The Excellent Care for All Act's Quality Improvement Plans: Reflections on the First Year

Sudha Kutty, Nizar Ladak, Cyrelle Muskat, Jillian Paul and Margo Orchard

Abstract

In 2010, Ontario passed the Excellent Care for All Act (the EFCA Act). Although the purpose of the Act was clear, the legislation itself was relatively non-prescriptive in relation to the mandatory quality improvement plans (QIPs), and hospitals needed direction on how to proceed. A task group was established to develop a common provincial QIP template, along with guidance, support and educational materials. The template was field tested across the province and, subsequently, all hospitals developed their QIPs, posted them publicly, and submitted them to Health Quality Ontario (HQO).

Despite challenges including short time frames, limitations in data availability and a variance of skills in performance measurement, the implementation of QIPs in hospitals was a success. Success is part could be attributed to a strong tripartite partnership and good communication channels with hospitals. Hospitals with the most effective QIPs were those whose leaders used the opportunity of a provincially mandated QIP as a lever to drive and legitimize the need to have conversations regarding quality from the boardroom down to the front line. As organizations continue to develop and implement their QIPs, we will see this tremendous quality improvement effort sustained. The QIPs will remain a significant transformational lever to engage the system in improving performance and achieving excellent care for all.

Ontario recently passed the Excellent Care for All Act, 2010 (ECFA Act), legislation and associated policy aimed at improving quality and value in the healthcare system (Legislative Assembly of Ontario 2010). One of the cornerstones of this legislation was a requirement for hospitals to develop annual quality improvement plans (QIPs). The first year of implementation of these plans was a success, despite short time frames, limitations in data availability and a variance of skills in performance measurement. The new legislation, combined with a strong tripartite partnership and communication channels to a receptive environment, has allowed hospitals to accelerate Ontario's quality improvement journey and sets the stage for improving the culture of quality across the healthcare system. Through a review of the QIP development process during the first year, this article provides a summary of key success factors, critical achievements and opportunities for improvement in future QIP planning.

Key Success Factors

Several factors led to the success of year one of the QIPs.

1. Legislative Levers: The Excellent Care for All Act, 2010

One key success factor was the legislative force behind the ECFA Act, passed by all parties in June 2010. The act was established with the patient in mind and with the intent that by improving the health of patients and their caregivers, quality and value in Ontario's healthcare system would be improved and sustained. The legislation recognizes the value of transparency in the healthcare system and focuses on embedding quality oversight and improvement at the senior and board levels within healthcare organizations. It also focuses on encouraging a culture of quality to permeate to all levels of the organization. The passage of the act provided the foundation for quality improvement by making quality a responsibility of everyone delivering care in Ontario, and making the executive team and board accountable for quality improvement.

As part of the ECFA Act, hospitals are required to establish a quality committee responsible for overseeing the development

of an annual QIP and to make this plan available to the public. QIPs need to include performance improvement targets, and compensation of senior executives at the organization must be tied to performance on these targets, thereby setting clear expectations and accountabilities for performance on quality indicators. As part of the legislation, board quality committees are also required to review, assess and attest to the completion of the QIPs, thus engaging hospital governance.

Many hospitals in Ontario already had quality plans that were embedded in hospital culture and integrated with internal strategic and/or patient safety plans. The introduction of the QIP under the ECFA Act, however, provided for a common playing field and a standard template to permit province-wide comparison of and reporting on a minimum set of quality indicators. The intention of the QIP template and supporting materials was to complement and augment, rather than replace, existing quality work and planning materials.

