Quality Standards

Process and Methods Guide

October 2016

About This Guide

This guide describes the principles, process, methods, and roles involved in selecting, developing, and implementing Health Quality Ontario's quality standards. It will be updated according to the process described in section 11.

ABOUT HEALTH QUALITY ONTARIO

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, caregivers, and the public 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 the public 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 it often falls short of being the best it can be. We also know that certain vulnerable segments of the population are not receiving acceptable levels of attention. Our intent at Health Quality Ontario 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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1 INTRODUCTION

1.1 Quality Standards: Overview

One of Health Quality Ontario's legislated responsibilities is to "mak[e] recommendations to health care organizations and other entities on standards of care in the health system, based on or respecting clinical practice guidelines and protocols."[1] This document describes the process and methods Health Quality Ontario uses to develop the quality standards produced in response to this mandate.

Quality standards are concise sets of evidence-based, measurable statements that provide guidance on important elements of high-quality health care in a specific topic area. Quality standards focus on areas where experts, patients, caregivers, and the public have identified a need for improvement in Ontario. They address standards of care for clinically defined populations (for example, adults with schizophrenia), service areas (for example, preoperative-operative testing), and health system issues (for example, care transitions).

Each quality standard contains 5 to 15 quality statements. Each quality statement is a strong recommendation on high-quality practice for a specific aspect of care. Each quality statement is accompanied by one or more process, structural, or outcome indicators to help health care professionals and organizations measure their achievement of the practice outlined in the statement. Quality standards also include a small set of outcome indicators to measure the impact of the quality standard as a whole. Health Quality Ontario works with partner organizations to develop a multi-stakeholder implementation plan for each quality standard to drive and support its adoption across the province.

1.2 Quality Standards: Filling a Gap in Ontario

Quality standards are developed to be concise and measurable, making them easier for clinicians and organizations to implement. They are not intended to be professional standards of care or set minimum expectations of practice for individual health care professionals; rather, they describe what high-quality care looks like for a health system.

Quality standards are also intended to be accessible to patients, caregivers, and the public. It is often difficult for patients, caregivers, and families to determine what is most reliable or useful in the diagnosis and treatment of their conditions. To address this problem, each quality standard is accompanied by a plain-language patient reference guide that is designed to help patients, caregivers, families, and the public understand what high-quality care looks like.

1.3 How Quality Standards Can Be Used

Quality standards are useful for several audiences:

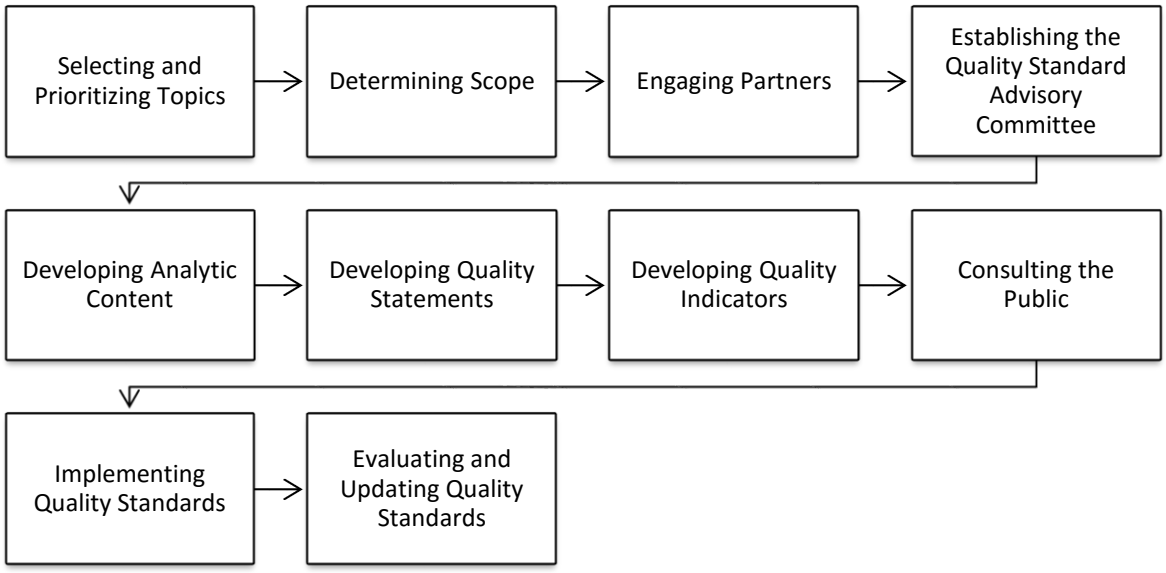
- **Patients, caregivers, and the public** can use quality standards to understand what excellent care looks like and what to ask for when receiving treatment.
- **Health care professionals** can use quality standards to guide and measure evidence-based quality improvement, and to support continuing professional development.
- **Local health integration networks and government agencies** can use quality standards to inform regional improvement strategies and performance measurement.
- **Government** can use quality standards to identify provincial priority areas, inform new data collection and reporting initiatives, and design performance indicators and funding incentives.

2 PRINCIPLES AND PROCESS OVERVIEW

The following principles underlie the selection, development, and implementation of the Health Quality Ontario quality standards:

- **They close the quality gap:** When selecting topics and developing quality statements for a quality standard, priority is given to areas where there is a significant gap between current practice and optimal practice, or where there is evidence of unwarranted variation in the quality of care in Ontario.
- **They are evidence-based:** Quality statements draw from high-quality clinical practice guidelines that are critically appraised and selected for their methodological rigour.
- **They are measurable:** Each quality statement is measurable and accompanied by one or more process, structure, or outcome indicators. A small set of overarching outcome indicators measures the impact of the quality standard as a whole.
- **They are implementable:** Consideration is given to how the quality standards will be accessed, used, and reported. Every quality standard is accompanied by tools and supports for adoption.
- **They are current:** Quality standards are reviewed each year and updated when necessary to reflect important changes in evidence or practice. Every standard is updated at least every 5 years.

The figure below provides an overview of the quality standards development process.



3 SELECTING AND PRIORITIZING TOPICS

3.1 Topic Intake

Potential topics are identified through several avenues:

- **Public input:** A quality standard topic submission form and accompanying instructions are available and accessible to the public on the Health Quality Ontario website.
- **Partner organizations:** Health Quality Ontario encourages partner organizations to submit topics that are of importance to them.
- **Internal priorities:** Health Quality Ontario conducts periodic internal scans to identify topics that will support its other programs, including the Quality Improvement Plans, health technology assessments, and performance reporting vehicles.
- **Health Quality Ontario Patient, Family, and Public Advisors Council:** The council suggests potential quality standard topics that are important to patients and the public.
- **External committees:** Performance measurement and reporting committees, provincial quality implementation committees, regional quality tables, and the Ontario Health Technology Advisory Committee may suggest new topics for quality standards.
- **Ministry of Health and Long-Term Care:** The ministry requests quality standards in topic areas that support government priorities and provincial policy direction.

3.2 Considerations for Quality Standard Topic Prioritization

Health Quality Ontario considers the following when identifying, selecting, and prioritizing topics for quality standards:

- Are there gaps between current practice in Ontario and optimal care as supported by the evidence?
- Are there gaps between current outcomes in Ontario and outcomes achieved in other jurisdictions?
- Are there unwarranted variations in practice or outcomes across regions, institutions, or populations in Ontario?
- What is the burden of disease and potential for overall health gain in the population or service area?
- What is the importance of the topic to patients, caregivers, and the public?
- What is the importance of the topic to the priorities of Health Quality Ontario's partner organizations, particularly the Ministry of Health and Long-Term Care?
- Does the topic align with Health Quality Ontario's strategic priorities and areas of focus?
- Does the topic extend beyond a single sector?
- Does the topic affect more than one profession?
- Is good evidence available to support the development of quality statements?

