Quality Improvement in Primary Health Care in Ontario: An Environmental Scan and Capacity Map

Final Report to the
Quality Improvement in Primary Healthcare Project Planning Group

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SUMMARY

This environmental scan and capacity map project was commissioned by a Planning Group of stakeholders to determine the nature and extent of quality improvement in primary health care (QI-PHC[1]) activity in Ontario and to map the related human resource capacity for QI-related work in this sector. Individual interviews of 20 strategically identified PHC stakeholders were undertaken during February and March 2010. A review of documents and other related online resources also supported collection and analysis of the scan data.

The results of this exercise provide background details regarding 43 identified QI-PHC activities in Ontario. Key aspects for each activity were identified, including funding, human resources/expertise, tools associated with the activity, and the available evidence regarding the activity impact.

This report provides a high level analysis of these activities situated within national and provincial health systems strengthening through PHC renewal contexts. The scan identified a consistent theme concerning QI-PHC capacity building activities: several key organizations and their partners focused on long-term QI capacity building in their programming while other organizations and individuals primarily focused on time-limited QI-PHC work, such as research, pilots and demonstration projects.

We take this project one step further and offer informed recommendations regarding future directions for QI-PHC in Ontario based on a recurring theme (or shared vision) that was underlying most activities examined within the scan:

that an integrated provincial framework and plan for quality improvement in the PHC sector must be developed and implemented in Ontario.

[1] Many acronyms are used in this report; some are common knowledge within the PHC sector in Ontario and are not spelled out within the body of this report. See appendix A for a full listing.

II BACKGROUND

This environmental scan and capacity map project was commissioned by a collaboration between the Primary Health Care System (PHCS) Program and the Quality Improvement and Innovation Partnership (QIIP) in January 2010. This work was part of a three-pronged initiative designed to support the development of a coherent, coordinated and efficient strategy for weaving continuous quality improvement into the fabric of PHC in Ontario. This sits within the context of an overall effort to enhance quality across the health care system. The three prongs of the initiative were:

1. **An environmental scan and capacity map of quality-related projects, programs, activities and expertise in Ontario that target PHC, including those that are cross-sectoral in scope;**
2. **An overview of evidence from Canada and other jurisdictions, regarding the effectiveness of quality improvement interventions in PHC; and**
3. **A facilitated workshop that brings together senior representatives of key PHC stakeholder groups and Ontario leaders in PHC quality assessment and improvement.**

This initiative was **guided** by a planning group consisting of stakeholder representatives and leaders in the delivery and evaluation of PHC quality improvement in Ontario. Many of the planning group members were direct contributors to this report as key informants during the interview process.

The **purpose** of the environmental scan is to identify recent, current and planned PHC *quality-related activities* in Ontario. This scan was to elucidate the following aspects of the quality-related activities:

- funding,
- human resources/expertise,
- tools associated with those activities, and
- available evidence regarding activity impact.

In its simplest form, Quality Improvement (QI) is a formal approach to the analysis of performance and systematic efforts to improve it (Duke University Medical Center, 2005). There are numerous models of QI used in an ongoing effort to make performance better. The definition of quality and quality-related work often varies depending on the stakeholders involved. For the purposes of this report, a broad **definition** of quality-related work provided in the original call for proposals was adopted. The various aspects of the definition included:

- education in quality methods,
- quality improvement research and program evaluation,
- performance measurement,
- quality assessment,
- quality assurance and accreditation,
- quality improvement practice facilitation,
- learning collaboratives, and
- learning communities.

III PHC and QUALITY IMPROVEMENT CONTEXT IN ONTARIO

Primary Health Care (PHC) is the first point of contact between a patient and the health care system. Primary care in Ontario, as an essential component of PHC, strives to provide for comprehensive PHC to respond to the needs of the whole person, and ensure continuity of care, acute and chronic disease management, as well as health promotion and disease prevention (Province of Ontario, 2010a). PHC is delivered in many settings such as the workplace, home, schools, health care institutions, the family physician's office, homes for the aged, nursing homes, day-care centers, and community clinics. PHC is also available by telephone, educational health information services, and the internet (Klaiman, 2004).

