Advancing Practice Improvement in Primary Care

Final Report

May 26, 2015
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Acknowledgement

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The views and recommendations expressed in this report are those of the Ontario College of Family Physicians for consideration by Health Quality Ontario. They do not necessarily reflect the consensus of the advisory committee or the views of the organizations engaged.
1. Introduction

In the Ontario College of Family Physicians’ Strategic Plan for 2014–2017, the stated vision is that every Ontarian should receive high-quality, coordinated, comprehensive and continuing primary care from a team led by family physicians and supported by an integrated, sustainable health-care system. Teams may be inter-professional, virtual, co-located or based in offices with two or more physicians. Regardless of practice size, family physicians and other primary care providers are committed to the health and well-being of their patients and to excellence in the delivery of care. Additionally, the patient-provider relationship is the foundation of ensuring quality primary care. These values anchor family physicians and other primary care providers across all practice sizes and models and are the greatest assets supporting practice improvement.

Further, as a member of the Ontario Primary Care Council, the Ontario College of Family Physicians (OCFP) supports the Council’s assertion that primary care is the foundation of the health system. To improve population health, deliver people-centred services and strengthen our publicly funded health system, we must create a stronger foundation for the delivery of primary care in this province. This principle is supported by strong evidence showing that investment in primary care is associated with improved quality, equity, efficiency and patient outcomes.

There have been several important achievements to build practice improvement capacity in primary care. Health Quality Ontario and many primary care organizations, such as the Association of Family Health Teams (AFHTO), Association of Ontario Health Centres (AOHC), Nurse Practitioners’ Association of Ontario, Ontario Medical Association (OMA), and the Registered Nurses’ Association of Ontario (RNOA), as well as individual practices have led and continue to advance capacity in the sector. While there are a number initiatives and tools available, few have been widely adopted across most practices. For example, only 400 of the 13,000 family physicians in Ontario receive Primary Care Practice Reports, and much-needed retrieval and use of electronic medical record (EMR) data is still in its infancy. Provincial and national initiatives, such as Health Links and Choosing Wisely Canada, provide further opportunities to improve care for targeted patients and the population as a whole. Other resources include Improving and Driving Effectiveness Across Sectors (IDEAS) graduates, decision-support specialists and others in Family Health Teams (36 in FHTs + 3 in AFHTO), Community Health Centres (CHCs) and a few Local Health Integration Networks (LHINs), and RNAO’s Best Practice Guidelines (BPGs) and BPG Champions and Best Practices Spotlight Organizations (BPSO). All these programs and individuals have the experience and knowledge to help support adoption and management of practice improvement in primary care.

While FHTs, NPLCs, CHCs and AHACs hold accountability for quality improvement, these team-based practices represent only about 25% of family physicians in the province. Most of the remaining family physicians have not participated in formal practice improvement initiatives, such as those led by Health Quality Ontario (HQO), the Ministry of Health and Long-Term Care (MOHLTC) or others. Empowering more frontline primary care providers to embrace improvement in their practices will entail striking a balance between the need for greater accountability to patients and the health system and practice autonomy. Efforts should build on family physician and primary care provider commitment to a strong patient-provider relationship and high-quality care.

To increase the spread and scale of practice improvement in primary care, a more coordinated and aligned strategy and an approach that is supported provincially and strengthened regionally
and locally are needed. Such an approach would facilitate identifying both common and targeted measures, enhanced dissemination of existing tools and resources, sharing of best practices, and developing a practice improvement culture among more practices and, importantly, across all practice models.

The recommendations suggested by the OCFP to HQO in this report provide the foundation for 1) leveraging the experience, successes and momentum built over a number of years though leadership from HQO and the MOHLTC, 2) partnering with AFHTO, AOHC, NPAO, OCFP, OMA/OntarioMD/SGFP, and RNAO and other relevant professional associations, and 3) drawing on the commitment and experiences of family physicians, registered nurses, nurse practitioners, other primary care providers, administrators and medical office assistants who work in primary care practices.
2. Project Background

The Ontario College of Family Physicians and Health Quality Ontario entered into a collaboration agreement to identify priorities and develop a targeted approach for advancing practice improvement in primary care. The agreement reflected the recognition that the landscape of family practice models has evolved over the past decade in Ontario with the introduction of new initiatives and expectations. While progress has been made by many, challenges to advancing and spreading a consistent quality agenda in primary care remain. During the period from September 2014 to March 2015 the project to advance practice improvement in primary care sought to identify and address these challenges. The scope of the project was to-

1. Investigate what is needed to support the advancement of continuous practice improvement in primary care and close the gap among practices, focusing particularly on the family physicians who have not previously been engaged and those not practising in models with teams of interprofessional health-care providers (IHPs), such as fee-for-service, family health groups and family health networks that are not FHTs
2. Engage frontline health-care providers in dialogue to inform an approach to advancing practice improvement that incorporates learning from international and national best practices and improvement activities currently underway in Ontario
3. Gain input from Ontario Primary Care Council (OPCC) member organizations and HQO to inform a targeted approach to advancing the spread and scale of practice improvement across the province

With a focus on both improving the overall quality of primary care service delivery in Ontario and closing the gap among practices in practice improvement initiatives, this report outlines an approach for advancing this work in the primary care sector. At present, other than practices such as FHTs, NPLCs and CHCs that have IHP team members and explicit accountability requirements (though the FHT contracts cover only the FHT-funded part of the organization and excludes physicians), few primary care practices have undertaken practice improvement efforts; several others have only just begun. **Primary care is a foundational element of the health-care system and the delivery of high-quality, comprehensive care is critical in this sector.** Given that the approaches to funding primary care and the associated expectations are varied and that there are several competing demands for change and improvement in the sector, the extent of the uptake of practice improvement has been limited. Based on the evidence, a review of existing programs and resources, and input from stakeholders, **this document outlines some of the gaps and barriers to change, as well as strategies and approaches to help overcome them and support the increased spread and scale of practice improvement.**
3. Project Methods and Deliverables

Primary Care Policy and Quality Improvement Inventory

The goal of developing an inventory was to provide a snapshot of the provincial quality and policy initiatives underway in Ontario and gain an understanding of the demands placed on primary care. The objectives were to develop an inventory of initiatives underway at this time and describe their current state. In total, 16 interviews were conducted with 11 organizations, 28 websites were searched and 117 initiatives were identified. This work produced this final report that included an inventory and general observations on implementation, a description of the impact of the multiple demands and discussion of the lack of an integrated approach.

Review of Best Practices

HQO completed a review of select articles aimed to identify best practices and building blocks for practice improvement efforts. Several articles were summarized that highlight improvement efforts from various jurisdictions. The examples selected were intended to provide a breadth of experience and show what is possible without advocating one approach over another. The summaries highlight impacts of improvement initiatives at the primary practice level and, where possible, identify lessons or effective strategies for use in Ontario. As well, additional articles were later reviewed to support the development of the recommendations in this report.