4 DETERMINING SCOPE

Once a quality standard topic is selected, the first stage of development work is to establish the scope of the standard, including the populations, care settings, and types of interventions that the standard will address. This helps determine the outcomes and issues that the standard will focus on.

The scoping process involves scanning existing clinical practice guidelines and other evidence sources. Where available, Ontario data are used to quantify key dimensions of the standard related to epidemiology and burden of disease, health care utilization, and quality of care.

The proposed scope of the standard, the supporting rationale, and all key information obtained in this phase of work is summarized in a **topic brief**. The topic brief supports the engagement of partners to help refine the scope and provide background information for the Quality Standard Advisory Committee (QSAC), the expert committee that develops the quality standard. See section 6 for a description of the QSAC.

4.1 Scoping Principles

- Wherever feasible, the scope should be cross-sectoral (that is, it should not be confined to a single sector, such as acute care or long-term care) and interprofessional (that is, it should not be confined to care from a single profession).
- The scope should support common, consistent standards across the health system.
- The scope defines what care should be provided, but not (unless there is good supporting evidence) who should provide it or where it should be provided.
- The scope should be clinically meaningful to health care professionals and other users of the quality standard. If the scope is too broad (for example, if it includes multiple distinct patient populations with very different care pathways), it may be appropriate to develop more than one quality standard.

4.2 Scoping Process

First, Health Quality Ontario conducts a broad search of materials related to the topic area, including:

- Clinical practice guidelines
- Existing clinical or quality standards (provincial, national, and international)
- Relevant policy and legislation
- Any current or prior Health Quality Ontario work in this area
- Published studies with relevant data on epidemiology, economics, use, and clinical practice, paying particular attention to studies published in Ontario or elsewhere in Canada
- Studies or analysis using Ontario datasets
- Information on current practice, as well as any safety and quality issues
- Information on types of interventions and their safety and efficacy
- Information on patient/client, family, and caregiver experiences

This search supports the development of the scope, including potential inclusion and exclusion criteria, and key issues to be addressed by the standard. The search is intended to be broad and is not systematic in nature.

Next, Health Quality Ontario develops a framework for new analysis using Ontario data to fill information gaps from the literature search. This includes providing relevant information on current Ontario incidence, prevalence, use, and quality issues.

Analysis may draw on materials from the previous step (such as previously validated cohorts or interventions). It may also involve exploratory analysis using Health Quality Ontario's in-house administrative data analysis capacities (for example, IntelliHealth, Canadian Institute for Health Information Portal [CIHI], and eReports) or the development of analysis plans to be executed by external research partners, such as the Institute for Clinical Evaluative Sciences (ICES). In some cases, these activities will involve simply updating previous analyses or generating alternate queries using existing protocols.

The data analysis in this stage supports decision-making around the scope of the standard, as well as subsequent stages of work. These may include the selection of key priority areas for quality statement development, the development of quality statements, and the development of quality indicators and technical specifications.

Then, using information gathered from the previous steps, Health Quality Ontario conducts an analysis of the following themes:

- Population
- Burden of disease
- Current practice, including variations in service delivery and use of interventions
- Patient, family, and caregiver experiences
- Equity issues
- Datasets and data elements that are currently available in Ontario to identify and characterize populations, health care utilization, and quality issues related to the topic area

The quality standard should aim to address key issues of quality, areas of unwarranted variation in practice or outcomes, and areas that health care professionals have identified as priorities for guidance.

Finally, Health Quality Ontario initiates a high-level implementation plan for the quality standard, identifying key partners who need to be involved in scoping, development, and implementation. It also identifies implementation issues (for example, system barriers and challenges) early on as the scope is being developed. This initial implementation plan is expanded and refined as the standard is developed.

5 ENGAGING PARTNERS

Health Quality Ontario engages partners, health care professionals, patients, families, and caregivers throughout the development of the quality standard. During scoping, Health Quality Ontario performs an initial analysis and consults with partners and system users (including health care professionals, patients/clients, families, and caregivers) to discuss key issues, obtain guidance, and validate the scope. Consultations may include informal discussions with partners and system users or more formal initiatives, such as public consultation on the Health Quality Ontario website.

Regardless of how consultation is carried out, it happens early (for example, during the scoping phase and development of the topic brief) and aims to:

- Obtain feedback on the scope and desired outcomes
- Obtain feedback on key issues and areas for improvement
- Discuss equity issues and groups that require special consideration
- Identify implementation barriers and facilitators
- Identify stakeholder groups or individuals who might join the Quality Standard Advisory Committee (QSAC) or be involved in future consultations

The results of consultation are consolidated into the topic brief, which is shared with the QSAC before its first meeting. The scope is also revised (if necessary) based on consultation feedback and shared with partners and the QSAC.

While the scope is being defined, Health Quality Ontario identifies key stakeholder organizations with an interest in the topic. Organizations may be specific to the topic (for example, disease advocacy organizations, patient advocacy organizations) or they may be standing professional or sector-based organizations that are relevant for most standards. Initial meetings are arranged with organizations to discuss:

- The scope of the standard while it is being developed (for example, how do the scoping options align with the interests and activities of the organization?)
- How partners can support development of the standard (for example, can they suggest individuals who might be considered for inclusion on the QSAC?)
- How partners can build awareness and support dissemination of the standard among their constituencies
- How partners can support the implementation and adoption of the standard

Where appropriate, Health Quality Ontario establishes official partnership agreements with key organizations. These agreements are in place for a limited time to support quality standard development and implementation.

6 ESTABLISHING A QUALITY STANDARD ADVISORY COMMITTEE

6.1 Selecting Chairs

Each Quality Standard Advisory Committee (QSAC) has two co-chairs. Co-chairs are typically recognized leaders in their field in Ontario and are chosen for their credibility, content knowledge, and facilitation expertise. Co-chairs should also be relatively free of conflicts of interest that would hinder their ability to chair the committee objectively. Co-chairs are usually selected during the scoping phase, and they provide input on scoping development. Co-chairs are usually identified by consultation with thought leaders in the topic area.

6.2 Selecting Members

The formation of each QSAC begins with the development of a skills matrix. The goal of the skills matrix is to ensure that QSAC members represent the most pertinent perspectives and areas of expertise for the topic area. Some criteria for QSAC membership are consistent across topics, such as:

- Patient and/or caregiver representation
- Geographic representation from across the province
- A mix of gender representation
- A mix of urban and rural representation
- A mix of clinical and nonclinical experiences from across the sectors, as appropriate for the topic

Health Quality Ontario also considers topic-specific membership criteria based on the scope of the project. The QSAC should include a comprehensive and appropriate mix of professional and patient perspectives.

For transparency and consistency, Health Quality Ontario posts a public open call for QSAC members. The open call is posted on the Health Quality Ontario website for approximately 2 weeks. Those interested in being part of the QSAC fill in a form that includes questions to evaluate their fit with the skills matrix, and they complete a conflict of interest statement.

The open call also goes to a list of partners, with input from the co-chairs. Partner organizations are encouraged to identify candidates for the QSAC and direct them to the open call form on the website.

6.2.1 Health Care Professionals

Health care professionals may include physicians, nurses, nurse practitioners, psychologists, occupational therapists, physical therapists, social workers, pharmacists, administrators, and researchers. The professions or specialties represented should reflect those that are typically involved in providing care or services for the topic area. It is generally desirable for clinicians to be actively practicing in the topic area.