PHC Context

There has been much discussion regarding PHC renewal and primary care reform in Canada (Calnan & Lemire Rodger, 2002; EICP, 2006; Hutchison, 2008; Kirby, 2002;

Lavis & Shearer, 2010; McPherson & McGibbon, in press; Ontario Medical Association, 1998; Romanow, 2002). However, there is no current publically available guiding PHC framework for Canada or provincial PHC framework for Ontario.

Ontario has become a national leader in PHC renewal and health system reform with the introduction and growth of Family Health Networks (FHNs), Family Health Groups (FHGs), Family Health Teams (FHTs) and Family Health Organizations (FHOs, a consolidation of two earlier models, Health Service Organizations and Primary Care Networks), the expansion of the nurse practitioner role, and the strengthened role of Community Health Centres (CHCs). The provincial government has invested heavily in response to a serious physician shortage (Ministry of Health and Long-Term Care, 2010). Primary care practices, as a major component of PHC, are organized under different models of care in Ontario, most of which emerged following a series of provincial initiatives over the past four decades that aimed to build a more accessible, patient-oriented system and to eliminate the barriers inherent in traditional fee-for-service models (Muldoon, Rowan, Geneau, Hogg, & Coulson, 2006; Ontario Medical Association, 2007; Province of Ontario, 2010a, 2010b).

Early primary care reform in Ontario in the 1970s introduced Community Health Centres (CHCs) and Health Service Organizations (HSOs). FHNs, FHGs, FHTs and FHOs were established in the early and mid-2000s. As of January 2010, 34% of the Ontario population was enrolled with a FHN or FHO (capitation-based models) and 32% was enrolled in a FHG (fee-for-service-based model). CHCs serve 3% of the population (Glazier, Klein-Geltink, Kopp, & Sibley, 2009) while FHTs (an interdisciplinary model, most of whose physicians are remunerated through a FHN or FHO payment model) serve 16%. There are several notable differences among these models, including physician payment schemes, composition and degree of multidisciplinarity within the team, and priorities, such as populations served and according to which principles. (See appendix B for models associated with the QI-PHC activities identified within this scan).

The range of primary care models within PHC services in Ontario is important to consider in interpreting the results of this environmental scan. The various model

contexts, such as the funding mechanisms, human resources and other capacity to do the work, and QI accountability expectations, have an impact on the nature of the QI-related activities.

Quality Improvement in PHC Context

In Ontario there has been an increasing focus on quality improvement in health care over the past decade, and in primary health care in particular over the past 5 years. This has dated back to key influential events, such as the publication of a high impact US Institute of Medicine report on quality in health care (Institute of Medicine, 1999), the federal Primary Health Care Transition Fund (Health Canada, 2007), the introduction of Family Health Teams in 2004 (Province of Ontario, 2004), and the piloting and subsequent designation and funding of the Quality Improvement and Innovation Partnership by the provincial MOHLTC (QIIP, 2010), to name several. There has been a push from the Ontario provincial government, the Ontario Health Quality Council (OHQC, 2010), and professional colleges and associations to make quality improvement a standard cultural element of primary health care practice, rather than a solo activity driven by individual interests. The related governmental roles and contributions have likewise started to align with this QI cultural trend. For example, the MOHLTC initiated accountability agreements, which set out the mutual understandings between the MOHLTC and LHINs regarding their respective performance obligations. These developments, among others, have created opportunities for increased attention and thus funding to be paid to QI-PHC federally, provincially, and locally within health regions.

Leadership has been provided by key organizations and individuals in helping to develop an informal QI-PHC community of interest—or loosely connected network at this point—across the province. This increasing collective interest seems to have had a positive impact on the beginning level of integration of the activities. Within this context, PHC practitioners, managers and researchers have been sharing learnings across institutions and, to some extent, practice sectors, and many are beginning to work collaboratively on QI-PHC planning and projects.

The PHC system in Ontario is complex and it is not necessarily interconnected. There are many opportunities for improvement in client outcomes through enhanced QI processes, for sustainability of the QI changes, and for sharing QI-PHC knowledge across this diverse sector. However, issues related to readiness for continued change, PHC quality cultural shifts, and availability of related sustainable and appropriately targeted funding co-exist within the complexity of health system strengthening through PHC renewal.

IV ABOUT THIS REPORT

The process informing this report was multi-dimensional. We worked with several partners in developing the workplan to determine the nature and extent of QI-PHC activity in Ontario and to map the related human resource capacity for QI-related work in this sector. We met with QIIP and PHCS leaders to discuss the issues and to seek their informed advice on project development and implementation.

