Ontario Primary Care Reporting Alliance

Strategy Recommendations

Contents

Introduction

This document summarizes recommendations developed by the *Ontario Primary Care Reporting Alliance*. These recommendations will be submitted to the Ministry of Health and Long-Term Care, and disseminated to Alliance members, as well as other partners and stakeholders in primary care.

The recommendations in this report reflect an eight-month effort among primary care partners. In June 2017, Health Quality Ontario convened a roundtable of primary care partners and experts to discuss the future of primary care audit and feedback (practice reporting) in Ontario, and opportunities for developing a shared vision and commitment towards aligned and/or integrated practice reports and other supports. (See June 2017 meeting minutes in Appendix A). Meeting participants agreed to create a time-limited formal alliance to further these deliberations and collaborate on improving primary care measurement and reporting in the province. (See the Alliance's Terms of Reference in Appendix B). Since its establishment in September 2017, the Alliance has identified five key recommendations to integrate primary care practice reports and better support family physicians, nurse practitioners and interprofessional teams practising in primary care in the use of data to create practice change. Alliance membership includes senior representation from the following organizations.

Type of member	Organization
Report producers and consumers	− Association of Family Health Teams of Ontario − Alliance for Healthier Communities (formerly the Association of Ontario Health Centres) − Canadian Primary Care Sentinel Surveillance Network − Cancer Care Ontario − Electronic Medical Record Administrative data Linked Database − Health Quality Ontario − OntarioMD − Institute for Clinical Evaluative Sciences − Ministry of Health and Long-term Care
Report consumers	− Primary Care LHIN Leadership − Nurse Practitioners' Association of Ontario − Ontario College of Family Physicians − Ontario Medical Association, Section on General & Family Practice
Observer	− Canadian Institute for Health Information

Following the release of this strategy document, the Alliance committee will close and its efforts will be carried forward through the development of a Memorandum of Understanding among Alliance members, with secretariat support from Health Quality Ontario and strategic oversight from the Ontario Primary Care Quality Advisory Committee.

Current Status of Primary Care Reporting in Ontario

Current State

Over the past few years, several organizations in Ontario have worked to fill a gap in the availability and accessibility of practice-level data to support family physicians, nurse practitioners and interprofessional teams practising in primary care. As a result, there has been an increasing number of primary care indicators, reports and quality improvement supports available from various provincial and national organizations. While a greater focus on measurement and quality improvement is warranted, these efforts have lacked coordination. A few reports make reference to other reports so that recipients are aware of them, but there is little coordination of reporting schedules or any degree of integration between reports.

While practice reports are increasingly being used in primary care team practices, many clinicians still do not access or act upon the practice reports that are available; others currently do not have access to them. Some data in the reports are not perceived to be relevant, comprehensive, or timely and some frontline clinicians and practices do not feel sufficiently equipped or supported to pursue quality improvement. More focused measurement and support could help improve the work life of family physicians, nurse practitioners and interprofessional teams, while catalyzing improved quality and patient care.

Self-Assessments by the Primary Care Reporting Alliance

Alliance members are currently responsible for seven reports. To inform the Alliance's deliberations, each reporting organization completed a self-assessment tool developed based on the 15 suggestions for improving audit and feedback (practice reporting) outlined in *Brehaut et al 2016.* The objective of the assessment was to help define and outline the benefit and value to users of the various reports, and to provide direction for rationalizing and reconciling the various reports.

Overlapping target audiences and purpose were found among the reports. Overlap in purpose included improving data quality, team-level performance, population health, cancer screening and chronic disease management, and supporting accountability reporting and operational management. There is also a high degree of overlap – but not necessarily complete alignment in technical specifications and definitions – in many of the reported indicators. The following are the results of the self-assessments.

