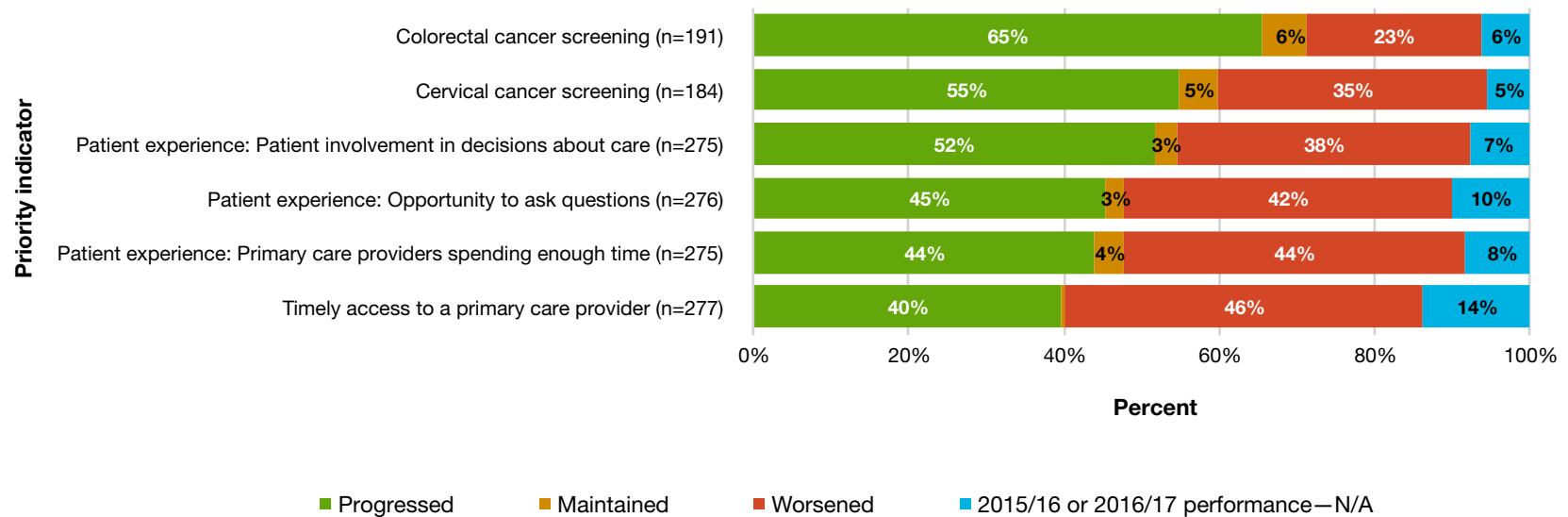
- Collection and analysis of data (e.g., demographic data)
- Cultural competency training
- Program planning
- Access to care among different populations (e.g., low-income or homeless populations, or those residing in rural or northern communities)

The efforts of the primary care sector are commendable, but much work remains to be done on this important issue. In early 2017, Health Quality Ontario will be releasing a Health Equity Snapshot to summarize and share examples of the activities related to health equity that were reported in the 2016/17 QIPs. We encourage organizations to read this report to learn about what other organizations are doing to promote health equity across the province.

### **Looking back: Change in performance from the 2015/16 QIPs**

Figure 2 shows the rate of progress (i.e., the percentage of organizations working on a priority indicator that improved their performance compared with last year) for the priority QIP indicators. The indicators with the highest rate of progress included the colorectal and cervical cancer screening indicators. The patient experience indicators showed a moderate rate of progress, while the lowest rate of progress was observed for the timely access to a primary care provider indicator.