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2. A Tripartite Partnership: The QIP Task Group

Although the purpose of the ECFA Act was clear, the legislation was relatively non-prescriptive, and hospitals needed direction on how to proceed. Through the direction of the Minister of Health and Long-Term Care, an implementation working group (IWG; see http://www.health.gov.on.ca/en/ms/ecfa/pro/ecfa_act.aspx for more information about the ECFA Act IWG) was convened to provide that direction. The IWG consisted of members from the Ministry, the Ontario Hospital Association (OHA), Health Quality Ontario (HQO), Local Health Integration Networks (LHINs) and senior hospital leaders. This group developed a phased approach, using a set of basic principles to guide implementation, with the first year focusing on implementation and compliance and getting everyone to the same level, or "floor." The following years would focus on driving standardization and improved performance and raising the "ceiling." The IWG provided hospitals with a single point of contact and communication for all things related to the Act. This included providing guidance on the role and responsibilities of quality committees, recommendations on conducting patient surveys and the development of a patient declaration of values. These tools and supports were provided to hospitals through existing communication methods to help hospitals implement all of components of the act.

While the IWG provided guidance on the components, the QIP required more targeted and detailed attention. A task group was established to provide this additional assistance and guidance. The goal of this the QIP task group was to develop a common provincial QIP template and guidance materials (see http://www.health.gov.on.ca/en/ms/ecfa/pro/updates/qualityimprove/update.aspx for more information) for hospitals to enable QIP submission.[1] This group consisted of representatives from the ministry, the Ontario Hospital Association and Health Quality Ontario, and reported directly to the IWG. The following principles guided the work of the QIP task group in developing a provincial template:

- Support hospitals in being compliant with the legislation and related regulations
- Be easy to interpret, and provide a snapshot view of quality;
- Be generalizable to all hospitals, regardless of size or type
- Create a QIP that is standardized and comparable across the province, with a core set of indicators that are relevant to all hospitals
- Create a QIP that is unique enough to each hospital to allow room for indicators that were especially relevant to a particular region or centre
- Streamline the reporting requirements of hospitals, rather than adding a new layer of reporting to duplicate regional efforts

The QIP template itself was based on the Institute for Healthcare Improvement's Model for Improvement framework (Langley et al. 2009) and required hospitals in a clear and logical way to outline the Aim, Measure and Change for each of their quality initiatives across four dimensions: safe, effective, accessible and patient-centred.[2]

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Keeping all this in mind, the QIP template was field tested across the province to ensure that it could be used consistently by all hospitals, independent of geography, size and type. The educational and support materials were developed through expert consultation, and by all groups involved, ensuring alignment of key messages. The template (an excel file and an accompanying narrative) and accompanying support materials were then shared with hospital CEOs and senior management through existing communication channels (webcast, Internet and e-mail).[3] All hospitals subsequently developed their QIPs, posted them publicly, and submitted them to HQO.

The guidance and support materials provided by the QIP task group were important to build on the momentum created by the passing of the ECFA Act. This group optimized the strengths of each organization in the design and dissemination of the QIP support materials. For example, the OHA used its strong and well-organized educational services department to provide webcasts, conferences and educational workshops to support the pre-testing and communication strategy for the QIPs. The task group benefited from HQO's methodological foundation, gained through its experience in developing products such as the annual quality report for the Province. The ministry, by virtue of its role as funder and policy steward for the health system, could ensure that political support and leadership interests were aligned and thereby ensure alignment on the aims of quality improvement. Indeed, the very nature of the multi-party task group provided the necessary levers to achieve a higher probability of success.

3. Communication Channels to a Receptive Audience

Although the role of the tripartite task group was an important factor in ensuring that all hospitals submitted a QIP in accordance with the legislation, the communication of this information and receptivity of Ontario hospitals to the QIP guidance was perhaps the most important success factor in the first year of the ECFA Act. Hospitals were at varying levels in their quality improvement journey, but all embraced the components of the Act and posted QIPs in accordance with the legislation. This was a tremendous success, given the short time frames provided and lack of consistency in quality improvement capacity across hospitals prior to the act's passage.

> **… hospitals were working** under very tight time frames to develop a QIP, introduce the concept of performance-based compensation and get board sign-off.