Domain	Number of reports (out of 7)
Recommends actions consistent with established goals/priorities of patients	4
Recommends actions that are consistent with established goals and priorities of primary care providers	5
Recommends actions that are consistent with established goals and priorities of the health system	6
Includes specific recommendations for improvement	5
Includes recommended actions under the control of the person who actually views the feedback (where this is not a clinician, includes recommendations and/or supports to ensure those who carry out the relevant processes of care are engaged)	6
Is co-designed with end users	7
Provides information as soon as possible such that the data are viewed as credible and relevant to current performance on a given indicator	6
Repeatedly provides measurement on indicators at a frequency informed by the number of new patient cases or by the time required to see a change in performance on a given indicator	7
Provides comparator(s) that reinforce desired behaviour(s) such as the performance of higher performers in the peer-group, rather than average performance	7
Provides short, clear, actionable summary messages that highlight the key points of the report	5
Actionable messages are in close proximity to the visual display	4
Key summary messages are simple to understand, with optional details readily available	6
Provides feedback in more than 1-way (e.g. text, numerical, graphical, etc.)	6
Addresses credibility concerns that users may have about the data and the goals of the initiative through acknowledging limitations of data sources	7
Addresses credibility concerns that users may have about the data and the goals of the initiative through risk adjustment and/or relevant peer-group comparators	7
Guides reflection and makes explicit a non-judgemental, quality improvement-oriented approach to prevent defensive reaction to feedback	7
Provides data customized to the report user with clinician-specific data for each clinician and team-level data for administrators	5
Provides suggestions in terms of clinical processes or tips to overcome barriers to using data for quality improvement	5
Allows for iterative assessment of the usefulness of the report with end-users	7

Alliance Vision, Purpose and Principles

Vision

Ontario family physicians, nurse practitioners, primary care teams and patients have input on and access to timely, meaningful, actionable and comparative information, along with the support necessary to enable learning and continuous improvement in practice processes, patient care and outcomes.

Purpose

The purpose of the Ontario Primary Care Reporting Alliance is to improve patient care and outcomes through increased alignment of reporting efforts across partner organizations, as well as improved provider experience, uptake and use of reports for quality improvement.

Principles

- Primary care is critical to a high-performing health system
- Sharing resources and processes among Alliance members will support more effective implementation and strengthen collective impact to best serve the needs of patients
- Alliance objectives should be designed to advance the Quadruple Aim of: enhanced patient experience; better work life for family physicians, nurse practitioners and interprofessional teams; improved population health; and reduced costs
- Improving primary care depends on delivering timely information that is supportive of a learning health system, proven to support change and is meaningful and valued by family physicians, nurse practitioners, interprofessional health care providers, patients/clients/caregivers and the public
- Information must be robust, evidence-based, and actionable to support the delivery of high quality, equitable care
- Reporting should be linked with the support mechanisms that help clinicians act on the information
- Any plan to report data publicly would entail clinician engagement and prior consent
- The burden on practices and family physicians, nurse practitioners and interprofessional teams to receive and process information about their practices should be kept to a minimum
- Recommendations will be implemented using a phased approach and outputs will be evaluated to promote continuous improvement

Recommendations

The members of the *Ontario Primary Care Reporting Alliance* representing the above-listed organizations have committed to working together to implement the following recommendations, developed on the basis of analyses of the existing reports and input from members.

Recommendation 1: Make it easier for family physicians, nurse practitioners and interprofessional teams by moving from seven to two reports

The increasing expectations placed on primary care (managing complexity, preventative care and population, as well as individual patient/client, health) necessitate an efficient and effective infrastructure to support the fulfilment of practice and system needs. Currently, multiple primary care reports are available from a range of associations, agencies, specialty-organizations, regulators and academic institutions, and family physicians, nurse practitioners and interprofessional teams feel overwhelmed by the number of reports and indicators. Reporting lacks coordination, standardization and knowledge sharing among organizations, contributing to the sense of competing priorities and confusion, and greater burden, for practices and clinicians. This is a barrier to achieving population health goals. To address these concerns and reduce reporting burden and duplication, the Alliance will work together to:

1a) Consolidate the key strengths of the Mypractice, SAR, OntarioMD, CHC and AHAC Practice Profiles, EMRALD and CPSCNN reports all into one new report. This reporting will include aggregated and patient-level data