6.2.2 Patients, Caregivers, and Others With Lived Experience

Similar to the recruitment of health care professionals, Health Quality Ontario also carries out a public open call to recruit patients, caregivers, and people with lived experience in the topic area. Patient associations and disease-specific associations are also invited to submit candidates for consideration. From the candidates identified by targeted recruitment and the open call, two to four people are chosen to be members of the QSAC.

6.2.3 Final Committee Membership

Once the open call period is finished, Health Quality Ontario maps information about the interested individuals onto the skills matrix. The list is shared with the co-chairs for their review and input. Successful candidates are contacted to confirm their membership, notify them of the QSAC meeting schedule, and request that they confirm their ability to participate.

Once the selected QSAC members have confirmed their participation, the unsuccessful applicants are informed that they have not been selected and thanked for their interest. For some quality standards, they are also asked if they would be interested in participating in the public comment process or in the dissemination and implementation of the quality standard.

6.3 Setting the Meeting Schedule

In most cases, the QSAC meets three to five times. All meetings are in-person, except for the last meeting, which is held by teleconference after the public comment process. Each meeting has a specific content focus, as described below:

- **Email survey before the first meeting:** Identify and prioritize key areas for quality statement development and key outcomes for the standard

- **First meeting:**
  - Approve the terms of reference
  - Review the process for quality statement development
  - Review the process for quality indicator development
  - Review the process for quality standard dissemination and implementation planning
  - Review and discuss data analysis to highlight the Ontario context, background, quality issues, and areas of practice variation
  - Review and approve the proposed scope of the standard
  - Identify key desired outcomes for the quality standard
  - Prioritize key areas for quality statement development
  - Review and discuss draft quality statements in key areas

- **Email survey before the second meeting:** Prioritize outcome indicators for the quality standard

- **Second meeting:**
  - Prioritize outcome indicators for the quality standard
  - Finalize quality statements
  - Finalize indicators that accompany quality statements

- **Third meeting:**
  - Finalize any outstanding content related to quality statements or indicators
  - Discuss implementation, including barriers and facilitators, levers for change, evaluation, and tools to support implementation

- **Fourth meeting (if needed, via teleconference):**
  - Review public comment results
  - Review and approve the final quality standard for board approval and launch
  - Refine the implementation plan

7 DEVELOPING QUALITY STATEMENTS

After a quality standard topic has been selected and its scope has been defined, the quality statements are developed following the steps below. These steps are listed in the order they are typically conducted in. Depending on the project, some steps may happen at the same time.

	Process Step	Description
1.	Searching guidance sources	Comprehensive search to identify guidance sources relevant to the quality standard topic
2.	Appraising and selecting guidelines	Critical appraisal of the identified sources to select relevant, high-quality guidelines as the evidence base for the quality standard
3.	Comparing guideline recommendations	Comparison of recommendations between included guidelines to identify key topic areas and assess for consistency and potential gaps
4.	Prioritizing key areas for quality statements	Identification and prioritization of key areas for quality statement development
5.	Developing quality statements	Drafting of the quality statements, taking into account the attributes of an ideal quality statement, the evidence levels, and wording

7.1 Searching Guidance Sources

Quality statements are based largely on existing high-quality clinical practice guidelines, and in some cases, on Health Quality Ontario's previously published health technology assessments and accompanying Ontario Health Technology Advisory Committee recommendations.

Once the scope of the standard has been determined, Health Quality Ontario conducts a comprehensive literature search to identify published clinical practice guidelines related to the quality standard's topic populations and settings, as well as potential priority areas for quality statements. Ideally, the guidelines identified will cover the full scope of the standard. However, in some cases, comprehensively addressing the scope may require identifying guidelines that are specific to a particular population or interest area within the broader scope of the standard: for example, guidelines specific to care for adolescents, or particular pharmacological treatments.

The search strategy draws on input from clinical experts in the topic area. We routinely search the following databases for all standards:

- Trip database (http://www.tripdatabase.com)
- National Guideline Clearinghouse (http://www.guideline.gov/#)
- CPG Infobase/Canadian Medical Association Clinical Practice Guidelines Database (https://www.cma.ca/Infobase)

Following the initial search, Health Quality Ontario consults members of the QSAC to ensure that all key relevant guidelines have been identified. There is some allowance for iteration in the process, depending on the results of the search (for example, if the QSAC identifies a key priority area that is not adequately addressed in the initial pool of guidelines).

Health Quality Ontario staff also conduct a search of previous Health Quality Ontario health technology assessment reports and Ontario Health Technology Advisory Committee recommendations to identify statements that are relevant to key priority areas in the standard.

7.2 Appraising and Selecting Guidelines

Once the relevant guidelines have been identified, Health Quality Ontario selects them for review based on the following inclusion criteria:

- English language
- Published within the last 5 years (may be extended to 10 years in some cases)
- Relevant to the defined scope of the standard
- Original guideline (that is, not an adaptation of another guideline)
- Clearly reported methods of development
- Recommendations supported by systematic evidence searches, with a clear appraisal of the quality of evidence supporting each recommendation

Guidelines that meet the criteria above are assessed using the Appraisal of Guidelines for Research and Evaluation (AGREE) II instrument, the most widely used international guideline critical appraisal tool.[2] The AGREE II instrument is composed of six domains:

- Scope and purpose
- Stakeholder involvement
- Rigour of development
- Clarity of presentation
- Applicability
- Editorial independence

Each domain has contains two to seven individual criteria. Two members of the quality standards team independently evaluate each included guideline using AGREE II and compare their scores. For any criterion with a difference of three or more points between the two scores, the team members discuss the discrepancy and arrive at a consensus. The scores from one or both members for that criterion may then be revised to reflect the consensus and reduce the discrepancy.

All AGREE II domains are used to evaluate each guideline, but rigour of development is the primary domain used to compare quality across guidelines.

For most standards, depending on the number of guidelines available, the five to seven guidelines with the highest scores in the rigour of development domain are selected. There may be occasional exceptions to this process; for example, if a guideline scores slightly higher than another in rigour of development but has major comparative deficits in other domains, in such a case, the guideline with the higher overall score may be included. These exceptions are documented case by case.

Where available, one Canadian guideline is included for its contextual relevance; if no Canadian guideline scores among the top guidelines according to rigour of development, a Canadian guideline is generally included, regardless of score.

7.3 Comparing Guideline Recommendations

Once the included guidelines have been chosen, Health Quality Ontario creates a table to compare recommendations side by side. Each guideline occupies a table column, and the recommendations are organized into rows by key content area (for example, assessment or transitions). In this way, recommendations can be easily compared across guidelines to assess for agreement or disagreement.

In areas where the guidelines disagree, a deeper exploration of the evidence supporting the relevant recommendations may be warranted.

This guideline comparison is the starting point for developing draft quality statements. In many cases (particularly when multiple guidelines agree on a similar recommendation), guideline recommendations also provide the key concepts for quality statements.

In some content areas, recent Health Quality Ontario health technology assessment recommendations are available (issued through the Ontario Health Technology Advisory Committee). These should generally be accepted as the "gold standard" of evidence, because they are based on systematic reviews and economic modelling, and they have been developed specifically for the context of the Ontario health care system.

7.4 Prioritizing Key Areas for Quality Statements

Prior to their first meeting, Health Quality Ontario develops a survey for the Quality Standard Advisory Committee (QSAC) members, asking them to identify and prioritize key content areas according to their perceived importance. The aim of the survey is to draw on the committee's knowledge and have them prioritize up to 10 key areas with the greatest potential to improve the quality of care in Ontario.