QIP Challenges

A number of challenges emerged during QIP implementation, including tight time lines, data quality issues and shortages in hospital capacity for performance improvement. The ECFA Act was passed in June 2010, and hospitals had ten months to put most of the components of the legislation in place. The QIP materials themselves were released at the end of January 2011. As a result, hospitals were working under very tight time frames to develop a QIP, introduce the concept of performance-based compensation and get board sign-off. This challenge was compounded by the intersection between the requirement for performance-based compensation and the public sector salary freeze for non-union employees enacted by the Broader Public Sector Accountability Act, 2010 (see http://health.gov.on.ca/en/legislation/bpsa/).

There were additional challenges with the quality of Ontario health information. These data challenges have been well documented (Health Results Team for Information Management 2006), and the QIP task group continued to struggle with these limitations when selecting core indicators. Timeliness was also an issue, with long lag times between real-time and available data. It is anticipated that as the ECFA Act and the QIP gain momentum, timeliness and data quality will improve.

> **… a Web-based product** with enhanced functionality could significantly reduce data quality concerns …

Hospitals also faced challenges in performance measurement capacity, as shown in the marked variation in the complexity of QIPs submitted. It was clear that a number of hospitals did not have previous expertise in performance measurement and struggled with the requirements of the QIP. For example, some hospitals (from large teaching centres to small rural hospitals) set weak targets (that is, targets that required only minimal improvement), whereas others set ineffectual targets. A number of factors could have contributed to this, ranging from social to economic. For many hospitals, target-setting was a new exercise and a work in progress. This is an area for continued improvement, and HQO's work in establishing benchmarks and targets will support a more consistent approach across the province. Similarly, although some hospitals developed very sophisticated change ideas to address quality challenges in their QIPs (Health Quality Ontario 2011), others struggled with developing these change ideas. The divide in capacity for performance measurement was also clear during educational sessions led by the QIP task group. These challenges indicate that quality improvement and performance measurement capacity of the system requires further strengthening through education, regional decision support networks and mentorship to balance out the disparity of skills across the province. Table 1 provides a summary of the analysis of the QIPs in year one that was developed by HQO (Health Quality Ontario 2011).

In light of the above, the authors suggest that the QIP support strategy for subsequent years be enhanced. For instance, individual feedback to hospitals to create the opportunity for shared understanding through dialogue, though a resource intensive activity, would be well received and help address the issues listed in Table 1.

Another suggestion from the authors is the need for an online

TABLE 1.
Health Quality Ontario's Analysis for Learning

Themes	What went well	What could be better
Priority - setting	• Some hospitals chose a limited set of priorities, averaging 4.5 high-priority topics	• HQO to examine literature on relationship of goal achievement and number of priorities selected
Target - setting	• Aim for the theoretical best • Aim for the 90th percentile among peers • Aim to cut defect or waste in half in current cycle • Aim to match rate of improvement met by others	• Stretch targets were not the norm • Sometimes targets were below current performance • Sometimes targets represented insignificant or minimal improvement • Some QIPs did not include targets or baseline measures
Change ideas	• Measure and provide feedback to providers • Redesign or standardize processes • Provide clinical decision supports and reminders • Develop and verify staff skills • Ensure infrastructure, capacity properly configured • Engage patients • Create appropriate accountability mechanisms	• Unspecified or limited number of change ideas • Root cause analysis instead of change strategy • No process indicator or target for change ideas

HQO = Health Quality Ontario; QIP = quality improvement plan.

tool with automated validation rules, pre-populated data fields and reminders. While an electronic Excel and Word template was used, a Web-based product with enhanced functionality could significantly reduce data quality concerns found in the first year's submission and also include helpful reminders that reinforce tactics to address issues found.

In spite of these challenges, many hospitals were able to develop strong, robust QIPs. Hospitals with the most effective QIPs were those whose leaders used the opportunity of a provincially mandated QIP as a lever to drive and legitimize the need to have conversations regarding quality from the boardroom down to the front line. These leaders embedded their QIP into their broader strategic plan and saw one as a subset of the other. Additional detail regarding the analysis of year one QIPs is documented in HQO's report 2011 Quality Improvement Plans: An Analysis for Learning (Health Quality Ontario 2011).