1b) Maintain D2D in its present form to serve as an incubator for new measures drawn from patient experience, EMR and administrative data, and to co-design with its community of practice

Near-term tasks

- Develop an implementation plan for the consolidation and integration of seven to two reports, also considering Ministry of Health and Long-term Care reports (i.e., the electronic panel update and target population service report)
- Review the objectives and relative strengths of the existing reports and EMR integration to inform the content of an integrated report, including reference to the results from the assessment framework
- Prioritize indicators and data sources to ensure the consolidated report reflects local practice needs, has fewer indicators, and still captures important aspects of existing reports
- Determine how to align indicators with existing reporting requirements (i.e., quality improvement plans (QIPs), LHIN accountability agreements (MSAAs), and system digital strategies)
- Determine how to align practice reporting, and associated quality improvement efforts, with population health needs
- Support advocacy efforts for practices to gain access to their EMR data without paying extraction fees

Medium-term tasks

- Develop and launch an integrated reporting format and platform based on user-centred design and best practices for delivery of the consolidated report
- Develop a plan for allowing practices and clinicians to select measures from a suite of indicators that reflect their needs and leading practices, including options for modular, interactive, dashboard-based reporting at the clinician and practice levels
- Establish a collaborative approach for: identifying indicator gaps and priorities; standardizing indicator definitions; developing new indicators; ongoing indicator advancement and maintenance; and retiring indicators (Also see steps for implementation in Recommendation 2)

- Refine the consolidated report, once the engagement and patient experience recommendations below are delivered

Longer-term tasks

- Continue to work collaboratively with all stakeholders towards continuous improvement and achieving the vision of the Alliance (Also see steps for implementation in Recommendation 2)
- Plan and deliver integrated, real-time EMR reports

Recommendation 2: Adopt a common approach to clinician engagement so measurement and improvement priorities reflect leading practices and what matters most to physicians, nurse practitioners and interprofessional teams

Primary care practices and family physicians, nurse practitioners and interprofessional teams receive multiple messages via a number of methods from the organizations developing the reports and promoting quality improvement. These methods are not aligned and do not fall within an overall communication and engagement strategy. Many clinicians are unsure of the relative roles of the organizations involved and which messaging to prioritize. Moreover, many practices and clinicians believe that the information contained in the reports does not fully reflect their information and quality improvement needs. To address these concerns and facilitate the development and use of the consolidated report, the Alliance will work together to:

2a) Gain clinician buy-in and participation

- Craft a common communications plan and coordinate messaging to show the value of practice and clinician level reporting, including how the reports support the provision of clinical care, quality improvement efforts and achieving health system priorities
- Align efforts to engage family physicians, nurse practitioners, interprofessional teams and other stakeholders on quality improvement priorities to gain frontline buy-in and participation

2b) Gain clinician input on the content of the practice reports

- Develop and implement a clinician engagement strategy for input on the content of the consolidated reports to ensure they are evidence-based and meaningful and of value to users

Near-term tasks

- Develop a coordinated communication plan with regard to reporting and quality improvement that includes information about report purpose, content and timing, and related quality improvement opportunities (as per Recommendation 4)
- Ensure there is adequate and appropriate representation and input from a range of primary care practices and interprofessional teams to reflect the needs, barriers and perspectives of a diversity of practice settings
- Implement a near-term collaborative approach for clinical engagement on: prioritizing quality issues (including indicator selection); alignment between local and system improvement goals; report features and dissemination; and requisite support mechanisms

Medium-term tasks

- Refine and augment the collaborative approach for ongoing clinical engagement
- Gain consensus on an approach to peer comparison that takes context into consideration, allows for customized comparisons, and includes appropriate and acceptable comparator measures, (e.g., average, median, decile, aspirational targets, appropriate denominator, etc.)