**Figure 2. Looking back: Percentage of primary care organizations in Ontario that progressed, maintained, or worsened their performance between their 2015/16 QIP and their 2016/17 QIP on priority indicators, as reported in the Progress Reports of the 2016/17 QIPs**



*This analysis includes only organizations that selected the indicator in their 2015/16 QIP according to the original definition. For each organization, the current performance value reported in the 2016/17 QIP was compared with that reported in the 2015/16 QIP. This analysis is based on unadjusted self-reported data for each indicator. Due to recent changes to the data for the indicator measuring seven-day post-hospital discharge follow-up rate for selected conditions, this indicator was not included in this analysis.*



## Looking forward: Selection of priority indicators and target setting for the coming year

### Selection of priority indicators

The rate of selection of the priority QIP indicators was very high among primary care organizations, ranging from 94% to 100% (Table 1). Furthermore, the rate of selection has increased for every priority indicator when compared with the 2015/16 QIPs. We are pleased to see so many primary care organizations across the province focusing on these important issues.

### Target setting

Target setting is an important feature of the QIP. The targets chosen for any given indicator vary among organizations and may be influenced by many factors, including current performance and input from stakeholders. Most organizations set targets to improve over the coming year. The percent of organizations that set targets to improve ranged from 73% for the patient experience: primary care provider spending enough time indicator to 92% for both the timely access to a primary care provider and HbA1c testing indicators (Table 1).

A few organizations set retrograde targets in their 2016/17 QIPs (i.e., they aim to worsen their performance over the coming year). Some of these organizations may be performing well and may believe that additional improvement is unlikely, while some CHCs justified their retrograde targets by indicating that they are aiming for a Multi-Sector Service Accountability Agreement target. We encourage organizations to maintain a steady course toward improvement, rather than set a target that they have already surpassed. A discussion of target setting and performance measurement for the purposes of accountability versus quality improvement is included in our new document, [How the Quality Improvement Plan and the Service Accountability Agreement Can Transform the Health Care System](#).

**Table 1. Selection of priority indicators and direction of target setting for the coming year, as reported in the Workplans of the 2016/17 QIPs**

Indicator	Organizations that selected the indicator according to the original definition, n (%)	Organizations that selected the indicator and set a target to improve on the indicator, n (%)*
Timely access to a primary care provider	288 (100%)	234 (92%)
Colorectal cancer screening	279 (97%)	224 (89%)
Glycated hemoglobin testing	279 (97%)	158 (92%)
Patient experience: Patient involvement in decisions about care	278 (97%)	195 (76%)
Patient experience: Opportunity to ask questions	279 (97%)	193 (76%)
Patient experience: Primary care providers spending enough time	277 (96%)	185 (73%)
Cervical cancer screening	277 (96%)	225 (90%)

\*Organizations for which the target setting direction could not be calculated (e.g., those reporting their current performance as “collecting baseline”) were excluded from this analysis. Due to recent changes to the data for the indicator measuring seven-day post-hospital discharge follow-up rate for selected conditions, this indicator was not included in this analysis.

# Chapter 2: Priority Issues/Indicators: Highlights from the 2016/17 QIPs

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This section of the report contains highlights on organizations' performance on the priority issues/indicators for the 2016/17 QIPs.

We present a summary of organizations' approaches to improving on each issue/indicator, including key change ideas. We encourage organizations to review these key change ideas and consider whether any might be suitable for adoption in the future.

## Population health indicators

These three priority indicators are related to population health and were new priority indicators for the primary care sector in 2016/17.