The QSAC members receive the quality standard topic brief and may receive additional background information to inform their decision-making (for example, analyses of quality issues or practice variations using Ontario data; in some cases, the QSAC members may receive a draft of the guideline comparison table).

The survey is conducted using an online form sent out before the first QSAC meeting. In the survey, QSAC members are asked to rank 5 to 10 key areas according to their importance and potential for quality improvement in Ontario using the following criteria:

- Areas with evidence of variation in current practice and a gap between current practice and optimal care
- Areas with the potential to improve health outcomes or the use of health resources
- Areas where it is important to maintain current standards of care

They will also be asked to provide accompanying rationales for their rankings, and sources, where possible, such as:

- Evidence that current care in Ontario in the suggested key areas is poor or variable and requires improvement
- Evidence to support the effectiveness of the proposed interventions in the suggested key areas
- National or provincial data sources, if available, that collect data relating to the suggested key areas

For some quality standard topics, QSAC members may receive a prepopulated list of key areas drawn from the guideline comparison chart; for others, the survey fields will be left blank. Whether they work from a prepopulated list or a blank field, in all cases QSAC members will have an opportunity to write in additional key areas that they feel are important.

Health Quality Ontario synthesizes the survey responses into a single table for QSAC members to review at their first meeting, displaying the key areas and their overall rankings.

At their first meeting, the QSAC uses the list of ranked key areas and other background information to develop a set of up to 10 key areas for quality statement development. Members of the QSAC choose key areas by consensus. An important principle of this prioritization process is that a quality standard cannot include all care that should be delivered in a topic area, unlike a clinical practice guideline. Quality standards are intended to focus on a relatively limited set of areas where the potential for impact is greatest.

In some cases, the QSAC may choose to group several key areas they believe to be conceptually linked, or divide key areas they believe to contain multiple distinct concepts. Caution should be taken in merging key areas so that they are not too broad in scope. As well, grouping multiple key areas to include more concepts can make it more difficult to prioritize the quality statements in the next step of the process.

7.5 Developing Quality Statements

7.5.1 Language and Components

For each key area prioritized by the committee, the quality standards team develops one or more quality statements for QSAC review and input. Quality statements are written in declarative form, avoiding words such as *should* or *will* (for example, “People with hip fracture receive surgery within 48 hours”). Quality statements are written with the patient at the centre of the care or service recommended (for example, “People with [condition] are offered [intervention].” Occasionally, statements may be written from the perspective of caregivers or family. At all times, quality statements should be clear and avoid jargon.

Quality statements should be measurable, specific, concise, and patient-centred. Each quality statement typically covers a single concept. A quality statement may include two concepts that are closely linked if using separate statements would lead to a lack of clarity (for example, if a treatment depends directly on the results of an assessment).

7.5.2 Background

Each quality statement is accompanied by a background section that describes why the quality statement is important, provides context for the statement and, in some cases, outlines additional considerations related to its execution.

The intent and meaning of the quality statement should be clear without reference to the background section. If additional information is needed to make the intent of the quality statement clear, it should be provided in the definitions section (see section 7.5.3).

7.5.3 Definitions

Some quality statements are accompanied by a definitions section, which provides explicit key terms used in the quality statement, if needed. For example, a definition for “comprehensive assessment” might include the key components of the assessment; a definition for “cognitive behavioural therapy” might specify the minimum number of sessions required; or a definition for “urgent access” might specify a particular timeframe.

7.5.4 Audience Statements

Every quality statement is accompanied by three audience statements.

The **patient statement** interprets the statement from the perspective of patients, families, and caregivers. It is written in plain language and attempts to distil the quality statement down to its most important elements to help patients understand what high-quality care looks like. Patient statements also form the main content of the plain-language **patient reference guide** that accompanies each quality standard. Each patient statement should stand on its own and should not require reference to other content from the quality standard.

The **clinician statement** is a relatively straightforward interpretation of the quality statement from the perspective of clinicians interacting with patients. It may provide some additional detail, but should not significantly change the intent of the quality statement.

The **health services statement** is an interpretation of the statement from the perspective of organizational or system administrators, planners, funders, and policy-makers. It focuses on the structures, systems, and resources that must be in place so that health care professionals can deliver effectively on the quality statement.

7.5.5 Supporting Evidence

Quality statements are intended to be "strong" recommendations: the practice recommended in the statement should be applicable to a large majority (if not all) of the population specified. Our ability to make an appropriate strong recommendation is closely tied to the quality of the evidence available to support the recommendation. High-quality clinical practice guidelines typically specify the types and/or quality of evidence using appraisal approaches such as the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) methodology. Quality standards program staff appraise and summarize the quality of the evidence in each key priority area to support the QSAC's decisions; this includes an appraisal of whether the evidence is sufficient to justify a quality statement.

Quality statements for therapeutic interventions (such as drugs or surgical procedures) must be supported by evidence of effectiveness from high-quality randomized controlled trials, where the benefits of the intervention significantly outweigh any risks. Quality statements that involve lower-risk practices—such as assessment, shared decision-making, health promotion activities, or recommended timeframes for access to services—may be supported by other types of evidence (for example, prognostic studies for assessment statements).

When an intervention may be effective but it is associated with significant risks or side effects, or when its effectiveness depends on patient preference, the quality statement may recommend that a patient be *offered* the intervention. Such statements typically recommend a shared decision-making process between the patient and clinicians, where the patient is given information about the intervention's risks and benefits.

While quality statements are derived from clinical practice guidelines, the background sections for some quality statements may include additional contextual information that is drawn from primary studies and other sources.

7.5.6 Disagreements and Gaps in Guideline Recommendations

Sometimes, the selected guidelines may disagree in their recommendations on a particular topic area. In such cases, deeper exploration of the evidence supporting each guideline's recommendations may be warranted. For example, if one guideline is several years older than another, the more recent guideline may have based its recommendation in part on newer studies that were not available when the older guideline was developed.

As noted above, in some areas recent Health Quality Ontario health technology assessment recommendations are available (issued through the Ontario Health Technology Advisory Committee). These should generally be accepted as the "gold standard" of evidence, because they are based on systematic reviews and economic modelling, and they have been developed specifically for the context of the Ontario health care system.

There may also be cases where a topic area is identified as important, but has no corresponding recommendations in the guidelines selected. In these situations, the QSAC may choose to develop a quality statement based on consensus, akin to a "good practice statement."[3] However, given the absence of scientific evidence to support such recommendations, consensus-based quality statements should be made only in cases where the net benefit of the statement is large and unequivocal, and the potential harm or cost is minimal. Consensus-based quality statements should not be made for drugs, surgical procedures, or other therapeutic interventions.

A final option available to the QSAC when there is too much uncertainty in the evidence to develop a quality statement is to submit the topic to Health Quality Ontario's health technology assessment program as a candidate for assessment. This approach is particularly appropriate in situations involving therapeutic interventions, medical devices, and other technologies. Health technology assessments are reviewed by the Ontario Health Technology Advisory Committee, which makes a funding recommendation to government. Interventions that receive a positive funding recommendation may be incorporated into the quality standard when it is updated.

As statements are developed, Health Quality Ontario staff document the decision-making process, including how the QSAC evaluated the evidence sources and discussed the risks, benefits, harms, and costs of the interventions considered.

7.6 Developing Emerging Practice Statements

An **emerging practice statement** is a placeholder that describes an area that is a key priority for quality improvement, but for which there is insufficient or inconsistent evidence in the guidelines selected. An emerging practice statement acknowledges that the area is an important priority for development of evidence-based guidance, but that the evidence base is still emerging. It signals the need for further research in the topic area.