Recommendation 3: Be more inclusive of what matters to patients/clients and their caregivers

It is important that primary care reporting focuses on what's meaningful and important to patients/clients and their caregivers. Efforts are underway in Ontario to increase patient engagement in health system improvement. Many of these efforts are in early stages and continued work is required to gain patient input on measures that reflect the aspects of health care of most value to them. As part of this effort, a variety of different patient experience surveys are administered by primary care practices across Ontario, including some recommended by Alliance members. A common provincial approach and patient experience survey instrument would decrease data collection burden and support comparative analyses at the practice level. Additionally, customization should allow the survey to address unique practice needs. To support these efforts and facilitate the aligned reports, the Alliance will work together to:

3a) Develop and implement a common patient engagement strategy

Near-term tasks

- Develop common goals and approaches to engage patients/clients receiving primary care services
- Identify patient-reported, clinical and administrative indicators that reflect value to patients/clients/caregivers, as well as the health system. Consideration should be given to indicators for which there is evidence that reporting can lead to improvement, without onerous or expensive co-interventions
- Develop a joint proposal for a cost-efficient and sustainable provincial patient experience measurement approach that is meaningful to practices and patients/clients, with a mechanism for timely feedback to practices and clinicians[1]

Medium-term tasks

- Ensure patients/clients/caregivers have the requisite background information and context to optimize their input related to their data and reporting preferences
- Explore ways to support increased patient involvement in their care through disseminating patient education or information aligned with the consolidated report[2]

Recommendation 4: Offer coordinated capacity building and support for quality improvement

For most family physicians, nurse practitioners and interprofessional teams, it is difficult to find support and get guidance for quality improvement, and many do not have the personnel to implement it. For clinicians to take action on the information contained in the primary care reports, greater infrastructure and support is required. No single organization in Ontario supports primary care, and quality improvement structures, strategies and activities are not aligned among organizations. There are numerous opportunities for increased sharing and coordination of quality improvement efforts. Greater role clarity, priority alignment and harmonized approaches would provide greater coordination and a clearer way for clinicians to seek and obtain support. To support these efforts and facilitate the aligned reports, the Alliance will work together to:

4a) Determine the resources needed to support practices and clinicians, including the technical requirements and those who have not participated in quality improvement to date, and use this to form the basis for a joint proposal and business case for funding

[1] For example see: http://results.gp-patient.co.uk/report/explanation.aspx
[2] For reference, see research on public reporting in health care, e.g., UOttawa

4b) Develop a plan to coordinate training and deployment of existing frontline quality improvement and change management support

Near-term tasks

- Ensure the consolidated report contains information that is actionable and proven to support change in order to help family physicians, nurse practitioners and interprofessional teams determine where they can make changes in their practice to achieve their patient care goals
- Take stock of the existing resources and tools to support practice-level quality improvement, to determine practices' and clinicians' learning and quality improvement needs and to identify the gaps
- Coordinate efforts to enhance awareness among clinicians about the tools and resources available, their benefit, where to find them and how to use them
- Identify near-term opportunities for coordinated training and change management support (e.g., practice support and facilitation, academic detailing, peer audit, champions and mentors)
- Facilitate the alignment of continuing professional development (CPD), continuing medical education (CME) and accreditation requirements with quality improvement initiatives related to practice reporting
- Collaborate to strengthen communication and information sharing among primary care practices and clinicians, including coordinated quality improvement communication strategies, support for communities of practice for quality improvement, joint learning opportunities, peer mentorship, and other collaborative models

Medium-term tasks

- Develop a proposal to increase and enhance learning and quality improvement tools, supports and resources to assist practices in responding to the audit and feedback data contained in the reports

Recommendation 5: Establish a partnered Working Group to implement the above recommendations

Ongoing support and advice is required to maintain momentum and carry the work of the Alliance forward. Representation from all stakeholders is required to fulfil the recommendations outlined above. To achieve this goal, the Alliance supports:

5a) Establishing a Memorandum of Understanding for a partnered effort focused on the implementation of recommendations #1-4