A case study approach (Yin, 2003) was used to guide planning logic and frame the environmental scan activities, which provided geographical, time, stakeholder, and issue parameters. The case was the 43 QI-PHC activities identified by stakeholders. A convenience and snowballed sample of 20 key stakeholders was identified. Individual telephone interviews were held with these 20 people (see appendix C for approved listing of Interview Participants and Appendix D for Interview Schedule). An online review of relevant websites and documents arising from the interviews was then undertaken. Scan data analysis used rapid Framework Analysis (Spencer, Ritchie & O'Connor, 2003) augmented by Prior's approach to document analysis (Prior, 2003). Analysis took place between and among individual activities and the activity pool as a whole. This was an iterative process that allowed us to identify key themes related to the activities arising from the interview and associated documentary data. Preliminary results were presented to the Planning Group for verification and final adjustments to the report were then made. Final interpretation drew in known relevant PHC context and background documents.

There are clearly additional QI-PHC activities taking place in Ontario that were not identified through this environmental scan. The **scope** of this report is necessarily limited by a number of factors. The key factors include: the time and resources available to develop and implement data collection processes, the nature of the consultation list (i.e., recommended lists of interviewees from the Planning Group and PHCS program and availability of these potential participants), and the recommendation that we rely on the consultation experts as the main source of data, augmented by other related sources arising from the interviews (e.g., recommended QI-PHC initiative websites). After consultation with the project leaders, it was determined that the scan should focus primarily on activities that were either recently completed (i.e., within past year), activities that are currently underway, and activities that will be starting within the next year.

The remaining sections of this report represent a synthesis of our findings from these multiple sources. Section V presents the identified QI-PHC **activities** and Section VI presents the QI-PHC related **capacity map** for Ontario. Section VII presents **key issues** arising from this scan and concluding remarks.

V THE QI-PHC ACTIVITIES

Within the outlined scope of this project, a series of recent, current, and planned QI-PHC activities were identified by the environmental scan. The activities fell into three broad categories:

(1) Research-intensive activities primarily associated with the six Ontario family medicine programs within academic health science centres (academic FHTs) and/or health research institutes often connected with extensive programs of research (e.g., PHCS EBRI), including:

- McMaster University
- Northern Ontario School of Medicine (NOSM)
- Queen's University
- University of Ottawa

- University of Toronto
- University of Western Ontario

(2) QI capacity development activities associated with several key organizations including (listed alphabetically):

- Association of Ontario Health Centres and its member organizations:
    - Aboriginal Health Access Centres (AHACs)
    - Community Family Health Teams (CFHTs)
    - Community Health Centres (CHCs),
- Cancer Care Ontario
- College of Physicians and Surgeons of Ontario
- Quality Improvement and Innovation Partnership

(3) A variety of other QI-PHC activities taking place within local and provincial contexts arising from a broad spectrum of the PHC sector (e.g., CCO, FHTs, OCFP, OHQC, RNAO).

Two Thematic Clusters

For the purposes of this report, we align the discussion around two thematic clusters:

I **Programs for Long Term QI-PHC Capacity Building**: QI-PHC activities in the form of ongoing programs that deliberately build in long-term QI capacity building with a province-wide reach, and

II **Time-Limited QI-PHC Activities**: Activities that are time-limited (research, pilot, or demonstration projects) whose primary aim is research production, including short term pilots and programs of research.

Although the first cluster has commonalities as outlined, it should be acknowledged that this is also a heterogeneous grouping in terms of governance structures, age of organizations, and history of doing QI-PHC work, among other factors. The second time-limited cluster contains a variety of different QI-PHC activities that do not fall under long term province-wide programs. This too is a heterogeneous grouping comprised of

full-scale programs of research, pilot projects, and demonstration projects and committees that is distinguished from the first cluster by its more local or regional reach. Taken collectively, all 43 activities contribute to the overall strength of QI-PHC activities in Ontario.

Appendices E and F provide an overview of the 43 identified QI-PHC activities. Table 3 (appendix E) reviews identified activities associated with Cluster I: Programs for Long Term QI-PHC Capacity Building. Table 4 (appendix F) reviews the identified Time-Limited QI-PHC Activities. Tables 3 and 4 provide the available details related to each activity, including:

- project title,
- brief description of project,
- timeframe for activity,
- activity leads,
- funder(s),
- tools associated with the activity,
- knowledge translation activities, and
- contact information.