Once an emerging practice statement has been made, the quality standards team, in collaboration with other Health Quality Ontario colleagues, determines the best way to review the evidence for the statement, including the possibility of initiating a health technology assessment. When quality standards are reviewed for potential updates (see section 11), particular attention is paid to any emerging practice statements.

7.7 Creating a Patient Reference Guide

For each quality standard, Health Quality Ontario develops and distributes a plain-language **patient reference guide**. The patient reference guide is a short document that presents the patient statements associated with the quality statements. The content of the patient reference guide is drawn from the content of the quality standard, but some of the patient statements may be reorganized to make the content of the guide more accessible. The patient reference guide may also include additional background and contextual information that would be helpful to patient, family, and caregiver audiences.

8 DEVELOPING QUALITY INDICATORS

Quality standards are intended to guide quality improvement, monitoring, and evaluation. Measurability is a key principle in developing and wording the quality statements; each statement is accompanied by one or more indicators. This section describes the measurement principles behind the quality indicators, the process for developing quality indicators, and the creation of technical definitions.

8.1 Measurement Principles

Health Quality Ontario uses the well-known process, structure, and outcome indicator framework developed by Donabedian[4] in 1966 to develop indicators for quality standards. The three indicator types play essential and interrelated roles in measuring the quality of health care and the impact of introducing and using quality standards.

8.1.1 Process Indicators

Process indicators assess the activities involved in providing care. They measure the percentage of specified individuals, episodes, or encounters for which an activity (process) is performed. In most cases, the numerator should specify a timeframe in which the action is to be performed, established using evidence or expert consensus. When a quality statement applies to a subset of individuals rather than the total population, the denominator should reflect the population of the appropriate subgroup, rather than the entire Ontario population.

Process indicators are central to assessing whether or not the quality statement has been achieved; nearly all quality statements are associated with one or more process indicators. In most cases, the numerator and denominator for process indicators can be derived from the language of the quality statement itself; in some cases, additional parameters (such as a timeframe) may appear in the definitions section.

While most quality statements should focus on a single concept and be linked with a single process indicator, some statements may include two or more closely related concepts. In these cases, multiple process indicators may be considered to capture all aspects of the quality statement.

Examples of process indicators include the percentage of patients with hip fracture who receive surgery within 48 hours, or the percentage of patients with schizophrenia who are offered clozapine after first- and second-line antipsychotics have been ineffective.

8.1.2 Structural Indicators

Structural indicators assess the characteristics and resources that influence and enable how care is delivered. These may include physical plants and equipment, systems of care, the availability of resources, and the existence of teams, programs, policies, protocols, licences, or certifications. Structural indicators assess whether factors are in place that are known to be important for enabling the achievement of the quality statement.

Some quality statements have structural indicators associated with them. Structural indicators are binary or categorical and do not require the definition of a numerator and denominator. However, in some cases it may be useful to specify a denominator defining an organizational unit, such as a hospital, a primary care practice, or a local region.

Structural indicators should be defined for a quality statement or for the quality standard as a whole when there is evidence or expert consensus that a particular resource, capacity, or characteristic is important for enabling the effective delivery of a process of care. It should be theoretically feasible for such structural elements to be implemented across Ontario, even if implementation is aspirational in some cases. In rare instances, a quality statement may have two or more associated structural indicators, if the QSAC decides that multiple factors are crucial to the delivery of the quality statement.

Examples of structural indicators include the availability of a stroke unit, the existence of discharge planning protocols, or access to a specialized behavioural support team.

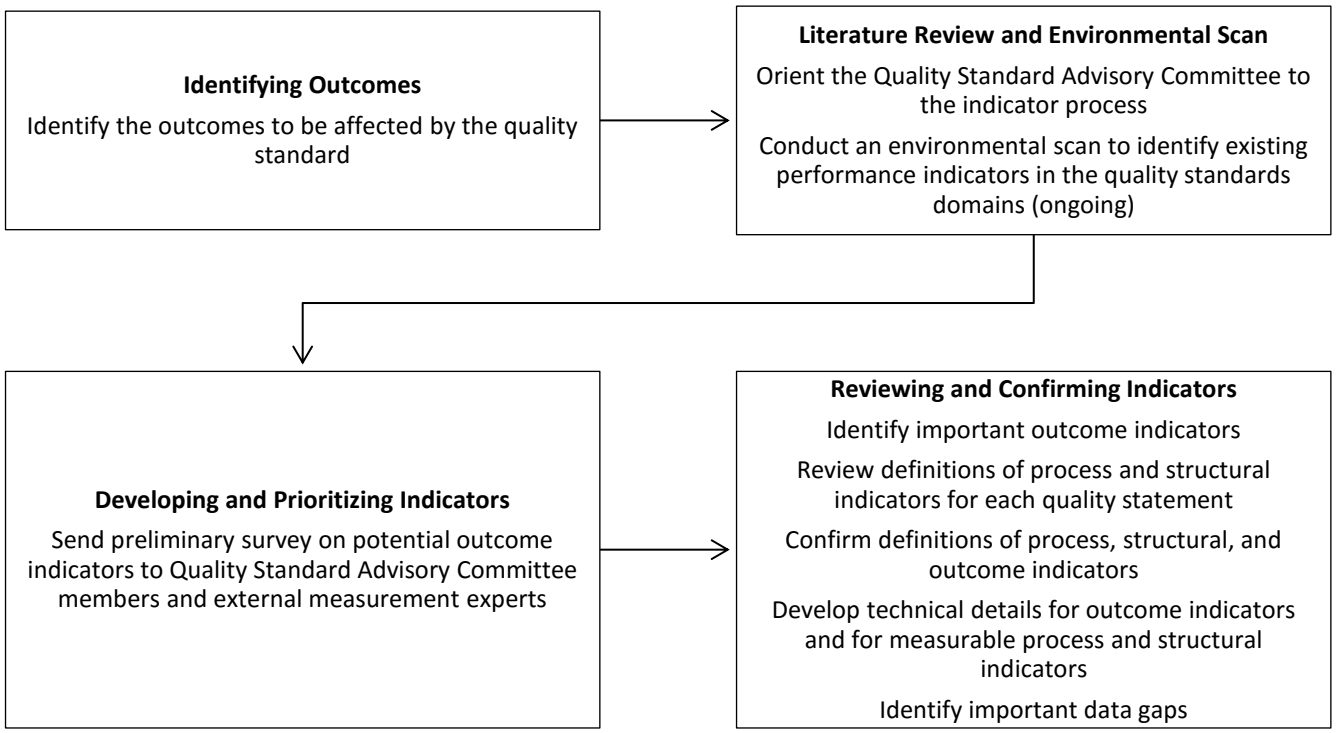
8.1.3 Outcome Indicators

Outcome indicators assess the end results of the care provided. They are crucial and are arguably the most meaningful measures to collect, but many health outcomes—such as mortality or unplanned hospital readmissions—are often the product of a variety of interrelated factors and cannot be reliably attributed to a single process of care. For this reason, although relatively few quality statements are directly linked to an outcome indicator, a set of five to seven key outcome measures is defined for the quality standard as a whole, reflecting the combined effect of all of the quality statements in the quality standard. Similar to process indicators, outcome indicators should be specified using a defined denominator and a numerator that, in most cases, should include a clear timeframe.

Examples of outcome indicators include mortality rates, improvement (or decline) in function, and patients' experience of care.