5b) Ensuring adequate representation to implement the recommendations effectively by including existing committee members, frontline family physicians, nurse practitioners, other primary care clinicians, administrators, policy makers and planners, patients/clients/caregivers and other stakeholders, giving consideration to regional representation

Near-term tasks

- Develop and negotiate a partnered Memorandum of Understanding among partners
- Confirm membership, roles and terms of reference of the Working Group formed as part of the Primary Care Quality Advisory Committee to operationalize the recommendations
- Plan and deliver near-term tasks outlined in the above recommendations
- Develop policies for information management, data sharing and release
- Cost initiatives, identify potential funding sources and advocate for the requisite resources
- Align planning with other sector initiatives to increase collaborative and sharing of resources and to ensure overall efficiency and common purpose

Medium- and longer-term tasks

- Plan and deliver medium- and longer-term tasks from the above recommendations
- Oversee and monitor partnered reporting efforts and implementation
- Develop a plan for patient/client/public accountability and reporting
- Continuously evaluate and report on the progress and collective impact of the consolidated reporting approach, including advancing the Quadruple Aim

Appendix A: June 2017 Roundtable Meeting Summary

Location

Health Quality Ontario offices, 130 Bloor Street, Toronto

Participants

Chair: Adalsteinn Brown

Tara Kiran (SMH, ICES, HQO)	Angelika Gollnow (CCO)
Darren Larsen (OMD)	Robert Reid (Trillium Health Partners)
Noah Ivers (WCH)	Jessica Hill (OCFP)
Suzanne Strasberg (CCO)	Leanne Clark (OCFP)
David Schieck (OMA SGFP)	Jennifer Everson (HNHB LHIN/HQO)
Kathy Bugeja (OMA SGFP)	Richard Birtwhistle (CPCSSN, Queens)
Cathy Faulds (Family Physician)	Karen Tu (Clinical researcher)
Sarah Newbery (Family Physician)	Joshua Tepper (HQO)
Rick Glazier (ICES)	David Kaplan (HQO)
Jennifer Rayner (AHC)	Anna Greenberg (HQO)
Beth Cowper-Fung (NPAO)	Lee Fairclough (HQO)
Theresa Agnew (NPAO)	Gail Dobell (HQO)
Kavita Mehta (AFHTO)	Lisa Bitonti-Bengert (HQO)
Carol Mulder (AFHTO)	Jonathan Lam (HQO)
Jason Garay (CCO)	Patrick Rich (HQO)
Laurie Bourne (CCO)	
Nicki Cunningham (CCO)	

Objective

Articulate a shared vision and commitment for Ontario primary care partners to work collaboratively towards a coordinated, aligned, and/or integrated delivery of supports and reports to Ontario family physicians.

Introduction

Chair Adalsteinn Brown, Dalla Lana Chair in Public Health Policy at the University of Toronto, restated the objective of the meeting to develop a shared vision, commitment and buy-in to working towards a coordinated and aligned approach to develop a joined-up series of reports and supports which would be useful for family physicians. He said participants should also consider supports for using the information and data which is available involving dashboards, decision supports and quality improvement support. Anna Greenberg, VP for Health System Performance at Health Quality Ontario (HQO) welcomed the participants on behalf of HQO who hosted the meeting. She said many people working in primary care in Ontario had voiced the notion that there was a very good opportunity, not yet realized, to work together to support enhancing quality improvement in primary care. She noted that in a fairly short time Ontario had gone from having essentially a void in data and supports for professionals delivering primary care, to a crowded space with many different partners' reports and supports, sometimes inadvertently competing with each other for the attention of those on the frontline. She also said HQO was committed to working towards greater alignment, including facilitating a formal partnership for a new approach in primary care reporting and QI support.