FINDINGS

This environmental scan identified many passionate efforts designed to strategically build QI-PHC capacity, to identify promising QI-PHC practices and outcomes, to spread the QI-informed PHC practice changes, and to make QI a core organizational strategy in health care delivery. The six academic centres are involved to some extent in QI-PHC research that is demonstrating positive changes over time. This exercise also identified many local (primarily through the CHC sector) and provincial (through CCO, CPSO, and QIIP) initiatives that are steadily contributing to QI-PHC capacity building and local and provincial QI-PHC knowledge development and mobilization.

The activities of most PHC practitioners, managers and researchers as well as other PHC stakeholder organizations (e.g., MOHLTC, RNAO, OCFP, OMA, OHQC, to name

several) involved in this scan remarkably demonstrated a shared vision about QI-PHC for Ontario. However, this vision was not necessarily collaboratively developed and the activities were not necessarily strategically linked.

I Programs for Long Term QI-PHC Capacity Building

The scan revealed a notable theme related to time, geographical reach, and programming commitments regarding QI-PHC capacity building. *Capacity building* is taken here to mean deliberate efforts to build QI-PHC skills through programming.

Cluster A included several organizations that have similar characteristics. For example, the organizations identified that fit into this cluster—AOHC, CCO, CPSO, and QIIP—all have a province-wide geographical focus and strategic organizational commitments to QI-PHC capacity building. This is operationalized through programming and policy with accompanying accountability frameworks. For example, CHCs are funded by LHINs, and LHINs have accountability frameworks where QI is one of the deliverables.

The province-wide mandate of the organizations within this cluster offers a wide and inclusive “reach” and, in some cases, geographically disperses staff to support the QI-PHC effort. With the exception of QIIP, these organizations have been established for some time, and in the case of AOHC, many of its member CHCs have been in operation for more than 40 years. With the exception of CPSO, which is largely member supported, and to a lesser extent AOHC, these organizations are primarily funded by the provincial government. Some of these organizations have also been working collaboratively (e.g., some CHCs participated in QIIP training). This may demonstrate that there is readiness to work across capacity building organizations to support QI-PHC goals.

II Time-Limited QI-PHC Activities

The lion’s share of the MOHLTC and national research grant funding for the QI-PHC and related activities reviewed is situated primarily within the academic health centres. The major strengths of this cluster are the longstanding leadership and world-renowned

PHC researchers within its practitioner-faculty; the university infrastructure that is accustomed to project- and pilot-based funding; and the large, diverse and geographically dispersed population that activities within this cluster targets. The informal role of these activities is to fundamentally move the QI-PHC agenda through implementation and KT associated with pilot projects that may or may not evolve into sustainable QI programs. Further, the QI-PHC related programs that do exist (e.g., IDOCC) do not necessarily co-exist within a coordinated QI-PHC plan for the province.

This cluster of activities is diverse; it is made up of a combination of PHC service models, governance models, and differing commitments to and interests in QI-PHC. The environmental scan analysis revealed that, in comparison to the programs for long terms capacity building, this cluster of activities has some established (and some newly developing) research capacity and has attracted funding because of this capacity. However, these activities lack an integrative strategic plan, governance home, and accountability framework that would likely advance a focused and strategic provincial QI-PHC agenda. Further, given the enormity of the ground that these activities try to cover within the province, it is remarkable that the majority of these QI-PHC activities rely on a relatively small pool of research leaders and on primarily unpredictable and one-off pilot and project-based funding. Further, it should be noted that the primary care branch at the MOHLTC does not support research and evaluation through its current funding pool. All of this work is done either in-kind or through application to other grants.

Although there is remarkable common ground across the two clusters of activities (i.e., long term programs vs. time-limited activities), the relative planning disconnect between both in terms of an overall province-wide strategy has obvious implications and limitations. Based on the activity data and the scope of this environmental scan, it is fair to conclude that

> **the current QI-PHC environment in Ontario is essentially uncoordinated, underfunded, and without a cohesive vision for a provincial QI-PHC plan.**

This situation is *incongruent* with other current provincial, national and global environments that have prioritized PHC renewal, and its associated QI-PHC component, within a health system strengthening agenda.