8.2 Development Process

Developing quality indicators involves several steps. The majority of the indicator development process begins once the draft quality statements have been agreed upon by the Quality Standard Advisory Committee (QSAC), but the literature review and environmental scanning work begins before this.


Identifying Outcomes
Identify the outcomes to be affected by the quality standard
Literature Review and Environmental Scan
Orient the Quality Standard Advisory Committee to the indicator process
Conduct an environmental scan to identify existing performance indicators in the quality standards domains (ongoing)
Developing and Prioritizing Indicators
Send preliminary survey on potential outcome indicators to Quality Standard Advisory Committee members and external measurement experts
Reviewing and Confirming Indicators
Identify important outcome indicators
Review definitions of process and structural indicators for each quality statement
Confirm definitions of process, structural, and outcome indicators
Develop technical details for outcome indicators and for measurable process and structural indicators
Identify important data gaps

8.2.1 Identifying Outcomes

At its first meeting, the QSAC is asked to identify the outcomes that the quality standard is intended to affect. Selected outcomes should align with the dimensions of quality outlined in the Quality Matters[5] framework: safety, effectiveness, patient-centredness, efficiency, timeliness, and equity. The QSAC selects a limited set of outcomes that reflects the treatment goals of the quality standard and can reasonably be influenced by many (if not all) of the practices outlined in the draft quality statements. Outcomes should be factors that may reasonably be affected by province-wide adoption of the quality standard as a whole.

8.2.2 Literature Review and Environmental Scan

At the initiation of each quality standard project, the Health Quality Ontario performance measurement team reviews the existing measurement-related literature on the topic of interest and conducts a literature review and environmental scan. This is performed separately from the review conducted during the scoping phase (see section 4).

The literature review includes an international inventory of existing performance indicators related to the topic (with associated definitions and information on validation). In particular, it is important to identify existing outcome indicators for prioritization by the QSAC.

The environmental scan focuses on measurement, reporting, and data collection in Ontario and similar jurisdictions. It describes existing reporting efforts in Ontario related to the topic and the vehicles used in these efforts, such as public reporting, custom reporting, accountability agreements, and Quality Improvement Plans. It also describes existing provincial datasets that capture information relevant to the scope of the quality standard. For example, in a quality standard for care of major depression, people with major depression may present for treatment in both primary care settings and in hospital settings (including emergency department, acute inpatient beds, and inpatient mental health beds). The data, reporting, and measurement considerations in these settings are very different; measurement considerations for the quality standard require an understanding of the availability of relevant data for each of these settings.

8.2.3 Developing Process and Structural Indicators

Once the draft quality statements have been agreed upon by the QSAC, the Health Quality Ontario measurement team develops draft process and structural indicators for each statement.

As described above, the development of process indicators tends to be quite straightforward: numerators and denominators can generally be derived from the quality statement itself. In some cases, measurement teams require further consultation with the QSAC co-chairs, members, or external experts to clarify or better define parameters, such as the timeframe required for the actions described in the quality statement.

The development of structural indicators is more complex. Identifying meaningful structural indicators typically requires an understanding of the clinical and administrative considerations involved in effectively delivering the actions described. Such insight may be gathered from QSAC members and from the literature review. Structural indicators should be developed for quality statements only when there is good evidence or strong expert consensus that the element described is important for implementing the quality statement; many quality statements will not have associated structural indicators.

The existence, availability, and quality of current data in Ontario should rarely factor into the development of definitions for structural and process indicators. In each quality standard, structure and process indicators are clinically meaningful and closely linked with each quality statement. Because the main purpose of these indicators is to support local-level quality improvement, their "measurability" is a theoretical concept that assumes reliable and valid data and a reporting infrastructure are available.

Certain exceptions to the above rule may be considered when an existing indicator is commonly used in Ontario that closely aligns with the intent of the quality statement (for example, an existing measure that employs a slightly different timeframe). In such instances, the QSAC may consider revising the quality statement to align with the accepted measurement timeframe, as long as it does not conflict with the meaning, intent, or evidence behind the draft quality statement.

8.2.4 Developing Outcome Indicators

Based on the outcomes identified (see section 8.2.1) and the literature review and environmental scan (see section 8.2.2), the Health Quality Ontario measurement team prepares a short list of potential outcome indicators for review and prioritization (if necessary) by the QSAC. Considerations for prioritization should include:

- **The importance of the outcome:** Is it meaningful to patients, health care professionals, and/or system managers?
- **The strength of the outcome's association with draft quality statements:** will consistent achievement of the quality statements have a measurable influence on the outcome?
- **The balance of outcome indicators:** Do the selected outcome indicators span a range of different domains, such as effectiveness, efficiency, and patient experience?
- **Balance measures:** Do the outcomes capture the potential negative consequences of changes in care, if necessary?

The QSAC prioritizes the outcome indicators by voting on the importance and strength of association for each indicator, and by achieving group consensus on a balanced set of outcome indicators.

As noted earlier, few individual quality statements lend themselves well to association with an outcome indicator. Such instances should be identified case by case with input from the QSAC.

8.2.5 Reviewing and Confirming Indicators

The draft outcome indicators are shared with the co-chairs before the second meeting and confirmed by the QSAC during that meeting. The draft structural and process indicators are also reviewed and revised in consultation with the QSAC at the second meeting. Similar to the quality statements, quality indicators should be reviewed by the QSAC in a systematic, itemized fashion.

8.3 Technical Definitions and Measurement Recommendations

After the indicators have been defined by the QSAC, the Health Quality Ontario's measurement team and technical experts (potentially including members of the QSAC, as appropriate) reviews the indicators and considers the technical details of calculating the indicator, including the following:

- Is the indicator feasible to calculate using currently available provincial datasets? Can a reasonable "proxy" of the indicator be calculated (for example, measuring drugs prescribed for people aged 65 and older as a proxy for offering drugs to individuals)?

- If the indicator is not provincially measurable, what information needs to be made available so that health care professionals and administrators can calculate it (numerator and denominator definitions) using locally collected data?
- For outcome indicators that are suitable for provincial reporting, will risk adjustment be required? What considerations need to be taken into account for risk adjustment?
- If data are currently available to calculate the indicator, what limitations of the indicator and the methodology would need to be considered when using it to monitor performance?
- What are the key data gaps for indicators that cannot currently be calculated using provincial data elements but are deemed to be good candidates for provincial reporting?

For the last two questions, if additional provincial data collection related to quality standard indicators is important, Health Quality Ontario will prioritize the area for future data advocacy efforts in partnership with the Ministry of Health and Long-Term Care and other partners and data providers.

9 CONSULTING THE PUBLIC

9.1 Phases of Consultation

After a draft quality standard has been prepared, it undergoes two phases of public consultation.

First, it is sent to organizations that have been identified for feedback and potential endorsement (including those that represent the interests of patients, others with lived experience, and the public). This phase allows organizations time to consider the endorsement opportunity and prepare robust feedback for Health Quality Ontario.

Then, it is posted on the Health Quality Ontario website for a 3-week public consultation period to solicit feedback from patients, others with lived experience, and the public. During this time, Health Quality Ontario may initiate other engagement efforts, such as discussions with patient advocacy groups and research involving focus groups.