Future State: a case example: Dr. Rob Reid

Reid introduced himself as the chief scientist at Trillium Health Partners whose former role for the past 15 years had been responsibility for quality improvement (QI) and strategies for measurement in the large Group Health Cooperatives' which pioneered the patient-centred medical home in Seattle, Washington. He said that the US in the 2000s, he said, there was tremendous growth in reporting and QI infrastructure directed at primary care physicians and practices. This involved a "huge number" of indicators which were promulgated by a number of payer organizations and other agencies using different frameworks in a way that was overwhelming for physicians. Reid described how one of the two divisions of Group Health Cooperative functioned as a regular insurance company contracted to buy care from independent family physicians across Washington State. To provide QI, he said, work was undertaken to send periodic case-mix adjusted reports about care being received by patients, detailed assessment methods, and QI experts being sent to help practices improve. However, he said, the practising communities complained constantly about this. He said the issue was that only about 20% of patients in the practices were covered by Group Health Cooperative, while the remaining 80% of patients were insured by other plans who were also providing reports based on different methods and with different priorities. Reid that just as he left the organization significant improvement occurred as insurers across the State formed the Puget Sound Health Alliance which decided on which health indicators to measure and provided one report to primary care practices rather than 15. He said that it was important to focus and prioritize certain key indicators rather than just measuring variables that people think need to be measured. He said now that Kaiser Permanente has purchased the Group Health Cooperative they have chosen to focus on control of blood pressure as one of the key quality indicators because of its impact on mortality. As a result more than 90% of patients have BP that is adequately controlled.

Current state: The view from my practice: Dr. David Kaplan

In his presentation, Dr. Kaplan who is a family physician to about 1100 patients in North York and is also primary care clinical lead for Health Quality Ontario, traced the evolution of his time in practice. In addition to Quality Improvement Plans and Primary Care Practice Reports, Kaplan noted that he receives a number of reports which have nothing to do with primary care but deal with QI in specific areas of medicine such as obstetrics or which are required by regulatory authorities or the university. Kaplan said this experience, which is shared by many other family physicians, is why they are reluctant to layer QI on top of the data-gathering and other reporting that is required. Implementation of EMRs in practice has not necessarily improved matters or made data more useful for reporting purposes. However, he singled out the work being done by the Canadian Primary Care Sentinel Surveillance Network (CPCSSN) and the Screening Activity Reports (SARs) produced by Cancer Care Ontario (CCO) as providing useful data.

Presentations Summary – Brown

Brown summarized the following key points from the two presentations:

- Primary care is critical for the health care system as a whole
- There is a global recognition of the need to support improving primary care
- Current QI practises in primary care are a bit uncoordinated and can be a source of burnout
- Ontario is on the same journey as Washington State but is at a different stage
- Washington was able to cohere around a small set of quality indicators
- Leadership is very important and heads of organizations have to agree to work together

Current state in Ontario – Key discussion points

- A tension exists in that those working in primary care are part of a highly fragmented dysfunctional system where 75% of the province's physicians do not practice in
- Inter-professional team-based models.
- Primary care practitioners can access a host of different reports from many sources including associations, agencies, regulatory authorities, specialty-based organizations, and academic institutions
- Many primary care physicians do not access or do not read the reports that are currently produced and do not have the capacity or mandate to measure or report on anything, or act on quality improvement data.
- The situation is similar for Nurse Practitioners who are expected to report out on a number of indicators that are not being read.
- Electronic Medical Records (EMRs) are a huge source of stress for many family doctors rather than being a useful tool to facilitate QI. To address this, the successful EMR Practice Improvement Program used by OntarioMD has focused on the change management process and making the program meaningful to the clinics involved.
- Many clinicians do not have the skills or interest in aggregating data and much data produced at the primary care level has to be "cleaned" to make it useful for comparison purposes.
- There is wide variation in primary care practices, making it difficult to pick indicators of care that will be appropriate for all.
- The concept of a high-reliability organization – what patients should be able to rely on - should provide a frame for what gets measured in primary care.
- Priorities for measurement need to be considered in the context that LHINs have already been provided with a very clear mandate letter on their areas for focus such opioids and access and this is unlikely to change before the next provincial election.
- Primary care professionals are generalists and as such the sector is not well-suited to narrow compliance measures; it is better at addressing at general outcomes