VI QI-PHC CAPACITY MAP

The capacity[2] map answers the question: What is the pool of resources working on QI-PHC in Ontario? The intent of this section is to capture the expertise, personnel, and related funding that are currently being deployed in QI-PHC related work. The data informing the capacity map were collected within the scope of the environmental scan process and represents the human resource component associated with the identified QI-PHC activities in Appendices E and F. Table 5 (appendix G) presents the current QI-PHC capacity in Ontario identified within the scope of this scan. Roles, rather than names, and associated organizational and geographical locations as well as budgetary considerations are provided. Significantly, much of the human resource data associated with the reviewed activities were unavailable or were reported as an estimate.

Findings

The review of the 43 environmental scan activities and related documents resulted in the identification of some general capacity patterns for QI-PHC. Analysis revealed that the QI-PHC expertise for activities under Cluster I (Long Term Programs for QI-PHC Capacity Building) resides primarily within specific roles in each organization, including a small number of head office staff and regional or outreach staff. For example, for AOHC, this includes the limited Education and Capacity Building Team and the four Regional Decision Support Specialist positions. The expertise includes, but is not limited to, advanced program measurement, data management within community-based health services, and QI knowledge capacity building for community-governed PHC services. The CHC sector has developed internal knowledge capacity with consistent messages and content to meet their current QI-PHC strategic priorities. In terms of human

[2] The term *capacity map* was predetermined within the terms of this project, so was not changed. This is not to confuse the reader with the *capacity building* language used in describing the Cluster I activities.

resources, this workload continues to be absorbed within current staffing levels. One implication of this current environment for an organization such as AOHC is a question of how much of a threshold remains to add more Q I-PHC activity to existing staff workloads. The situation is similar for CCO, CPSO, and QIIP in terms of QI-PHC capacity building staff : PHC workforce ratios. Thus, overall, the pool of existing human resources working province-wide through ongoing, long term QI-PHC programs is very small relative to the populations and the PHC workforce served by this cluster of activities.

The capacity for QI-PHC work arising from the second cluster (i.e., Time Limited Activities) is aligned with the previously discussed QI-PHC activity trends that were primarily research project-based. There are world-class QI-PHC researchers essentially located within the six academic health centres in the province. Many of the nationally known leaders in the PHC field come from these geographical areas. They have their own established collaborative networks of investigators, research assistants, and other research personnel to support the work. Researchers in these centres are either located within or well connected to leading PHC research centres (e.g., EBRI, PHCS). This very small pool of PHC researchers is also consistent with trends identified by the North American Primary Care Research Group (NAPCRG, 2010), where increasing the number of active PHC researchers is a critical priority for the field.

The implications of the current QI-PHC capacity layout in Ontario is that the capacity appears to be gathered around academic settings for research expertise and research infrastructure, and the QI-PHC capacity has a province-wide spread—sometimes through regions or through individual organizational members—for capacity building among front-line professionals. Further, we note that many of the research projects now being carried out by university-based researchers do include QI capacity building components.

VII KEY ISSUES & CONCLUSIONS

Although the findings are organized around two different activity clusters, it is essential to emphasize that there is also common ground and commitment between the two clusters such that coordination, cooperation and integration across the entire PHC sector may be achievable. It is important to continue with long term capacity building programming province-wide that is informed by research and local pilot successes, and it is also crucial that research, pilots, and other time-limited initiatives continue to build the evidence- base to appropriately inform the programming interventions.

Ten **key issues** were identified within the scope of this environmental scan that may be interpreted as supports and barriers in advancing QI-PHC. Where appropriate, recommendations for addressing the key issue are offered. The literature is also used to support discussion within this section.