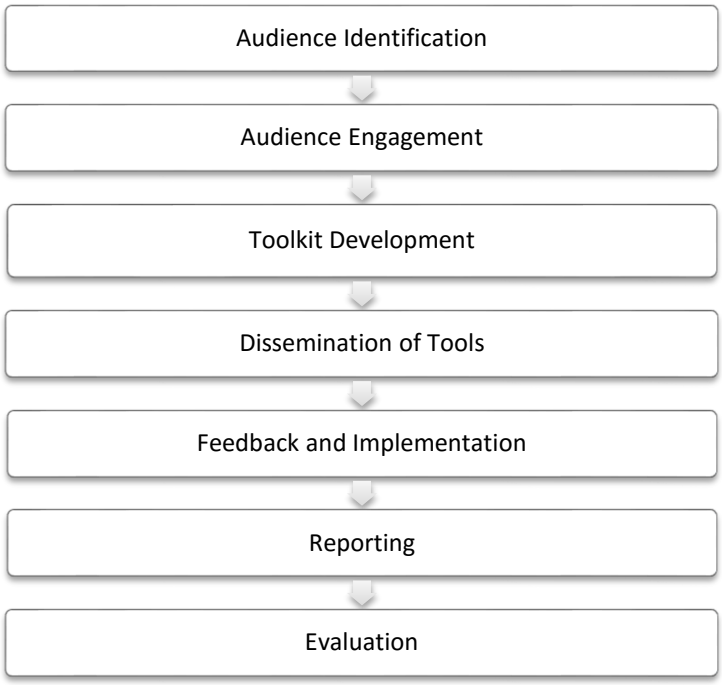
All feedback from potential endorsing organizations, public comment, and targeted engagement activities is analyzed and synthesized thematically into a consultation report. The draft consultation report is circulated to the Quality Standard Advisory Committee (QSAC) as background for a fourth meeting, where the QSAC discusses any proposed changes or revisions to the quality standard. A public version of the consultation report is then prepared, which describes the feedback, comments, and suggestions received, as well any revisions made to the quality standard along with the rationale for each change. The report also notes where the QSAC opted *not* to make changes, along with their rationales.

9.2 Further Consultation with Patients, Caregivers, and Members of the Public

All quality standards are considered for the need to consult further with patients, caregivers, and members of the public. If such a need is identified, the patient, caregiver, and public engagement team at Health Quality Ontario designs a customized plan that outlines the topic-specific engagement approach.

10 IMPLEMENTING QUALITY STANDARDS

For each quality standard, Health Quality Ontario develops a multistakeholder implementation plan. Implementation plans are working documents that support a dynamic and ongoing implementation and adoption process. The figure below describes the key phases for dissemination and implementation.



10.1 Audience Identification and Engagement

During the scoping phase, Health Quality Ontario identifies stakeholders to engage in dissemination and implementation planning. Some of these individuals participate by joining the Quality Standard Advisory Committee (QSAC), and others are engaged through meetings, focus groups, surveys, and interviews. The purpose of this engagement is to determine the most effective ways to support implementation.

Target audiences for quality standards include health system partners, clinical leaders, administrators, advocacy organizations, community partners, patients, and caregivers. Audiences also include internal Health Quality Ontario committees and programs such as Health Links, the National Surgical Quality Improvement Program (NSQIP), the Adopting Research to Improve Care program (ARTIC), Quality Improvement Plans, and Improving and Driving Excellence Across Sectors (IDEAS).

By leveraging the QSAC or an implementation advisory committee, Health Quality Ontario seeks advice on approaches and tactics for implementation. Members of these committees are expected to be champions for the quality standard in their communities, practices, and organizations.

10.2 Toolkit Development

To support implementation, Health Quality Ontario develops a toolkit for each quality standard. The toolkit is informed by the QSAC, focus groups, and consultation with other stakeholders, as appropriate.

The toolkit consists of two types of supports. The first involves general quality standard supports modelled after existing best-practice resources (a "getting started" kit) and may include a gap assessment tool, a barrier assessment tool, and general resources on change management. The second is specific to the quality statements and includes links to existing templates and tools, as well as data that highlight the case for change.

Where tools and templates do not already exist, Health Quality Ontario considers whether existing partners can develop the tools or if it should develop the tools.

10.3 Dissemination of Tools

Following the launch of a quality standard, the standard and related tools are disseminated to target audiences. To achieve this, Health Quality Ontario develops tailored strategies for dissemination to patients, caregivers, the public, clinicians, provider organizations, local health integration networks, and partner organizations.

Health Quality Ontario develops a communications plan that uses social media, traditional media, newsletters, webinars, and other channels to share updates, educate, and create awareness of the quality standard. Web and provincial platforms are used to build a central space for quality standards on the Health Quality Ontario website. Platforms such as shareIDEAS, quality compass, and a quality standard app may be used for implementation.

Health Quality Ontario may host an adoption event following the launch of the quality standard. The event may include a presentation on the standard; a presentation from an early adopter, speaking about lessons learned from implementing the standard; and facilitated workshops to discuss barriers and facilitators to implementation and adoption. The toolkit is shared at the adoption event. Webinars and speaking opportunities follow the event.

10.4 Feedback and Implementation

Health Quality Ontario continues to support clinical and patient champions throughout the implementation phase. Once the core set of tools has been disseminated, informed by the engagement of stakeholders, additional interventions to facilitate implementation will be considered. Health Quality Ontario determines the level and type of intervention based on available resources and need.

The following interventions and levers are used to inform implementation, as appropriate[6-9]:

- **Decision support tools:** Prompts to alert or remind clinicians to perform a clinical action
- **Audit and feedback:** A summary of clinical performance over a period of time that may include recommendations for action; it can be used by health care professionals in training to conduct audits of quality standard implementation
- **Educational materials:** Published or printed recommendations for clinical care delivered personally or through mass mailings
- **Education meetings/workshops:** Workshops or conferences where health care professionals are engaged in learning through lectures and discussions

- **Academic detailing:** Visits by trained individuals to provide face-to-face information on practice change
- **Local opinion leaders:** Individuals regarded as important or influential among their peer group who encourage change in practice through modelling, information discussion, or mentoring; the engagement of opinion leaders and champions could take place through a community of practice hosted by Health Quality Ontario
- **Patient-mediated interventions:** Clinical information provided to patients to help change practitioner behaviour; this can include pamphlets and posters in waiting rooms or online
- **System levers:** Funding, incentives, accreditation, public reporting, and continuing medical education credits can be used to influence practice change
- **Awareness raising and education:** Informing people of new quality standards through presentations at conferences, workshops, and webinars; communications and marketing via social media, newsletters, and academic journals can enhance awareness of quality standards
- **Local champions:** Individuals who promote the innovation can help tailor the implementation to the practice setting; champions can also help raise awareness of a quality standard among their local contacts
- **Patient champions:** Clinical information provided to patients through patient reference guides can encourage practitioner use of the quality standards and raise awareness and use of quality standards in the community
- **Other Health Quality Ontario assets:** Quality Improvement Plans, the Adopting Research to Improve Care (ARTIC) program, Regional Quality Tables, and other programs can be selectively used to support implementation of the quality standards as appropriate

The tools and implementation plan should be in place when the quality standard is complete and posted on the website to allow for effective and timely facilitation and use of each quality standard.

10.5 Reporting and Evaluation

Reporting of quality standard indicators is a key lever for provincial adoption of the quality standards. However, given the diverse range of indicators, Health Quality Ontario analyzes the indicators for each quality standard to determine the most appropriate reporting vehicle for each indicator, rather than using a single “one size fits all” reporting vehicle.

Each quality standard contains a number of process, structural, and outcome indicators defined by the QSAC. Many of these indicators—particularly the process and structural indicators related to each quality statement—cannot be calculated using currently available provincial data (that is, administrative data) and are meant to be used by clinicians at the local level to support quality improvement initiatives. Many of the outcome indicators can be calculated using provincial data, and technical definitions are developed as part of the quality standard development process.