Future State – Key Features

- An alliance or collaboration of key stakeholders who currently produce reports on the quality of primary care practices; clear leadership for coordinating the alliance and providing secretariat support
- Adequate participation by leaders from the LHINs
- Participation/engagement of patients should inform the goals and work of the alliance
- A set timetable and proper governance structure for the alliance as well as short- and long-term goals
- Pooling of resources and QI personnel to harmonize reporting and to offer targeted and tailored supports
- Reporting on a small set of indicators
- The Ministry of Health needs to be at the table and endorse the terms agreed upon for the prioritized indicators.
- Among the Indicators should be a generic clinical measure and a patient experience measure
- The alliance collaborates on a synthesis of primary care reports or a single report that provides information of value to primary care practitioners accessible through a single sign-on
- Joint reporting enables all of the different models of primary care, and the different professionals who deliver primary care
- Enable delegates to easily access reports (with email notification to actual provider) along with push options for summary of data from alliance.
- Consider having the joint report issued by the practitioner's professional association
- Maintain strong focus on data for learning/quality improvement for educational purposes rather than on accountability

- Use geographic or risk-based peer groups comparators so as not to disadvantage or not be meaningful to primary care practices in underserviced areas
- Focus on practice-level reporting
- Ensure a balance which might reduce/streamline current demands on the 25% of primary care practices already involved in quality initiatives while introducing some requirements for the 75% currently not doing such activities.
- Future state: have the report(s) be easily accessible through the EMR
- Future state: work towards public reporting at the practice level
- Future state: invest in new areas of measurement to fill prioritized gaps
- Focus on offering comparative data to enable quality improvement

Next Steps and Proposed Timeline

Brown summarized the following next steps based on discussion at the meeting:

- Create an alliance or collaborative of groups currently producing primary care reports for the purposes of QI. **(By August 2017)**
- Develop a set of objectives for the alliance that are transformative **(By August 2017)**
- Create a work plan for the alliance with clear leadership, governance structure, principles for working together, and short and long-term goals. Have Health Quality Ontario serve as the secretariat for the alliance. **(By August 2017)**
- Goals for the alliance should include concrete goals on a timeline: E.g. At one month, ensure all primary care reports are available in one place. At 6-8 months develop a single report
- Once a work plan is agreed to, release a public statement on what the alliance hopes to achieve and when it will be completed. **(By September 2017)**
- Ensure the outcome of the work from the alliance is evaluated. **(By March 2018)**

Conclusion

HQO CEO Dr. Joshua Tepper talked about the sense of shared potential purpose that was emerging from the meeting. He acknowledged considerable effort would be necessary for the groups involved to work cooperatively but said that is what association members and patients
would want. “I think it’s fantastic – if can find principles and ground rules to engage in honest and forthright way this is potentially a really good pivot point. We should be able to do this.”

Appendix B: Ontario Primary Care Reporting Alliance Terms of Reference

Approved: September 29-2017

Background

Partner organizations and scientific experts acknowledge a recent proliferation of data, reports and quality improvement supports in primary care. Multiple reports and supports are now available from a range of regulators, associations, agencies, specialty-organizations, and academic institutions. While the focus on the sector and direction of change is welcome and celebrated, it is also acknowledged that this attention lacks coordination and knowledge sharing between partner organizations. This lack of coordination contributes to confusion in the field and the sense of competing priorities for quality improvement. Many clinicians do not access or read available reports, data may not be perceived as relevant or comprehensive (i.e. heavily dependent on administrative data), and a high burden of data collection and standardization is being placed on frontline clinicians and practices that may not be equipped or supported in pursuing improvement. At the same time, the EMR data landscape is changing rapidly, potentially impacting how physicians access, use, and share clinical data. There is a risk of disengagement, and even burn-out from the most committed clinical and administrative leaders.
Ontario is not unique in facing these challenges, and can learn from jurisdictions that have improved the state of affairs in primary care reporting and measurement. In particular, there is now broad acknowledgement of the benefits of focused, relevant measurement and support to catalyze action around key indicators of system and group practice performance. Good data is the essential underpinning of good measurement, and can be strengthened by better connecting local practice data to wider health system data for measurement of transitions, experience and outcomes in particular.
On June 12, 2017, a group of partners and experts met at Health Quality Ontario to discuss these developments in primary care measurement and reporting in Ontario and beyond, and to identify opportunities for improvement in reporting to practices, as well as opportunities to better support primary care clinicians to use their data to create practice change. Participants agreed on the need for a formal alliance to solidify commitments to change in reporting data and provide supports to primary care clinicians through collaboration and alignment. A shared leadership structure will help advance a common purpose and consolidate efforts to better engage clinicians and have more impact for patients.