Engagement Workshop

The OCFP held a Practice Improvement Engagement Workshop on December 9, 2014, in Toronto. The purpose of the workshop was to develop an understanding of what is needed to support further advancement of practice improvement in primary care. The session allowed for direct dialogue with frontline health-care providers, administrators and office assistants, as well as other stakeholders, on their experiences and needs related to practice improvement. Approximately 60 participants attended the workshop: 45 people representing family physicians, nurses, medical office administrators and practice improvement champions, and 15 people representing primary care organization and associations.

The focal question of the day was, “What are your priorities for practice improvement and what do you need to advance practice improvement and sustain it?” Participants were first asked to identify their questions, challenges and priorities related to practice improvement. Their input was reviewed and condensed to identify the following five priority topics for further discussion:

1. Strengthening leadership and clear improvement opportunities
2. Improving clinician participation
3. Enhancing education of staff about practice improvement
4. Extracting and using data for improvement
5. Making access to care a priority issue

Thereafter, a series of three breakout sessions were held to discuss the priority topics using the framework shown in Figure 1. Following the workshop, proceedings were developed and sent to all attendees and to individuals who were invited but were unable to attend.
Figure 1. Framework for Primary Care Feedback

1. What’s Problematic?
   - Topic clarification
   - Barriers / Obstacles

2. What’s Possible?
   - What works and why?
   - What doesn’t and why?
   - What held you back from trying something?

3. Moving the Needle
   - What should we do differently?
   - What could the next steps be?

Stakeholder Consultations

Following the completion of the inventory, best practices review and summary of the engagement workshop, a presentation was developed for stakeholder consultation. The presentation included the project background, principles identified for advancing practice improvement, a suggested approach that recognized where practices were on the improvement continuum, core enablers for advancing practice improvement, and recommendations nested within three priority areas drawn from the topics identified at the December 9 workshop. The recommendations discussed by workshop participants were presented at the micro (practice/individuals), meso (LHIN/networks) and macro (province/organization) levels. The presentation and supporting documents were circulated to the Ontario Primary Care Council member organizations, HQO, and the SGFP. Meetings were held with each organization to get input regarding their priorities and current practice improvement initiatives and to discuss the project findings and proposed recommendations. Their input is summarized in Appendix A.

Practice Improvement Project Advisory Committee

The OCFP created a Practice Improvement Project Advisory Committee to provide advice and guidance throughout the project. The committee consisted of core and adjunct members. Core members were the primary source of advice and adjunct members were invited to attend meetings and comment on meeting materials. The core members included an OCFP/Association of Family Health Teams of Ontario (AFHTO) family physician, an OMA/SGFP family physician, a medical office assistant, a Registered Nurse representing the RNAO’s Family Practice Interest Group, an Association of Ontario Health Centres (AOHC) family physician and the OCFP Acting Director of Policy and Planning.

Adjunct members included the OMA Executive Director, Director of Engagement and Program Delivery, and Senior Director of Health System Programs; the AFHTO Executive Director; the RNAO Policy Director; the AOHC Knowledge Management and Learning Lead; the Nurse Practitioners’ Association of Ontario (NPAO) Executive Director; the OCFP CEO; and the HQO Vice President, Quality Improvement. Staff resources included the OCFP Practice Improvement Lead, the OCFP Practice Improvement Advisor and the HQO Best Practices Lead.

Final Report

This document outlines strategies and approaches to support increased uptake and spread of practice improvement initiatives in primary care in Ontario. It outlines the current situation, the opportunity, guiding principles and a targeted approach for implementation, as well as a set of recommendations for HQO, focusing on practices that have not started or are early in the practice improvement endeavour.
4. Key Challenges Faced in Primary Care – What We Heard

| | “How can I integrate practice improvement into my day-to-day work to make it a priority and sustainable?”
| | “How do I find the time, energy and resources?” What is “doable in real life?”
| | “We need some kind of a trigger to take a break from our busy routine to consider the bigger picture and what small changes can make a difference.”
| | Many believe “what we are currently doing is working fine.”

| On Shifting Culture and Team Building | “Quality improvement is not an add-on. Quality improvement feels like an add-on now and as such it gets put off.” “A culture shift in the way we do business” is needed.
| | “It is important to find the motivation for improvement and to spur thinking to learn more, try more…”
| | “It doesn’t work when you don’t involve all the team…using staff from clerical through the MD in the right way.”
| | “How can we have some sort of standardized process when physicians at our office all have different opinions?” Physicians need to increase their “comfort reducing control, comfort with others’ scope.”

| On Time | “What I get paid for determines what work I spend my time on.”
| | “I don’t know how to make time. Medical needs don’t stop and business needs don’t stop and pile up and lead to backlogs. So if you tried to make time to try improvement, you’d pay for it with backlogs in your care.”

| On Access | “Access to same-day appointments; what is the best process? How has it worked for others? How many? When are they booked? What patient education, staff education?”
| | “Almost everyone has their own idea of what constitutes advanced access and we should provide more education as to what it really is and how to accomplish it, [and] if it is shown to be a successful change in scheduling.”

| On Data | “I know there is great data in my EMRs but it takes too long to set the EMRs up to get the data.”
| | “Data tells me where we are at now; what am I supposed to do to improve?”
| | “There is an overarching question before we can understand how to manage our data, know what data to pull and how to use what we have. That question is, ‘What are we going to use the data for’ or ‘What are we trying to improve?’ How do we find the answer to this? We lack support to understand this.”
| | Measures should be “tied into culture and identity.”

| On Support and Training | “Some people have lots of people to turn to; some people have no one to turn to.”
| | Practices value “having someone from outside to lean on and to remind/push them to keep trying.”
| | “Teaching and preaching and websites don’t always translate into actions.”
| | “It doesn’t work to expect people to travel and take major time away from a day. It works better if you find ways to work in brief spurts like huddles, or lunchtime Ontario Telemedicine Network sessions or websites.”

| On Patients | “What do patients think quality care is? Are we meeting their needs; are they satisfied with care?”
| | “What do we want to know from our patients regarding our care?”
| | “How do we use patient experience to design our care?”
Based on discussions and information gathered through the inventory and best practices review, engagement workshop and follow-up meetings with primary care stakeholders over the course of this project, a number of key themes emerged related to challenges faced by practices considering launching a practice improvement initiative, as well as by those that are further along the improvement continuum. The overriding challenge is the lack of a consistent and equitable infrastructure to support quality standards, expectations and measurement across the primary care sector. This and the other challenges described below need to be addressed to support the spread and scale of practice improvement across all primary care practices in Ontario.

**At the Practice Level**

**Different Practices, Different Needs, Different Starting Points**

Family physicians and other primary care providers in Ontario work in highly diverse practice models that are often fragmented from the broader health system. Those not practising in inter-professional teams represent the majority of primary care practices and OCFP membership, but there has been minimal uptake of practice improvement initiatives among this group because of a lack of attention to this group and insufficient infrastructure within practices to support these efforts. Practice improvement will require a culture shift to get started. Family physicians can become ‘quarterbacks’ and allow other primary care providers to take the lead on identifying practice improvement opportunities. These practices require a unique, targeted approach to support them in commencing and implementing practice improvement.