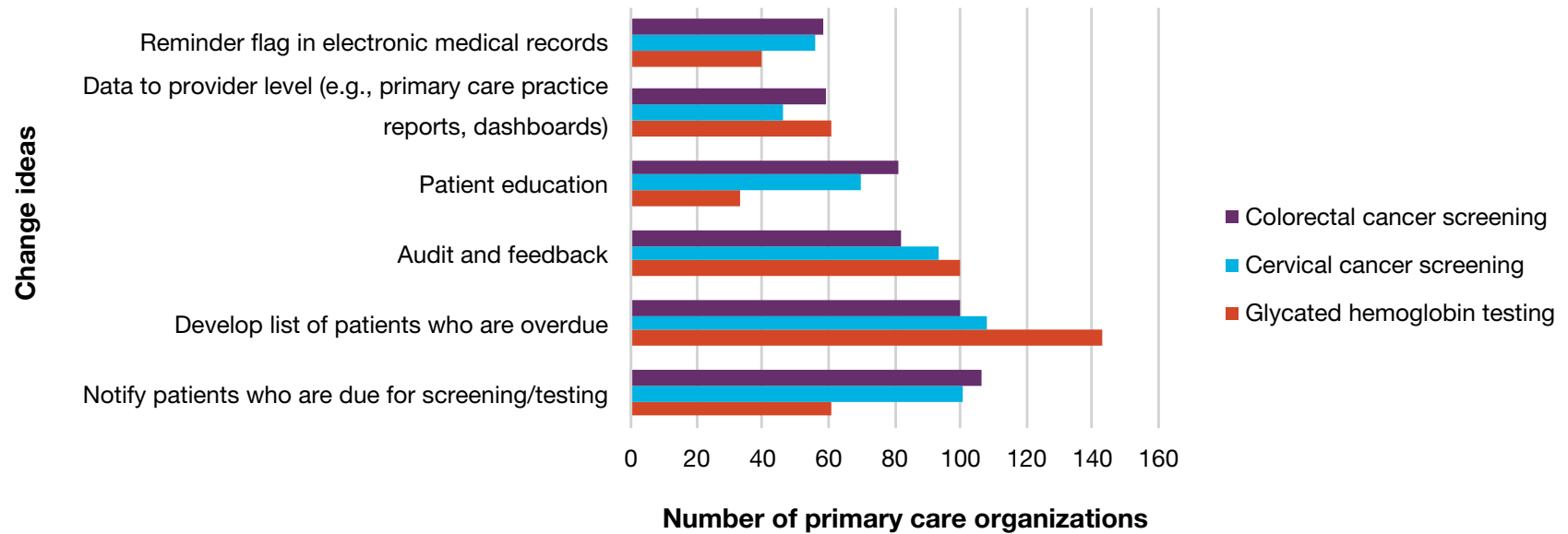
- **HbA1c testing:** Percentage of patients with diabetes, aged 40 or over, with two or more HbA1c tests within the past 12 months
- **Cervical cancer screening:** Percentage of women aged 21–69 who had a Papanicolaou (Pap) smear within the past three years
- **Colorectal cancer screening:** Percentage of screening-eligible patients up-to-date with colorectal cancer screening

## Progress and current performance

The two cancer screening indicators were included as additional indicators in the 2015/16 QIPs, while the HbA1c testing indicator is new in the 2016/17 QIPs. The median self-reported current performances in the 2016/17 QIPs were 61% for colorectal cancer screening, 69% for cervical cancer screening, and 59% for the new HbA1c testing indicator. There is considerable variation in the current performance for these indicators (e.g., for HbA1c testing, current performance ranged from 1% to 99%). On average, the targets that organizations set for these indicators were relatively ambitious (ranging from 4% to 9% improvement).

## Approaches to improving performance on these indicators

The most frequently cited change ideas were similar across these three indicators. Organizations applied the strategies they used for the cancer screening indicators to the HbA1c testing indicator as well (Figure 3).

**Figure 3. The most frequent population health change ideas planned for implementation in 2016/17**

Organizations have access to quality data on cancer screening at the Local Health Integration Network (LHIN), organization, and provider levels – for example, through Health Quality Ontario’s Primary Care Practice Reports (which also include data on HbA1c testing) as well as Cancer Care Ontario’s Screening Activity Reports. Sophisticated strategies are being implemented by organizations with access to business intelligence software that is able to mine the data to identify at-risk populations for program planning. For example, CHCs have access to the Business Intelligence and Reporting Tools (BIRT) platform, which provides analytical tools to look at data across the sector and benchmark performance.