After indicators have been defined for each quality standard, Health Quality Ontario applies the following high-level framework to determine potential reporting vehicles (see table below for a list of vehicles)

- Is the indicator most appropriate for public reporting through the Common Quality Agenda (will typically lean toward major outcomes)?
- Is the indicator most appropriate for public reporting through other vehicles (for example, long-term care and community care access centre quality reporting or hospital patient safety reporting; also typically leans toward major outcomes)?
- Is the indicator most appropriate for private reporting (for example, practice reports for primary health care, long-term care, National Surgical Quality Improvement Program)?

- Is the indicator most appropriate for inclusion in Quality Improvement Plans?
- Is the indicator most appropriate for local data collection and reporting (that is, for local quality improvement efforts)?
- If the indicator is appropriate for any of the first four vehicles but provincial data are not currently available, is the indicator a candidate for data advocacy efforts?

Reporting Vehicle	Purpose	Audiences	Call to Action (Current State)
Measuring Up*	Yearly report on the performance of the health system	Public	Transparency, information
Common Quality Agenda*	Set of indicators to focus the system on priority areas	System stakeholders	Accountability, performance (when included in Measuring Up)
Specialized reports	Reports to shine a spotlight on an issue of health system performance	Public	Transparency, information
		System stakeholders	Accountability, performance improvement
Indicator reporting (online)	Set of indicators that are sector-specific, demonstrate performance, and are important to track	Public	Transparency, information
		System stakeholders	Accountability, performance, quality improvement
Practice reports	Indicators meant to drive specific improvement initiatives	Individual providers	Quality improvement
Organizational reports	Indicators meant to drive specific improvement initiatives	Health care organizations (for example, hospitals, long-term care homes)	Quality improvement
Quality Improvement Plans	Indicators meant to measure priority quality issues for the Quality Improvement Plans	Organizations and health care professionals who submit Quality Improvement Plans	Quality improvement
Local quality improvement	Indicators used for local-level quality improvement	Health care professionals involved in implementing quality improvement at the local level	Quality Improvement

*At present, Measuring Up and the Common Quality Agenda are merged; they have a dual audience and purpose, and involve multiple calls to action.

Health Quality Ontario also considers how other reporting mechanisms that do not come from Health Quality Ontario may be used to report on quality standard indicators. For example, indicators for the quality standard on vaginal birth after Caesarean section might be reported through the Provincial Council for Maternal and Child Health/Better Outcomes Registry and Network; indicators for the mental health standard might be reported through the Mental Health and Addictions Quality Initiative or a provincial scorecard. New reporting initiatives may also be considered, if appropriate.

11 EVALUATING AND UPDATING QUALITY STANDARDS

11.1 Evaluating Quality Standards

There are two levels of evaluation for quality standards. The first involves evaluation of the quality standards program overall. Health Quality Ontario will develop a program logic model to define the evaluation framework for the quality standards program. The second involves evaluation of the implementation of individual quality standards. Following the completion and distribution of a quality standard, and working with health system partners, Health Quality Ontario evaluates the effectiveness of the standard and the implementation process around it. This evaluation focuses on whether audiences believe the quality standard is "fit for purpose"; whether target audiences are aware of quality standards that are relevant to their practice; and whether quality standards are embedded in practice settings. If not, Health Quality Ontario plans, prioritizes, and works toward closing this gap. Where possible, links should be made to manage clinical networks, national projects, and patient safety or quality improvement work.

The following table provides a list of sample evaluation questions that may help to assess how well implementation goals are being met.

Implementation Goals	Sample Evaluation Questions
Short-term goals • Guidelines disseminated • Champions engaged • Implementation linked with accreditation initiatives and continuing medical education	• How many people have visited the quality standard online? • How many people have used the associated tools and guidelines? • How many champions have been engaged?
Medium-term goals • Health care professionals, patients, and caregivers have received the education or training needed to follow the quality standard • Health care professionals are using quality standards in their practice	• Do patients know that a quality standard exists for a condition relevant to them? • How well do health care professionals know the quality standard? • How many patient advocacy organizations are actively sharing and promoting the quality standard with their stakeholders? • What percentage of organization/practice sites are using the quality standard?
Long-term goals • Health outcomes improved • Consistent care is being provided in the quality standard clinical area	• Do patients and caregivers feel empowered to make decisions about their care and have improved care experiences? • Have regional variations pertaining to specific clinical conditions been reduced?

11.2 Updating Quality Standards

Quality standards are based on the best, most up-to-date evidence, and they focus on areas in Ontario where current practice is not optimal. To keep quality standards current and relevant, they need to be updated regularly to reflect the most recent evidence and account for changes in practice.

Following the release of each quality standard, Health Quality Ontario performs a high-level annual scan of new evidence. This scan consists of reviewing web pages for the included clinical practice guidelines to check for any updates or revisions, and consulting with the co-chairs and selected

members of the Quality Standard Advisory Committee (QSAC) to discuss any significant recent changes in the evidence. If there is new evidence or guidance in the topic area and the co-chairs feel it is important to update the standard to reflect this, Health Quality Ontario may reconvene the QSAC to consider the new evidence and decide whether to update the standard.

Standards may also change if current Ontario practice changes. Certain quality statements may need to be retired over time if provincial performance in those areas has demonstrably improved without creating more regional variation in outcomes.

11.3 Updating This Guide

The quality standards program is new at Health Quality Ontario and as such, this process and methods guide will be updated as the development process evolves. For the first 3 years of the program's existence, the guide will be updated each year, and then less frequently thereafter. Between major updates, minor changes may be made as needed to improve the overall clarity of the guide if they do not affect an essential step in the process.

Comments and suggestions for adjustments to the content of the guide or development methods and process are welcome and can be sent to qualitystandards@hqontario.ca.

12 REFERENCES

(1) Excellent Care for All Act, 2010, S.O. 2010, c. 14.

(2) AGREE Enterprise. AGREE II [Internet]. AGREE Enterprise; 2010 [cited 2016 Sep 6]. Available from: http://www.agreetrust.org/agree-ii/

(3) Guyatt GH, Schunemann HJ, Djulbegovic B, Akl EA. Guideline panels should not GRADE good practice statements. J Clin Epidemiol. 2015;68(5):597-600.

(4) Donabedian A. Evaluating the quality of medical care. 1966. Milbank Q. 2005;83(4):691-729.

(5) Health Quality Ontario. Quality matters: realizing excellent health care for all [Internet]. Toronto (ON): Queen's Printer for Ontario; 2015 [cited 2016 Sep 8]. Available from: http://www.hqontario.ca/portals/0/Documents/pr/realizing-excellent-care-for-all-en.pdf

(6) Bero LA, Grilli R, Grimshaw JM, Harvey E, Oxman AD, Thomson MA. Closing the gap between research and practice: an overview of systematic reviews of interventions to promote the implementation of research findings. The Cochrane Effective Practice and Organization of Care Review Group. BMJ. 1998;317(7156):465-8.

(7) Davis DA, Taylor-Vaisey A. Translating guidelines into practice. A systematic review of theoretic concepts, practical experience and research evidence in the adoption of clinical practice guidelines. CMAJ. 1997 Aug 15;157(4):408-16.

(8) Davis DA, Thomson MA, Oxman AD, Haynes RB. Changing physician performance. A systematic review of the effect of continuing medical education strategies. JAMA. 1995;274(9):700-5.

(9) Yost J, Ganann R, Thompson D, Aloweni F, Newman K, Hazzan A, et al. The effectiveness of knowledge translation interventions for promoting evidence-informed decision-making among nurses in tertiary care: a systematic review and meta-analysis. Implement Sci. 2015;10:98.