In Ontario, there are 294 organized practices (10 aboriginal health access centres (AHACs), 75 community health centres (CHCs), 185 family health teams (FHTs) and 26 nurse practitioner-led clinics (NPLCs)) that currently undertake quality improvement as part of their work, and many other champions in the field across other practice models. There are also numerous practices that have implemented a practice improvement initiative but have been unable to maintain and/or spread the effort. Others may have implemented a change, but not proceeded any further. These practices also require targeted efforts to get them back on track and to move them further along the practice improvement continuum.

**Competing Priorities**

Family practices have many competing organizational and clinical priorities. These impede getting buy-in and initiating practice improvement. Getting buy-in entails convincing practice staff that the benefits will be greater than the pain of the change process. Changing practice is complex, context-specific and iterative in nature, and the sustained adoption of practice improvement efforts is relative to the perceived value of the change within the practice, especially change related to practice capacity and any additional workload required.

The Highly Adoptable Improvement model\(^1\) shown in Figure 2 illustrates how the design and implementation of an intervention are associated with the balance between workload/capacity and perceived value. For example, more workload, less practice capacity and lower perceived value are more likely to result in burnout, cynicism and workarounds, and are less likely to produce the intended results. Resistance to ongoing change may occur. This scenario reflects many primary care practices currently.

\(^1\) © 2015 Highly Adoptable Improvement, used with the author’s permission.
Time
It is difficult for practices to carve out dedicated time for practice improvement efforts, especially for small group or solo physician practices, practices that are not team-based and those funded via fee-for-service. Physicians need to be confident that the cost of protecting time for practice improvement will pay off. For fee-for-service practices, it may mean lost revenue in the short term. Many feel they do not have the time or resources to dedicate to quality improvement: “everyone is already working at maximum capacity.” It “doesn’t work to expect quality improvement on top of daily constraints.” Improvement programs need to address this reality and create an approach that is seen to add value.

Family physicians at the workshop reported that they already spend a great deal of time on activities that take away from patient care, including the time and effort spent on accessing specialist and other services and on paperwork for third parties (e.g., Workplace Safety and Insurance Board, Ontario Disability Support Program, insurance companies and employers). By reducing this burden or streamlining these processes, more time could potentially be freed up. Another critical issue related to time constraints is the limited time available to dedicate to optimizing EMRs and extracting the requisite data to support improvement efforts.

Perception of Relevance
Some family physicians feel that their perception of what is needed to improve the delivery of care is not aligned with government expectations and that improvement priorities are determined in a top-down manner. Improvement efforts should begin where practices themselves identify the greatest need (i.e.,
their main “pain point” or challenge) and be supported by data from EMR or primary care practice reports to test and validate actual pain points in the practice. Some workshop participants identified a tension between accountability requirements – for example, the Quality Improvement Plan (QIP) – and ongoing practice-specific improvement efforts, while others see them as an opportunity to improve their practice, and work with other parts of the health system on improvement. For some, practice improvement is perceived as an accountability mechanism and some fear that quality metrics will be used in a punitive way, and this may be a barrier to initiating practice improvement. Others believe that there should be more incentives to support practice improvement and greater efforts to reward quality, although not necessarily financial incentives.

**Lack of Data and Measurement**
Measurement is critical to practice improvement. Most of those consulted for this project believe that practice improvement efforts should begin with optimizing EMRs and improving practice-level data because these are fundamental to supporting any practice improvement initiative. Approximately 20% of primary care practices in Ontario do not use EMRs and most of those that do have EMRs are not optimizing their functionality, which makes accessing data and measurement challenging. As well, staff – including physicians, other primary care providers and administrative staff – need training to support EMR management and most practices do not have dedicated IT resources.

**At the System Level**

**Integration, Coordination and Alignment**
Several workshop participants indicated that “many provincial and regional organizations present themselves as primary care leaders” but asked, “who is in charge”? No one organization in Ontario represents primary care and there is no aligned provincial strategy and structure for practice improvement that provides leadership and drives change. Practices receive direction and support from the MOHLTC, HQO, AFHTO, AOHC, NPAO, RNAO, the LHINs, OntarioMD, professional colleges and others. There is insufficient coordination of direction and support to frontline providers among the various organizations representing primary care and supporting practice improvement. Greater role clarity, priority alignment and coordination of approaches are needed.

**Lack of Common Improvement Priorities, Targets and Language**
Competing priorities among provincial, regional and local organizations cause practice improvement efforts to appear unfocused. There is no single set of priority indicators, targets and projects provincially. Primary care providers feel that they have multiple, simultaneous, ever-changing expectations of them and have difficulty keeping up with and deciding which of the priorities they should focus on. Even within individual organizations (such as the MOHLTC, Cancer Care Ontario and HQO) supporting multiple improvement initiatives, the relationship and alignment among these initiatives is often unclear. Through this project and engagement with the primary care sector, these organizations recognize the need to increase coordination and identify the best approaches.

Frontline providers feel that practice improvement has become “professionalized” and now has its own language. More simplified, practice-based language with clearer definitions for outcome and process measures is needed. Additionally, skill building to help identify, plan and implement improvements across practices, such as IDEAS, needs to be reinforced. The inventory noted many policy initiatives with incomplete information about their goals on their websites (e.g., objectives, target audience, why practices should engage, how to engage and expected outcomes). As well, the majority of initiatives
documented did not have identified targets, explicit measures, or methods to assess the impact of the initiative and measure success.

There is also limited focus on, and prioritization of, prevention in primary care – issues associated with the social determinants of health and how they affect providers’ ability to deliver quality care and the sustainability of the system. Leadership in this regard is needed both within the practice and at higher levels.

**Practice Engagement**

Given the lack of an integrated structure with an aligned strategy and clear accountability for primary care practice improvement, there is limited coordination of efforts to fully engage clinicians across various practice models. There is also concern about the uneven distribution of resources and limited guidance to support practice improvement across practice models (e.g., fee-for-service, family health groups) and across LHINs. Getting started in these practice models is challenging, and some practices felt that guidance and support from a centralized source could provide a greater incentive for them to engage. Currently, practitioners are unsure of the relative roles of the organizations involved and find messaging unfocused – given that there are no common priorities, concepts presented are too broad, resources are uncoordinated and many providers do not know where or who to go to for support and guidance.

Organizations that promote practice improvement report multiple methods of engaging primary care practices. But often these methods are not aligned or do not fall within an overall communication/engagement strategy targeted to different practice models, given the variation in resources available. These organizations acknowledge limitations in confirming reach and/or impact on targeted end users. Moreover, there is often no clear distinction between communicating or “pushing out” messages and materials and meaningful exchange of information or engagement among frontline providers. As well, there is a need to differentiate between initiatives that are aimed directly at primary care providers (with a focus on communication and engagement) versus initiatives that are contributing to health system planning that implicate primary care (requiring a message to raise awareness but with less emphasis on engagement). Multiple messaging without clear objectives and direction may create additional barriers to engagement and relationship building by increasing the challenge for potential participants to prioritize among initiatives, and possibly even increasing the likelihood that they will “tune out.”