Seven CHCs in the Toronto Central LHIN have organized a quality improvement collaborative to share their quality improvement capacity with one another. Their first collaborative quality improvement initiative will be focused on

improving colorectal and cervical cancer screening rates. **Central Toronto Community Health Centre** (known as Queen West Community Health Centre) further plans to apply an equity lens to improving their screening rates for under- and never-screened populations (those who are low-income earners and those who have less than a post-secondary education).

Another organization that is taking health equity into consideration while working on the cancer screening indicators is **Noojmowin Teg Health Centre**. They plan to re-institute a stronger role in facilitation of screening campaigns specific to Aboriginal communities by capitalizing on existing campaigns (such as that of the Federation of Medical Women of Canada) and leveraging their involvement with the North East Aboriginal Screening Network (Under/Never Screened Network), the North East Aboriginal Cancer Advisory Committee, and Cancer Care Ontario – Aboriginal Cancer Control Unit.

Several organizations have also added My Cancer IQ materials to clinics to support learning. For example, **Brighton Quinte West Family Health Team** uses the My Cancer IQ tool at counselling appointments with the nurse or nurse practitioner. They have also integrated a new tablet with the preventative screening outcomes and demonstrated an increased rate of screening and counselling to reduce cervical cancer risks. A patient-centred approach is used for the counselling, which is reinforced through the additional training in “teach-back” that providers have received. Patient advisors are active participating members of the planning/implementation committees, ensuring a patient focus.

**Cottage Country Family Health Team** created a postcard-style mail-out that included a picture of the primary care provider, a hand-written note to the patient strongly encouraging them to submit their fecal occult blood test and with a “poop scoop” tip on the back of the card. They are now working to spread this change idea to other primary care providers.

## Patient experience indicators

Patient experience is measured using three distinct but related indicators:

- Patient involvement in decisions about care
- Primary care providers spending enough time with patients
- Opportunity to ask questions

Performance on these three indicators is typically correlated; thus, we have presented them together here.

### Progress and current performance

Overall performance on the patient experience indicators is high (median 92% to 93%). There was less variation in these indicators compared with the other priority indicators, with performance ranging from 59% to 100%. However, approximately 10% of these organizations set targets to worsen their performance over the coming year, by an average of 3% below this year's value. This might be due to a perceived ‘ceiling effect’, where organizations may not believe that there is room for improvement.

### Survey sample size

- There was a 30% increase in the total number of patients surveyed in the 2016/17 QIPs compared with the 2015/16 QIPs (more than 93,000 respondents in 2016/17 versus ~70,000 in 2015/16).
- There was a huge range in sample size among organizations (ranging from one to 4102 respondents).
- The median number of patents surveyed per organization was between 163 and 166 for these three indicators.

### Approaches to improving performance on these indicators

Patients at the **Tilbury District Family Health Team** had a greater voice in their QIP this year. Tilbury used the feedback from the basic patient survey and added new questions, provided in-depth discussion groups and had patients join their Quality Improvement Committee. This helped them identify areas of focus for improvement.

**East GTA Family Health Team** adopted an advanced care planning toolkit to ensure elderly patients are involved in planning for decisions regarding their care and treatment in the future, when they may be unable to be involved. These care plans are developed in consultation with the patients and their caregivers. The East GTA Family Health Team is also working in partnership with other organizations (e.g., hospitals, other community support organizations) to proactively develop integrated care plans in consultation with patients and their caregivers. The family health team went from collecting baseline data in 2015/16 to a performance value of 97% in their 2016/17 submission on the survey question related to involving patients in decisions about their care and treatment.