Long-term vision

Every primary care clinician practicing in Ontario and their patients have access to usable, timely, meaningful and comparative information and supports to enable continuous improvement in patient care and outcomes.

Near-term goals towards vision

Work together to develop:

1. A common webpage, made available on Alliance member sites, where all available reports can be presented and neutrally described, using standardized language.
2. A consensus framework to understand the value proposition of the existing practice-level primary care reporting assets in Ontario.
3. A strategy for a common and collaborative approach and forum to advance future enhancements to primary care reporting.

Principles

The Alliance commits to the following principles in fulfilling its role:

- Primary care is critical to a high performing health system
- Advancing the Quadruple Aim of enhanced patient experience, improved population health, reduced costs, and improved work life of providers
- Improving primary care depends on delivering better information that is valued by clinicians and patients.
- The value of the data in reports must be self-evident.
- Strive at all times to reduce the data burden on clinicians and ensure that information collected is usable.
- The sharing of resources and processes will strengthen collective impact.
- Aim to achieve a deliverable for every meeting.

Membership

Alliance membership includes senior representation from the following organizations:

Practice-Level Report Producers/Consumers

- Association of Family Health Teams of Ontario
- Alliance for Healthier Communities
- Canadian Primary Care Sentinel Surveillance Network
- Cancer Care Ontario
- Electronic Medical Record Administrative data Linked Database
- eHealth Ontario
- Health Quality Ontario
- OntarioMD
- Public Health Ontario
- Institute for Clinical Evaluative Sciences
- Ministry of Health and Long-term Care

Report Consumers

- Primary Care LHIN Leadership
- Nurse Practitioners' Association of Ontario
- Ontario College of Family Physicians
- Ontario Medical Association – Section on General & Family Practice

Experts

- Primary Care (via membership + clinical engagement representative of all models)
- Audit & Feedback Science
- Patients (via engagement)

Observer

- Canadian Institute for Health Information

Membership will be reviewed at each meeting to ensure that goals and objectives of the Alliance are being met.

Other experts (e.g. industry partners may be invited as guests). A broad engagement with stakeholders and experts in the field will help ensure the Alliance's work is evidence-driven and focused on improvement science.

Secretariat

Health Quality Ontario will provide secretariat support to the Alliance, drawing on scientific expertise as required.

Attendance and member alternates

To maintain continuity and consistency in discussion and group composition, members will strive to attend all meetings. If unable to attend a meeting, members are encouraged to provide written feedback if required.

Meeting facilitation

Adalsteinn Brown, Interim Dean, Dalla Lana School of Public Health, University of Toronto will facilitate the initial sessions, with ongoing chair or co-chair model to be determined.

Decision making

Members will strive to make decisions by substantial consensus.

Frequency of meetings and manner of call

The Alliance will meet a total of 4 times through March, 2018. Appropriate frequency will be reassessed at that time. Meetings may be held in-person and/or via tele/video conference. Additional meetings may be held, as determined by consensus of the group.

Communications

Agendas and materials will be distributed approximately one week prior to meetings, and members may add agenda items through the chairperson. Meeting minutes will be recorded by HQO staff and distributed to members within approximately one week of the meeting.

Review

Terms of Reference, mandate, activities, membership and relevance of the Alliance will be reviewed in March, 2018 upon completion of the first set of deliverables.