Organizations supporting practice improvement initiatives often seek input from primary care providers at the design and execution phases using a clinical or LHIN lead, representatives from a member-based organization (e.g., OCFP, NPAO, RNAO) and/or a clinical working group. However, the OCFP’s observation is that more engagement of frontline providers would help to better understand the needs, barriers and perspectives of the diverse practice settings. Practice leaders can play an important role in the engagement process. Examples from other jurisdictions and from other disciplines point to potential clinical engagement approaches that are a key factor for successful adoption.

**Principles for Advancing Practice Improvement**

Based on what the OCFP heard from frontline providers and primary care member organizations and the additional information gathered for this project, seven key principles for advancing the practice improvement agenda were identified. Practice improvement efforts in primary care should be tested against the principles described in Figure 3.
### Figure 3. Suggested Principles for Advancing Practice Improvement

**Principles**

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<td><strong>Building on our strengths</strong> Much has been accomplished in terms of practice improvement and increasing the quality of primary care in Ontario. This experience and expertise can contribute to successfully furthering these efforts.</td>
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<td><strong>Reducing variation</strong> Performance and the extent of practice improvement initiatives vary widely. There are opportunities to improve overall quality and performance, as well as reduce the number of practices that fall below average performance.</td>
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<td><strong>Staying the course</strong> Practice improvement activities can be challenging and time consuming. With adequate support, and keeping an eye on the prize, primary care practices can persevere in spite of the occasional setback. Practices would also benefit from consistent, ongoing provincial and LHIN support for their efforts.</td>
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<td><strong>Understanding that less is more</strong> Undertaking practice improvement can be a daunting endeavour. Practices can be overwhelmed by the various materials, “foreign language,” complex initiatives and expectations. Keeping it simple and straightforward and starting small will help practices ease into these efforts.</td>
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<td><strong>Enabling patient participation</strong> There is significant evidence that patient participation can provide valuable insight in setting priorities and augmenting practice improvement initiatives. If patient-centred care is to be achieved, patient needs must be at the core of practice improvement efforts.</td>
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<td><strong>Sharing leadership – a role for all</strong> Leadership capacity building and distributed leadership models show great promise and have been shown to support continuous practice improvement.</td>
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<td><strong>Acknowledging the change process</strong> Changing practice and culture is not easy and takes time. As part of any practice improvement initiative the challenges related to resources, time, level of effort and resistance to change must be acknowledged and addressed.</td>
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Based on the information collected and stakeholder input over the course of the project, several recommendations were made for moving forward. These can be found in Appendix B. These recommendations have been grouped into themes – leadership, support and education, and data and measurement – and are presented at the provincial, LHIN and practice levels.
5. The Opportunity

The Value Proposition

In a quality improvement organization each and every health-care provider and staff member believes that change and improvement are an intrinsic part of everyone’s work every day, in all parts of the system. Shifting to this new focus involves substantially reframing the idea of the work of health care and utilizing a wide variety of tools and methods.²

Practice Improvement Efforts Have Been Shown to Work

There have been several successful practice improvement efforts in Ontario, nationally and internationally. Practice improvement programs, often modelled on the Institute for Healthcare Improvement’s breakthrough series model, have been shown to increase patient and provider satisfaction and improve processes and health outcomes by enabling participants to share experiences, accelerate learning and spread best practices. There are numerous examples of improvements in quality as a result of primary care practices’ involvement in systematic practice improvement initiatives, such as those led by HQO. Systematic reviews of strategies to change providers’ behaviour or improve care processes have shown improvements in wait times, continuity of care, screening, patient self-management, care processes, chronic disease management and health outcomes when compared with no intervention.

Opportunities and Resources for Improvement in Ontario

Performance and outcomes are uneven in primary care practices across Ontario. About 75% of family physicians do not practice within a team-based model (e.g., FHTs, NPLCs, CHCs) and many would benefit from practice improvement efforts and support. National and international evidence shows there is significant scope for practice improvement. The Commonwealth Fund Health System Report (2014) ranks Canada ninth out of 11 countries in terms of quality of care (effectiveness, safe care, coordination and patient-centred care) and last in terms of timeliness of care. Ontario data indicate opportunities to improve screening, chronic care and prescribing patterns, as well as to reduce less-urgent emergency department visits (Cape triage score, CTS 4–5), avoidable hospital admissions, hospital re-admissions and specialist visits. As stated above, there are also opportunities to improve data and measurement within practices.

As shown in the inventory, several organizations advocate and/or support practice improvement in primary care. HQO is involved in several initiatives, including the Primary Care Practice Report, QIP, the Ontario Primary Care Performance Measurement initiative, IDEAS, Advanced Access and Efficiency, and Chronic Disease Prevention and Management. There are a number of frameworks and tools relevant to primary care and a commitment by HQO and MOHLTC for more coordination and alignment of these and other initiatives (Appendix C).

There Is Interest and Support

There have been effective initiatives undertaken to support primary care in Ontario. Organizations promoting practice improvement acknowledge that primary care is a priority area, and are open to learning how to improve engagement and collaboration with primary care. Many recognize that gaps, barriers and needs should be better understood to inform the design and implementation of an initiative.

² Adapted from Batalden P, Davidoff F. What is “quality improvement” and how can it transform health care? Qual Saf Health Care 2007;16:2-3.
There is also interest among family physicians and other health-care providers, and many of those providers who have already participated in practice improvement efforts say they “couldn’t go back.”
6. A Framework for a Targeted Approach to Practice Improvement in Primary Care

The following section outlines the recommended framework to support furthering the spread and scale of practice improvement in primary care across all practice models in the province. We propose a targeted approach to implementing practice improvement based on the individual practice environment, experience and readiness – with an emphasis on five core enablers. The overall aim is to increase the extent of primary care practice participation in practice improvement and to embed it in their culture and day-to-day work. The approach also recognizes that practices already engaged need to continue to evolve their own work and be part of the solution to ‘pass it on’ to their peers.

A Targeted Approach: Primary care practices in Ontario are at different places along the practice improvement continuum. The emphasis of this report is on those practices that have not yet started or are in the early stages of practice improvement. Also, many have undertaken practice improvement efforts that have not been sustained and others are assessing how to improve upon what they have done to date and expand their efforts. This report addressed their needs as well. Those that are getting started are looking to the early adopters for lessons learned and tips on avoiding some of the pitfalls they may have encountered. The proposed approach is therefore targeted and would address the issues encountered by practices at each of the stages illustrated in Figure 4: 1) Getting started, 2) Making it stick – Taking it further and 3) Passing it on.

Core Enablers: While there are distinct stages to implementing practice improvement, there are core enablers that apply throughout. The importance of these enablers was discussed consistently by stakeholders throughout this project and they were identified by improvement practitioners and in the literature as critical success factors for practice improvement all along the continuum.