## Timely access to a primary care provider

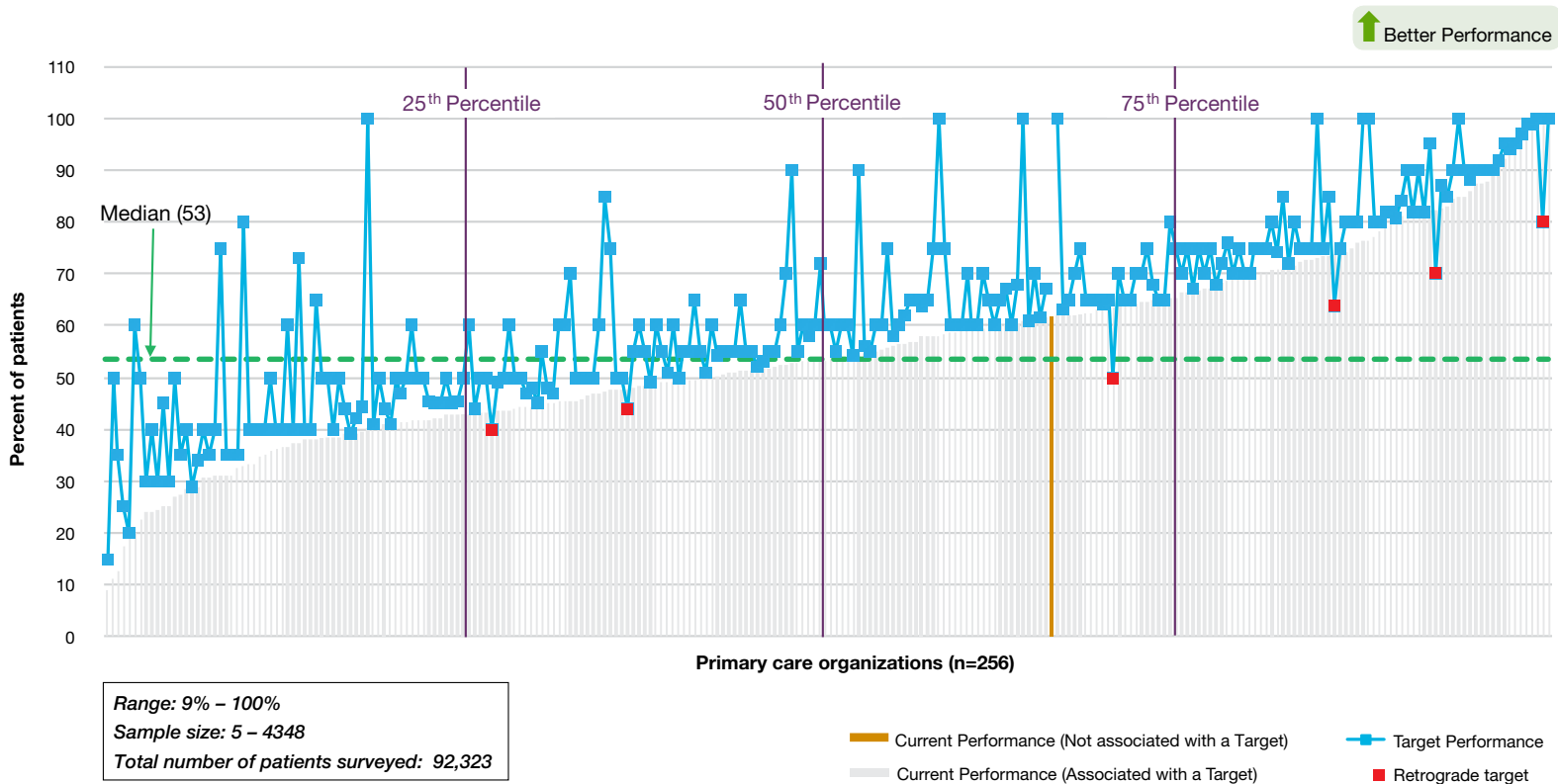
This indicator measures the percentage of patients and clients who reported that they were able to see a doctor or nurse practitioner on the same day or next day when needed. Organizations self-report data from their patient surveys on patients' perception of timely access.

For publicly reported data in Ontario, see Primary Care Sector Performance: [Timely access to a primary care provider](#).

## Progress and current performance

There is high variation in performance on this indicator, ranging from 9% to 100% of patients responding that they were able to see a doctor or nurse practitioner on the same day or next day (Figure 4). Some organizations with relatively low performance set targets to maintain their current performance rather than improve, and a small number set retrograde targets for the coming year. In addition, there was a huge variation in the survey sample size.