Reflections and Next Steps

In an informal survey of hospitals conducted by the Ministry of Health and Long-Term Care in the spring of 2011, nearly one quarter of respondents felt that the QIP focused their organization's quality goals and encouraged the board to talk about quality and quality improvement. Furthermore, 60% of respondents reported that the QIP had a moderate or significant impact on their quality improvement activities. These are great wins in the spirit of moving the quality improvement bar within the province. In addition, the QIP task group received the Ontario Public Service's ACE Award for Partner Relations from the Ministry of Health and Long-Term Care in recognition of the vision of the collective. This award was a reflection of the success of the combination of strong legislation, the tripartite partnership and effective communication to a receptive audience during the implementation of the QIP.

As we move into the third year of the QIP, the QIP task group continues with the quality journey, and, as with all quality initiatives, lessons learned will be applied to improvements each year. Table 1 presented some of the areas where we hope to see improvements in future years including the need for more aggressive targets and more sophisticated change ideas. Over and above these, we hope to see greater alignment with existing quality improvement processes and better communication of the QIP to the public.

QIP year one represented a starting point, a stake in the ground. As the QIP journey continues, there will be further refinements. The current focus is implementing the ECFA Act in hospitals, which have a long history of quality improvement, patient safety and governance. As the act matures, the development of QIPs should become more explicitly owned and driven by the organization's board of directors.

Specific examples could include routine reporting on the progress achieved on the QIP at board meetings and dashboards

to profile the progress made and progress to be achieved on the QIP. LHINs should be engaged in open conversations that highlight challenges being experienced and how they can support the achievement of quality aims.

Achieving high-quality care is a journey. As the ECFA Act expands to be a requirement of other sectors such as home care, long-term care and primary care, the focus on quality across all levels of the organization will be strengthened. It is expected that this will be accompanied by supports in benchmarking, regional data and more integrated care across the healthcare continuum, allowing for accountability for patient care to be shared across institutional walls. Our ultimate vision: the entire system focused on improving healthcare quality, resulting in excellent care for all.

Conclusion

The drive toward quality improvement is reflective across Ontario's healthcare organizations, and the QIP is one critical vehicle by which organizations are demonstrating their commitment to improving quality. The ECFA Act provides organizations with the opportunity to demonstrate their ongoing commitment to quality improvement efforts. The partnership between Health Quality Ontario, the Ontario Hospital Association and the Ministry of Health and Long-Term Care provided the necessary leadership and guidance to initiate implementation of the act. Strong communication channels to a receptive and captive audience were equally important, and, as organizations continue to develop and implement their QIPs, we will see this tremendous quality improvement effort sustained.

As Ontario healthcare organizations elevate these quality improvement efforts, the QIPs will remain a significant transformational lever to engage the system in improving performance and achieving excellent care for all. By leveraging the momentum of the QIPs across the hospital sector, we can continue to build on this strong foundation of quality improvement and engagement of all sectors in the province's quality improvement agenda. HQ

About the Authors

Sudha Kutty, BSc (Hons), LLB and MBA, is director, patient safety, physician and professional issues at the Ontario Hospital Association

Nizar Ladak, BA, MEd, is executive vice president & chief operating officer at Health Quality Ontario

Cyrelle Muskat, BA, MHA, is a consultant, patient safety, at the Ontario Hospital Association

Jillian Paul, BA (Hons), MA, is manager of the Health Quality Branch at the Ministry of Health and Long-Term Care

Margo Orchard, BSc (Hons), MSc, is a senior policy consultant in the Health Quality Branch at the Ministry of Health and Long-Term Care.

Notes

[1] The legislation requires the QIPs to be submitted to HQO in a format that permits province-wide comparison. This was interpreted as requiring a standard provincial template for all to use.

[2] HQO's nine attributes of a high-performing health system were condensed into the four dimensions of the QIP.

[3] See http://www.health.gov.on.ca/en/ms/ecfa/pro/updates/qualityimprove/update.aspx for the most recent version of the QIP template.

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