Based on the evidence (including systematic reviews), the impact of practice improvement initiatives is likely to be greater when baseline compliance with recommended practice is low, when the initiative targets a particular behaviour or barrier to change and when the intervention is provided more intensively. The impact is also likely to be greater when educational interventions are more interactive and have higher attendance rates. Many researchers have identified key factors for facilitating the implementation of practice improvement. Wilson emphasizes five factors: desire to change, social context, viable alternatives, ability to change and feedback, as opposed to less successful improvement programs that emphasize a single-purpose or magic bullet intervention. For Baker they are as follows:

1) The presence of a supporting culture, strategy and structure
2) The ready availability of requisite information and supporting systems
3) Education and training of staff
4) Understanding the time and change-management requirements
5) Alignment of goals and incentives
6) Leadership

7) The presence of the requisite skills
8) Adequate resources

Figure 5 outlines the five core enablers and key aspects of the enablers associated with each of the three phases outlined above and shown in Figure 4. The remainder of this section describes the enablers.
Figure 4. A Targeted Approach

Figure 5. Core Enablers

Phase 1
- Assess comparative practice-level data
- Support practices optimizing their EMRs and extracting data
- Use data to identify an improvement area
- Identify and support practice champions
- Lay the groundwork for a practice-based culture shift
- Address barriers to change
- Facilitate identification of pain points and setting of goals
- Use coaches and peer facilitators to develop knowledge and buy-in
- Provide simplified tools, guides and advice for getting started based on previous primary care experience
- Solicit patient input

Phase 2
- Continue monitoring of data to maintain gains
- Reassess targets
- Use data to identify next improvement area
- Address successes and challenges along the way
- Reassess and adapt processes
- Adapt required staff efforts and ensure clarity of roles
- Learn from setbacks
- Enhance skills
- Document and share stories and strategies
- Expand to other team members
- Coordinate communication within provider networks
- Develop provider partnerships
- Share models of success and failure with others
- Support local and regional efforts through user groups, lunch and learns, etc.
- Coordinate training efforts

Phase 3
- Share data strategies and stories of how data moved practices to action
- Have change champions lead local networking
- Use peer and practice coaching and mentorship
- Augment and improve educational materials and tools
- Develop provider partnerships
- Build a culture of improvement
- Reinforce and adapt processes
- Address barriers to change
- Lay the groundwork for a practice-based culture shift
- Identify, discuss and address the barriers to change
- Include patients as partners

Getting Started
- Laying the groundwork
- Making the case and getting buy-in
- Increasing practice improvement literacy
- Team building and shifting culture
- Developing leaders
- Improving practice data
- Identifying, discussing and addressing the barriers to change
- Including patients as partners

Making it Stick
- Addressing change fatigue
- Reassessing processes and ongoing adaptation of roles and efforts
- Measuring and maintaining gains
- Reframing failures into learning

Taking it Further
- Including more practice members
- Spreading to new areas of improved marketing of practice improvement
- Sharing models of success
- Networking and mentoring
Data and Measurement
Data and measurement drive improvement and are critical to the success of any practice improvement endeavour. Measuring to determine how the practice is performing at baseline, setting goals and targets, and monitoring progress along the way is fundamental. Optimizing EMRs and getting meaningful data are of utmost importance and should be the starting point for improvement efforts. As well, many primary care practices do not have procedures for collecting information such as workload processes, types of visits or patient experience. Some practices receive performance and comparative data from external sources, which are informative, but expansion to other primary care models and clear direction on how to interpret and apply data would increase their usefulness. One of the key challenges is the limited support and resources for data collection and management. Most practices lack dedicated IT resources; some primary care models have received more support than others.

Change Leadership
Change is difficult and any practice improvement initiative is bound to encounter challenges and some resistance related to the requisite changes. Practice improvement efforts need to address the elements identified in the Highly Adoptable Improvement model shown in Figure 2. Fundamental for success is practice staff’s willingness and active participation in the process. There are a number of barriers to implementing practice improvement, especially in small and non-IHP team-based primary care practices. Practice members must identify and discuss these before proceeding. They must also be prepared to adopt an effective approach and stick with it. It is important that practice staff understand that practice improvement is not a quick fix, but entails changes to their mindset and the way they do business over the long run, with successes and challenges along the way.

Doing justice to practice improvement requires dedicated leadership, focus and expertise. Strong and effective leaders are needed to support laying the groundwork and making the case through planning, managing and reinforcing the change. Family physicians need to actively support improvement efforts and work with other clinical and/or administrative staff in the day-to-day implementation and monitoring of efforts. For change to be supported, accountabilities and responsibilities need to be clarified and supported within the team – whether among a group of physicians or across an interprofessional team of providers. Strong leadership from any member of the team within the practice in this regard is crucial and can be supported by local change champions.

Skills Building and Continuing Education
To translate existing knowledge into action, an emphasis on skills building and ongoing support and education is needed. The success of practice improvement relies on support all along the change continuum. When getting started, practices need education on improvement methods through facilitation and/or formal training. Coaches, quality improvement champions and mentors can play an important role in this regard. To make it stick and take it further, practices may need ongoing coaching and mentoring, as well as individuals with augmented skills in leadership development, change management, governance, business administration and clinical practice. For passing on successful approaches, a number of methods could be applied, from peer-to-peer mentorship to a coordinated provincial training effort such as IDEAS, or the RNAOs BPSO.

Toolkits on websites are not sufficient and one-off training sessions have not been found to be as effective as incremental, ongoing training and support that starts with theory and continues with hands-on training and support in the practice. Practice improvement education needs to be simplified with accessible language and the content presented in a way that participants feel it is achievable. As well,
practices want to implement evidence-based practice and want training that helps them understand and translate this into practice for their patients.

Sharing and Collaborating
There are numerous opportunities for increased sharing and coordination of efforts in practice improvement. Many initiatives are occurring concurrently and while sharing of successes (and failures) is occurring in some organizations (AFHTO, AOHC, NPAO), it is not consistent. Efforts should be made to support cross-pollination and improved communication, as well as to leverage and build on local and LHIN capacity (e.g., regional networks and communities of practice). This approach could include matching practices with those that are more advanced or that have similar characteristics, peer-to-peer partnerships and/or secondments or exchanges, along with virtual linkages, online forums and roadshows. As well, practices undertaking practice improvement should be encouraged to document and share their experiences and the various peer and practice mentorship approaches explored.

Alignment and Integration of Efforts
As previously described, currently there is limited to no primary care infrastructure or one organization representing primary care charged with driving change in practice improvement in primary care in Ontario. Given that, there is no aligned provincial strategy and culture across primary care. Providers are faced with multiple expectations and have difficulty keeping up with and deciding on which of the requirements they should prioritize and address. There are significant opportunities for collaboration and partnerships among various primary care organizations and those supporting practice improvement, including clearly defining their relative roles; aligning their engagement approaches and messaging; coordinating resources; and harmonizing approaches, requirements, and training and support for practice improvement. Greater alignment would facilitate practices’ efforts along the practice improvement continuum. By undertaking this project through a collaborative partnership with Health Quality Ontario, MOHLTC, and with primary care member organization and associations, including with the OPCC, that there is a willingness to determine how best to integrate and align efforts to support all practices in primary care on their practice improvement journey.
7. Recommendations

For the OCFP, practice improvement includes all the ways in which clinical care, office-based processes and efficiencies, safety and program delivery can be improved by family physicians and other providers and staff in primary care practices for the benefit of patients.