**Figure 4. The percentage of patients who reported that they were able to see a doctor or nurse practitioner on the same day or next day when needed, 2016/17 QIPs**



### Approaches to improving performance on this indicator

The majority of organizations continue to focus on the following strategies:

- Audit and feedback, which includes the use of individualized reports for providers to give feedback on their performance.
- Survey methodology/increasing sample size. Over 92,000 patients were surveyed on their ability to access their provider. Options to administer surveys such as use of email continues to expand.
- Use of [Advance Access principles](#), which involve striving to improve access (providing timely patient access to a scheduled appointment with the patient's primary care provider) and *efficiency* (being more efficient in the office processes leading up to, during, and after a patient's appointment).

Patients at the **Carefirst Family Health Team** are informed of non-urgent laboratory reports by nurses, eliminating the need for physician visits to receive these results. The majority of patients are satisfied with this approach.

**East End Health Centre** refined a new physiotherapy triage process to allow for more clients with urgent musculoskeletal needs to be seen by a physiotherapist rather than see a nurse practitioner or physician where appropriate.

**Markham Family Health Team** reports that their Advanced Access efforts have reduced their Third Next Available measure (a process measure for timely access to care). They are now piloting online scheduling for same day/next day bookings to both enhance the ease of accessing an appointment and reduce the burden on their phone system.

### Additional approaches to improving timely access to care

Some organizations described initiatives intended to improve timely access to care as a way of working on other indicators. For example, **Maple Family Health Team**, the lead organization for the Kingston Health Link, has been working to lower the percentage of patients who attend the emergency department for conditions best managed elsewhere. Strategies employed by Maple include a seven day/week after-hours walk-in clinic, review of patient appointment scheduling by providers, working through the Health Link to link complex patients with primary care providers, and consistently working on communication strategies to educate patients about the team's hours, programs and services. Through the deployment of these approaches, Maple has been successful in lowering the percentage of patients attending the emergency department for conditions best managed elsewhere from 2.50% to 1.92%, well below the South East LHIN average of 3.1%. This represents a reduction of 262 emergency department visits.

## Seven-day post-hospital discharge follow-up rate for selected conditions

This indicator measures the percentage of patients or clients who see their primary care provider within seven days after discharge from hospital for selected conditions. There are certain limitations relating to the data available for this indicator;\* however, it provides organizations with insights into their patients' experiences as they move across the health care system.

For 2017/18, a new version of the indicator, which will measure follow-up by telephone or in person by any clinician within seven days of discharge, will also be available for organizations to use. This indicator will provide more timely data and will be more consistent with a full interprofessional team approach, as it will capture follow-up by other team members in addition to primary care providers. Improvement on these measures will be facilitated by the addition of an indicator for hospitals related to the provision of discharge summaries within two days of discharge to primary care organizations.

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\* In January 2017, we were notified of a revision to the data provided for this indicator for the 2014/15 reporting period. We have removed the analyses that may be affected by this revision from the present report, and will release an update with information on the revised 2014/15 data when it is available. Other limitations include the fact that the available data are delayed by close to two years. In addition, for the 2016/17 QIPs, there was a change in the indicator definition to include patients admitted with acute myocardial infarction (thus increasing the denominator of the indicator). This indicator also includes only patients rostered at the time of discharge to an Ontario physician, and includes only follow-up provided by any general practitioner/family physician, geriatrician, or pediatrician in the practice group the patient is rostered to.

### Approaches to improving performance on this indicator

Creating partnerships with other sectors (mainly hospitals) was the most common strategy reported by organizations working on this indicator. The second most common strategy was implementing electronic solutions such as Hospital Report Manager software.

**Guelph Family Health Team's** local hospital, Guelph General Hospital, has been testing processes for patients with chronic obstructive pulmonary disease and chronic heart failure to contact the office directly prior to discharge to book a follow-up appointment, as per the quality-based procedure. All 21 clinic sites across the Guelph Family Health Team have implemented Hospital Report Manager software. They are working with the hospital to turn on the eNotification feature, which will provide the admission, discharge and transfer information for visits to the emergency department.