The following recommendations describe how HQO (and other stakeholders) could further advance practice improvement efforts for all primary care practices in Ontario, as well as sustain the gains realized by practices that have already embedded a culture of improvement into how they provide care. The recommendations are based on what the OCFP heard directly from frontline providers – family physicians, registered nurses, nurse practitioners, other primary care providers, administrators and medical office assistants – and are supported by evidence and best practices.

1. Overall

a. At the heart of the proposed approach is the recommendation that HQO address the diversity of primary care practices and where they are positioned along the practice improvement continuum. A practice getting started has needs for support and education that are quite different from those of a practice that has an improvement culture integrated into how it operates and provides care for patients. Reaching the various primary care practices will require collaboration and coordination among member organizations that directly support the front lines. This includes an emphasis on local and LHIN efforts that leverage local knowledge and networks. By tailoring outreach, HQO, with its partners, will more effectively support the spread and scale of improvement efforts needed in Ontario to achieve the greatest gains for patients.

2. Data and Measurement

a. HQO should lead the coordinated identification and dissemination of a consistent set of provincial measures (with an identified set of core measures) that apply to all practice models, with a focus on increased uptake of Primary Care Practice Reports, and work in partnership to leverage and coordinate the work with AFHTO and AOHC. This could include setting targets for Primary Care Practice Report adoption and creating strategies for family physicians to join. HQO should evaluate the measures over a multi-year timeframe and monitor progress. Efforts should be characterized by the alignment and coordination of priorities, data collection tools and available data among provincial and regional organizations.

b. Practices should have the autonomy to choose improvements from a broader group of provincial health system improvements that make sense to them. They need to use data to decide on their own practice-based improvements based on their patient population and internally identified needs. In addition to the core set of primary care indicators, and with input from the various practice models on the front line, HQO should identify and provide a set of clinically and operationally relevant indicators – with definitions and algorithms – from which practices can choose.

c. Practices require support and training to optimize their EMR use and to standardize, manage, extract and interpret data. A partnership with AFHTO, AOHC, NPAO, the OMA/OntarioMD and ICES could support data standardization and report generation from EMRs. EMR use could be supported through coaching and education, including by the OMA/OntarioMD and OCFP. OntarioMD could also support EMR communities of practice and document the methods and tools created through
EMR/IT projects and pilots across the province, with the goal of streamlining efforts and sharing best practices.

3. Alignment and Integration of Efforts/Change Leadership
   a. Coordinate the integration of government and government agency primary care policy and practice improvement initiatives to reduce the fragmented approach that currently exists. This integration includes identifying gaps and challenges that need to be addressed; clearly defining their relative roles; harmonizing approaches, requirements and support for practice improvement; and a commitment to long-term, consistent support.

   b. Align primary care engagement strategies and messaging. This includes crafting messaging and engagement efforts with clearly defined objectives and target audiences (e.g., based on the practice’s stage of implementation and/or an individual’s role in the practice – physician, nurse, other IHP or office staff). Engagement will be facilitated by relevant, plain-language messaging and materials.

   c. Ensure there is adequate and appropriate representation and input from the range of primary care practices to understand and reflect the needs, barriers and perspectives of the diversity of practice settings.

   d. It is important to coordinate the effort to enhance awareness among family physicians and other primary care providers of the tools and resources available, where to find them and how to use them. These tools could include plain-language, straightforward “how to” resources that outline how practices can identify their own pain points and priorities; that provide simple case studies with strategies that clearly show the steps practices could take to improve their clinical practice and service delivery; and that address the unique needs of small practices, practices without teams and/or practices with limited administrative capacity.

4. Sharing and Collaborating, Skills Building and Continuing Education and Change Leadership
   a. Provide practices with consistent, ongoing support, facilitation and coaching throughout the stages of practice improvement – from initiating improvement through maintaining gains and launching a new endeavour. This support is best provided by peer champions, coaches, mentors and clinical leadership, locally and regionally.

   b. Augment, further invest in and leverage existing infrastructure, resources and programs. Mandate LHINs to create regional and local primary care quality networks that include graduates from IDEAS, HQO coaches, quality improvement/data management staff currently available to FHTs and CHCs, RNAO BPG Champions, Health Links leads, academic leaders, peer leaders and physician/nurse champions to promote and support practice improvement and strengthen local capacity. Local leaders and champions would craft and coordinate efforts to reach primary care practices and work with their peers to guide change. Support and guidance for this strategy could be provided by HQO, OCFP and other provincial organizations promoting practice improvement.

   c. Encourage and support organizations such as the OCFP, nurses’ associations and colleges, other health-care associations and colleges and groups working with administrative personnel to share and
collaborate on their practice improvement training priorities and methods, including collaborating on efforts to scale up educational opportunities. Other opportunities to share in education efforts include accredited improvement programs conducted in partnership with disease groups or networks; continuing medical education (CME) networks sharing common improvement tools, priorities and language; quality improvement modules for problem-based study groups; and practice improvement integrated into medical professionals’ curricula.

d. Promote and provide skills building in leadership development, governance and business administration; mentorship to lead practice improvement; and/or knowledge in a particular clinical area to ensure practices have the skills and knowledge to support practice improvement implementation. Opportunities for such training could be developed into CME credits.
## Appendix A. Summative Feedback: Primary Care Stakeholder Consultation

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>What Resonates</th>
<th>Current Work</th>
<th>Gaps</th>
<th>Next Steps</th>
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| Registered Nurses’ Association of Ontario | 1. Timely access  
2. Evidence-based guidelines embedded in practice  
3. All members working to full scope of practice  
4. Person-centred care  
5. Timely feedback to improve inter-professional leadership | 1. Access  
2. Best Practice Guidelines  
3. Primary Care Institute  
4. Specialty programs – Chronic Disease Prevention and Management, Wound Care, Mental Health and Addictions, Smoking Cessation, Falls Prevention Collaborative, Prevention of Elder Abuse.  
5. Best Practice Champions Workshops and Webinars  
6. Best Practice Spotlight Organizations (BPSO)  
7. NQuiRE Database system  
8. Primary Care Nurse Toolkit  
9. Leadership Programs  
10. Interprofessional Peer-to-Peer program  
11. Primary Care Solutions for Primary Care Report  
12. Enhancing Community Care for Ontarians (ECCO) report | 1. Funding models  
2. Solo physician practice models and at times FHT model limit RNs and NPs ability to work at full scope of practice  
3. Inter-professional leadership  
4. NP compensation/benefit inequities with other sectors | 1. Expanding RN practice scope to include prescribing |
| Nurse Practitioners’ Association of Ontario | 1. Members working to full scope of practice  
2. Importance of data and using evidence to drive improvements | 1. Rolling out practice improvement in an organic way: “did you do xx before, and are you doing xx now?”  
2. Choosing most available data vs. best available data  
3. Identifying small practice outcomes that are measurable  
4. Surveying members about key topics | 1. Infrastructure to support practice improvement | 1. Opportunities to integrate into curriculum and identify the next wave of NP leaders |
| Association of Ontario Health Centres | 1. Access and efficiency (based on SAMI scores)  
2. Clean data to support practice-level improvement  
3. Practice-level coaching and support  
4. Setting targets – finding baseline starting point through data  
5. Clinician Best Practice Targets – accreditation | 1. 6-month Access & Efficiency programs to help with run charts, etc.  
2. Strategic commitment to social determinants of health, health equity and measurement for improvement  
3. Achieving engagement and ownership of practice-level clinicians for improvement initiatives  
4. Coaching resources | 1. Coaching and support to use data for improvement  
2. Adequate resources to promote and support practice improvement initiatives  
3. QIPs can be perceived as an accountability exercise – without a real connection between the submission of QIPs and the day-to-day reality of QI/PI – submission of QIP is too often seen as the end (check mark on a list) rather than the beginning of practice improvement  
4. Clinicians can have limited/no ownership in QIPs  
5. HQO’s role needs to be understood – many are looking to it for leadership | 1. Book of change ideas for practices to choose from and adapt to own situation  
2. Practice assessment requires coaching/mentoring to get at root causes  
3. Need for peer to peer support for solo or small practices when beginning their QI/PI journey  
4. Make adapted QI/PI introductory sessions broadly accessible |
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<tr>
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<tbody>
<tr>
<td></td>
<td>2. Effective governance and leadership</td>
<td>2. Governance and leadership</td>
<td>2. Infrastructure</td>
<td>2. Opportunities exist to collaborate in areas such as team building, leadership, etc.</td>
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<td>3. Practice-level coaching and support</td>
<td>3. Effective use of teams</td>
<td>3. Physician staff need to support non-physician staff to be partners or leads of practice improvement efforts.</td>
<td>3. Opportunity to leverage D2D experience</td>
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<td>4. Quality Improvement Decision Support Specialists for decision support</td>
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<td>5. Starfield philosophy (capacity, cost, quality of patient centredness/ partnership with family physician</td>
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<td>6. Governance and leadership training programs</td>
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<td>7. Executive Director Advisory Tool Kit</td>
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<td>Ontario Medical Association</td>
<td>1. Data for improvement – extraction, use of meaningful data Education, coaching, support through peer leaders</td>
<td>1. OMA Peer Leader Program</td>
<td>1. Coordination and alignment on approaches to family physicians through collaboration with OCFP, HQO and AFHTO – also include SGFP, Cancer Care Ontario, LHINs, research groups, and MOHLTC</td>
<td>1. Negotiating funding for OMD with MOHLTC</td>
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<td></td>
<td>2. Leadership of the practice – physicians, nurses and office administrators working together</td>
<td>2. eHealth and EMR work through (OntarioMD)</td>
<td>2. Current fatigue of “do more with less”</td>
<td>2. Potential new tools such as eOrdering, eBooking, eConsult systems</td>
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<td></td>
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<td>3. EMR implementation and maturity work</td>
<td>3. Pain point for family physicians who do not have dedicated staff for PI – challenge for any change management</td>
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<td>4. Data extraction tools and building eReferral</td>
<td>4. Accountability level with an undercurrent of fear, punitive measures</td>
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<td>5. Partnership with HQO</td>
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<tr>
<td>Section on General and Family Practice</td>
<td>1. Data for improvement</td>
<td>1. March 28 summit on access and equity to define a blueprint</td>
<td>1. Lack of dedicated staff for QI in most practices</td>
<td>1. Work with other primary care organizations to inform and direct quality care initiatives affecting family physicians</td>
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<td>2. Support in practices</td>
<td>2. Work with Family Medicine Alliance on issues of shared interest</td>
<td>2. Professionalization of QI – quality is day-to-day work in practices with every patient interaction. How to allow practices to determine improvements needed based on their patient profile or clinical needs</td>
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<td>3. Autonomy to choose improvement based on patient population</td>
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Appendix B. Suggestions from the Front Line for Moving Forward

Several suggestions for moving forward emerged from the information and stakeholder input collected for this report. These have been grouped below into the following themes: leadership, support and education, and data.

**Strengthen Leadership**

**At the Provincial (Macro) Level**
- Initiate efforts to centralize and coordinate leadership for practice improvement in primary care in ways that incorporate and align top-down and bottom-up approaches
- Improve marketing efforts related to practice improvement in order to better “sell it” and clearly communicate the multitude of practice improvement initiatives and the benefits of participation
- Collaborate to engage practices and align and disseminate information consistently
- Use language that resonates with primary care practices and builds the sector’s understanding of basic practice improvement concepts
- While autonomy is important, the province should leverage accountability mechanisms to support the call to action
- Adequately resource and support primary care participation in practice improvement
- Provide behaviour-change and change-management strategies to support practice improvement

**At the LHIN (Meso) and Practice (Micro) Levels**
- Support the identification of practice and regional priorities
- Build and support regional peer networks
- Support greater efficiencies in patient access
- Facilitate the adoption of mentoring strategies for practices ready to start
- Align practice improvement with addressing the social determinants of health – support the achievement of overall health and well-being, not just clinical outcomes
- Link primary care practices with local practice improvement leaders/champions
- Implement a toll-free number and/or online support to support practice improvement

**Enhance Support and Education**

**At the Provincial (Macro) Level**
- Coordinate and streamline training efforts among provincial organizations
- Assess the needs and resources of non-team-based models
- Identify the regional and local infrastructure needed to expand reach
- Ensure mentoring and practice facilitation support is available for improvement efforts
- Tailor existing initiatives to be more applicable and doable for practices with one or two providers
- Heighten awareness of the various ways of commencing practice improvement (e.g., understanding learning concepts, assessing needs, setting priorities)
- Develop a simple how-to guide that provides steps for getting started, including using Quality Improvement Plans (QIPs) (e.g., how to identify a starting point, set priorities, define an improvement goal, and test, implement and adapt)
- Share “quick wins” and tips on getting started (i.e., sharing and collaborating)
- Put practice tools, tips, how-to guides, quick wins and technical projects in a central place that is accessible and available to all practices
• Develop and provide practice improvement education for primary care
• Develop and provide skills-building training for leadership development, change management, governance, business administration, leading practice improvement and particular clinical areas

At the LHIN (Meso) Level
• Help practices find ways to protect time for practice improvement, (e.g., practice facilitators to help identify strategies)
• Leverage existing networks/communities of practice and formalize and support regional networks
• Ensure small practices are included in regional networks
• Facilitate mentorship
• Disseminate success stories (i.e., sharing and collaborating)
• Provide training based on adult learning principles and problem-based learning

At the Practice (Micro) Level
• Assist practices assessing their readiness for change
• Support team building in all practices (i.e., those with two or more people), including efforts to understand and optimize everyone’s scope of practice
• Support practices to identify their pain points and starting point (based on their current situation, identified needs, motivation, resources and perceived benefits), and consider using QIPs to identify and manage ongoing improvement
• Provide structured support (e.g., administration, data management, change management), especially in small practices
• Support practices to integrate patient perspectives across the continuum of improvement efforts