**The VON Nurse Practitioner-Led Clinic** described the following approaches to achieve their target of 100% follow-up after hospital discharge:

- Contacting the local hospitals and ensuring the nurse practitioners were listed as primary care providers
- Creating a wallet hospital card with contact information for the clinic and nurse practitioners for the patient to present at the emergency department
- Informing and educating their patients and the community of the importance of follow-up after a hospital visit
- Tracking the known emergency department and hospital discharge dates and follow-up dates on a spreadsheet
- Implementing use of Hospital Reports Manager software

# Chapter 3: Moving Forward

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## Adapting successful approaches to other indicators

Organizations have been able to successfully adapt their approaches to improving on the cancer screening indicators to the HbA1c testing indicator. The same strategies could also be adapted to monitor other population health indicators. To go further, organizations could consider assessing their patient populations based on the determinants of health (e.g., income) and developing interventions that are tailored to the groups of patients with the most opportunity to improve. The outcomes for the groups with the best health outcomes should be considered as a goal for improvement for the groups with the worst health outcomes.

## Developing partnerships to support effective transitions in care

Primary care organizations need to be able to identify patient transitions in care and any significant changes in patients' care plans in order to take action to smooth these transitions. To do this, they will need to continue to grow partnerships and create technological bridges across sectors and to other community supports. Organizations have reported partnerships with hospitals and through Health Links as strategies to improve these transitions.

## Engaging patients

Primary care organizations have increased their efforts to engage with patients and their families/caregivers over the past year, and should continue to work on this in the future. More information about how organizations have engaged patients and their families/caregivers can be found in our report, [Engaging with Patients: Stories and Successes from the 2015/16 Quality Improvement Plans](#). In addition, we have produced a guide, [Engaging with Patients and Caregivers about Quality Improvement: A Guide for Health Care Providers](#), which focuses specifically on engaging about quality improvement and QIP development.

## Promoting health equity

Of the four sectors of the health system that submitted QIPs in 2016/17, primary care has made the most progress in terms of incorporating consideration of health equity into their quality improvement initiatives. The primary care organizations focusing on health equity should be commended for their work on improving this important aspect of care for Ontarians.

Looking forward, organizations should consider collecting demographic data, which can be associated to outcomes to determine which populations require special focus when planning quality improvement efforts. More information on this and other approaches to health equity that health care organizations across Ontario have described in their QIPs will be presented in Health Quality Ontario's health equity snapshot, which will be released in early 2017. Organizations should also refer to Health Quality Ontario's [Health Equity Plan](#), which provides more information about health equity in Ontario and what we plan to do to address it.



## Selecting priority issues

Primary care organizations are working hard on priority issues and their corresponding indicators, as demonstrated by the high selection rates for all of the priority indicators. While recognizing that it is important for organizations to retain focus on the issues that are important to them in their QIPs, we are pleased with the current level of commitment to improving on the priority issues.

## Setting targets for improvement

Many primary care organizations set targets for improvement this year. Ideally, targets will be set in the direction of improvement, and should be aspirational yet realistic. Stretch targets should be set in areas that are particularly important to the organization (e.g., for indicators on which their performance is poor). It may also be appropriate for organizations to set a target to *maintain* their performance on an indicator. For example, an organization may be performing well on a priority indicator and may choose to focus their improvement efforts elsewhere while still using the QIP to share their ongoing change ideas and monitor their performance. Organizations should refer to Health Quality Ontario's [QIP Guidance Document](#) for more information on target setting.

Close to 25% of organizations that selected the patient experience indicators did not set targets for improvement. Performance on these indicators was generally high (median 92% to 93%). If organizations are already performing very well on an indicator – such as in this case – they could consider adapting the measurement of these indicators to measure ‘top box performance’ (i.e., rather than counting the number of respondents who responded ‘always’ and ‘often’ to these survey questions, organizations should only count the number who responded ‘always’). There may be more room for improvement when these indicators are measured in this way.