Facilitate Use of Data

At the Provincial (Macro) Level
• Provide leadership to ensure EMR vendors provide platforms for ease of access to data that support improvement efforts
• Support efforts to assist practices in optimizing EMR functionality
• Create an inventory of indicators (a suite of measures) that can be selected and used based on a practice’s improvement initiative
• Heighten awareness of existing EMR resources and supports
• Heighten awareness of existing sources of data, such as HQOs Primary Care Practice Reports, Canadian Primary Care Sentinel Surveillance Network (CPCSSN) and ICES
• Create an inventory of EMR/IT projects and pilots and document their methods and tools
• Support EMR communities of practice

At the LHIN (Meso) Level
• Facilitate the sharing of templates and techniques for accessing and using data for improvement
• Support practices in setting meaningful indicators/targets, including population-based, social determinants and quality of life indicators

At the Practice (Micro) Level
• Support and train practices to use data for improvement (e.g., signing up for HQOs Primary Care Practice Reports, generating practice reports from EMR data, run charts)
• Make comparative practice reports readily available and help practices use them to assess the areas most in need of improvement
• Provide practice-level training and support for accessing and using data for improvement (including setting practice goals based on their patient populations)
Appendix C. Frameworks, Tools and Resources Available

Frameworks
There have been practice improvement initiatives in many international and national jurisdictions and there are many examples to draw on. Examples of existing frameworks include the following:

- The Institute for Healthcare Improvement (IHI) Model for Improvement is a framework for improvement work based on testing changes on a small scale using Plan-Do-Study-Act cycles.
- Triple Aim is a framework to support organizations transitioning from a focus solely on health care to optimizing health for individuals and populations, including patient and provider experience, patient outcomes and the cost of care.
- HQO’s Quality Improvement Framework incorporates the IHI Model for Improvement, Lean and Six Sigma methods, and Deming’s System of Profound Knowledge.
- Starfield Principles are AFHTO’s approach to primary care measurement. It focuses on the primary care team’s relationship with patients and their ability the care patients value. Its objectives is to optimize quality, access and total health system cost of care for patients, using indicators from Health Quality Ontario’s Primary Care Performance Measurement Framework.
- The Patient-Centred Medical Home model is a central feature of American health-care reforms. Several of its characteristics and associated processes are associated with practice improvement and quality:
  1. An ongoing relationship with a personal physician
  2. A physician-led team that collectively takes responsibility for ongoing care
  3. Whole-person-orientation care at all stages of life
  4. Coordination/integration across the entire health-care system
  5. An emphasis on quality and safety
  6. Enhanced access to care
  7. A payment system that recognizes the added value provided to patients.
- The CFPC’s 2011 A Vision for Canada: Family Practice – The Patient’s Medical Home included the following 10 goals that contribute to quality at the practice and system level:
  1. Be patient-centred
  2. Ensure each patient has a family physician who is their most responsible provider
  3. Offer a broad scope of services carried out by teams or networks of providers
  4. Ensure timely access and coordination of timely care with other health services
  5. Provide a comprehensive scope of services
  6. Provide continuity of care
  7. Maintain EMRs
  8. Serve as sites for training health professions and research
  9. Carry out evaluations of services through continuous quality improvement
  10. Be supported by defined governance and management structures and external stakeholders.
- The RNAO’s Enhancing Community Care for Ontarians (ECCO) report proposes the expanded reach and role of inter-professional primary care organizations into geographic care networks. The ECCO model proposes that these organizations provide complete care coordination and health system navigation, including referral to home care and support services. Current CCAC case managers and care coordinators would transition to the primary care setting. The ECCO model also calls for an expansion of the LHIN mandate to include all sectors, such as primary care, home care and public health.
The RNAO’s *Primary Solutions to Primary Care Report* provides a prototype role description for RNs and RPNs to optimize scope and enable improved access to timely quality care.

The *Chronic Care Model* is based on making changes to support improved outcomes for the chronically ill by 1) increasing provider expertise and skill, 2) educating and supporting patients, 3) providing team-based and planned care delivery and 4) better using registry-based information systems.

The National Health Service (NHS) in the U.K. produced *Quality and Outcomes Framework*, which sets targets across clinical, organizational and patient experience domains and uses a points system to measure achievement within a range of threshold targets. The NHS also invested in health information technology at the practice level and standardized measurement and reporting systems.

The NHS’s *Leadership Framework* is a set of domains that support building shared leadership and set out the competencies that doctors and other professionals need to improve quality of care.

European jurisdictions have adopted *Practice Management Assessment and Accreditation* to support improvement at the practice level, using the European Practice Assessment instrument, which consists of five domains (infrastructure, people, information, finance, and quality and safety).

**Tools and Resources**

There are several approaches, tools and resources available to support practice improvement, including the following:

- **Plan-Do-Study-Act (PDSA) Cycles**: based on the IHI Model for Improvement, which includes an Improvement Project Roadmap, worksheets and planning forms
- **Knowledge Translation**: communication and exchange sources that inform primary care practices and help them adopt findings to their practices
- **Readiness Assessment**: assesses readiness of practice members (collaboration, communication, decision-making, attitudes about the change) and readiness of the organization (resources, leadership, support for quality initiatives) for change
- **Audit and Feedback**: assessment of practice patterns against peers or the norm and reflection on differences or similarities, ideally provided by a supervisor or senior colleague and delivered both verbally and in writing at least monthly; aims to decrease rather than increase provider behaviours and provides instructions with explicit goals and an action plan
- **Practice Improvement Facilitation**: an individual with change management and primary care practice expertise assisting in adapting clinical practices to optimize patient care delivery through increased adherence to evidence-based guidelines; strategies usually involve chart audits and feedback on practices and processes, goal setting and consensus on strategies for reaching the goals
- **Canadian Foundation for Healthcare Improvement Assessment Tool**: based on six levers for healthcare improvement:
  1. Engaging frontline managers and providers in creating an improvement culture
  2. Focusing on population needs
  3. Creating supportive policies and incentives, including incremental processes
  4. Building capacity/collective learning
  5. Engaging patients and citizens
  6. Promoting evidence-informed decisionmaking
- **Primary Care Practice Report**: practice-level and patient population data, as well as data on patient use of health services, that enables practice comparisons with their peers
- **Data Repositories**: AFHTO’s Data to Decisions (D2D) and BIRT (AOHC) are data repositories that enable AFHTO members or AOHC members respectively, to compare team-level performance to peer teams
- **Improving and Driving Excellence Across Sectors (IDEAS):** a learning program based on the Advanced Training Program for health professionals to support practice improvement projects
- **Quality Book of Tools:** practice management and clinical care indicators in eight categories for improving quality in primary care: patient-centred, equitable, timely and accessible, safe, effective, efficient, integrated and continuous, and appropriate resources
- **Public Reporting:** available, to varying degrees, in some jurisdictions; studies show a link between public reporting and practice improvement