## The 2016/17 QIP Program Evaluation Survey

In May 2016 – shortly after the 2016/17 QIPs were submitted – we conducted a survey of QI leads, Executive Directors, CEOs, administrators and Board Chairs to ask about their opinions and experiences with preparing and supporting QIPs in their organizations.

Respondents generally reported positive opinions on the QIPs:

- 70% of Executive Directors or administrators agreed or strongly agreed that the QIP is helping to build a quality-driven culture in their organization.
- The majority of Board Chairs (81%) said that the QIPs encouraged the Board to talk about quality and quality improvement.

However, the survey responses also revealed opportunities for improvement and areas where organizations need more support. For example, we will be increasing our efforts to get organizations thinking about how they can use the QIP to support their efforts toward patient engagement and integration/partnerships.

As part of this effort, we have released a report that shares stories of patient engagement from the 2015/16 QIPs ([Engaging with Patients: Stories and Successes from the 2015/16 Quality Improvement Plans](#)) and a [guide](#) for health care providers looking to engage patients and their families/ caregivers in quality improvement. We are also working on a similar analysis related to stories of integration and partnerships in the 2016/17 QIPs, and have released 14 [LHIN Snapshots](#) meant to facilitate local collaboration/ integration. Finally, we have included sections on both patient engagement and partnerships in this report. We hope that these actions will bring patient engagement and integration/partnerships to the forefront of the QIP program in future years.

## Moving forward with QIP development

Several emerging issues are becoming increasingly prominent in Ontario, including palliative care, mental health, opioid use and prescribing practices, and workplace safety. Primary care organizations in Ontario should consider how they can improve on these issues, as they may be incorporated into the QIP or other initiatives in coming years. Organizations should also focus on participating in regional collaborations, which can help them to understand the health care issues affecting their area, and learn about the initiatives that their regional partners are working on and how they can be involved. Finally, as organizations work to develop their 2017/18 QIPs, they should be sure

to engage all of their staff clinicians in the process. QI is conducted most effectively when there is buy-in from all who will be affected by a change.

Overall, the 2016/17 QIPs demonstrate that primary care organizations are not simply recognizing that opportunities for improvement exist, but are taking meaningful action towards improvement, engaging their patients and partners and learning from successes and failures along the way. It is this commitment to relentless improvement that will result in a just, patient-centred health system for all Ontarians.

## Where to go for more information

This report is intended to be a summary of our observations, rather than a detailed description of all of the information in the 2016/17 QIPs. There is a vast amount of data presented in these QIPs that is not discussed in this report.

Here are a few key sources for more information on the 2016/17 QIPs and tools for improvement while developing next year's QIPs:

- [Query QIPs](#) and [Download QIPs](#): The Query QIPs tool allows the user to search within all submitted QIPs using filters such as keyword, LHIN or indicator. For example, users might search the Workplans of all QIPs for a particular indicator to read how organizations plan to improve on that indicator, or might search for “equity” in any section of the QIPs to identify how organizations are supporting health equity across the province. The Download QIPs tool is a searchable database of all QIPs submitted to Health Quality Ontario, and allows the user to read the full text of any QIP that they are interested in.

- [The Indicator Library](#): This resource is a fully searchable library that includes all indicators on which Health Quality Ontario reports. Each indicator page includes a description of the indicator, its technical specifications, information on its alignment with similar indicators, information about and/or links to data sources, and other details about the indicator.
- [Quality Compass](#): This evidence-informed, searchable tool presents best practices, change ideas, targets and measures, and tools and resources for the priority indicators selected for the coming year's QIPs, as well as for other common indicators.
- [Measuring Up](#): Health Quality Ontario's yearly report on health system performance presents data on indicators described in the [Common Quality Agenda](#), which largely align with the priority and additional indicators described in the QIPs.

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## References

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