1. Health system strengthening through PHC renewal is a complex issue. Thus, QI-PHC, as a critical aspect of PHC renewal, is also embedded in these complex health system strengthening and PHC renewal environments. There are many unknowns in terms of how to best advance PHC renewal in Canada (Hutchison, 2008; McPherson & Shamian, 2010) and in Ontario, in particular. There are also many unknowns in terms of how to shift the QI culture within PHC service organizations at all levels while also shifting the way that practitioners, managers and funders have traditionally worked (Glazier, Klein-Geltink, Kopp & Sibley, 2009; McPherson & McGibbon, in press; Russell, Dahrouge, Hogg, Geneau, Muldoon, & Tuna, 2009). Thus, efforts to advance QI-PHC should carefully consider that QI is but one aspect of the health system and culture that is being shifted as many other features are concurrently being changed. This creates an opportunity to synergize reform efforts to advance QI-PHC. An integrated and coordinated provincial strategic plan that includes all PHC sectors could help this effort.
2. Many PHC clinicians and administrative support staff are dedicated to QI-PHC issues as a part of their everyday work. The interview participants described many impassioned efforts to shift the QI-PHC cultures within their organizations

and within provincial stakeholder organizations. This suggests that many stakeholders at the frontline now view QI as a crucial issue, even within their current complex and ever-changing health system environments. Many are fundamentally dedicated to the best possible individual and population health outcomes for Ontarians and their activities suggest that they see QI-PHC as pivotal in the care process. This commitment and readiness are critical supportive factors in advancing the QI-PHC agenda.

3. There is an immense amount of QI-PHC work that has taken place provincially within FHTs. Almost every academic department of family medicine has established a formalized, or at least loosely organized, QI group that has been engaged in some sort of project or QIIP-related activity. This demonstrates commitment to advancing QI-PHC, even in the absence of an integrative provincial framework. This commitment is crucial for health care improvements (Reinertsen, Bisognano, & Pugh, 2008). For example, the McMaster FHT has engaged all staff from reception to practitioners to complete 66 projects in the last 18 months. The projects have run from the logistics of how the clinic runs efficiently to safety in practice. These projects have been funded by several agencies, including the MOHLTC as a key funder. A next step may be to synthesize these small projects so that others could benefit from the learnings, especially since they might not be published or there may be a lag time in knowledge mobilization. A call for proposals through QIIP or PHCS that targets this local synthesis and then presents it to all PHC stakeholders in the province may be a next step in mobilizing this local knowledge across PHC practice settings.
4. The CHC sector appears to have been developing QI-PHC expertise and processes somewhat separately from the academic FHTs and other PHC stakeholders. Much of the work is done ‘in house’ in a collaborative style and without substantial external funding supports. There are likely substantial QI-PHC learnings that would be relevant and could easily be transferred from the CHC sector to the FHT and other PHC sector and vice versa. Establishing a mechanism (or reconfiguring an existing organization), such as a QI-PHC

network or similar community of practice/learning community for Ontario may support this knowledge mobilization and thus capacity building. These efforts should be connected to an overall QI-PHC strategic plan and governing body to lead the vision.

5. There are grass-roots issues that would need to be considered in system-wide QI-PHC reform. Many of the activities reviewed within this scan were very individual and physician-centred. Further, the process of quality improvement in primary care in Ontario, and across Canada, has historically been limited to professional development in hospitals. However, the CHC sector seems to have a system-based and patient-centred view of QI-PHC. Although individual values and behaviour change are integral to a QI cultural shift, it narrows the scope of the reform effort (McPherson & Shamian, 2010). This may also point to a philosophical difference between the CHC sector and the predominantly FHT sector within PHC service delivery. This potential philosophical difference would have implications for knowledge sharing and collaborative strategy development among the PHC stakeholders (Bosch, van der Weijden, Grol, 2007; Reinertsen et al., 2008).
6. There was an incredible lack of clarity regarding QI-PHC human resource capacity for the time-limited cluster of activities identified within this scan (i.e., who is doing what, which portion of an FTE is being used, how much does it cost, etc.). This situation points to the further need for some sort of integrative body that could accurately determine the QI-PHC capacity baseline and track it for system capacity growth and Qi intervention outcomes.
7. QI-PHC in Ontario may learn from how AOHC, CCO and QIIP are advancing the effort. However, family practice QI-PHC efforts are seriously challenged within the practice setting due to a lack of formal governance system. AFHTO is a newly developing organization that currently has minimal infrastructure and is governed by a group of volunteers who are currently employed full-time in the PHC sector. However, the fact remains that there is no integrative Primary Health Care Ontario counterpart to AOHC and the newly developing AFHTO to coordinate and to strategically lead a collaborative vision of patient-centred QI-

PHC across all PHC sectors. This is clearly a barrier to advancing the QI-PHC agenda (Bosch et al., 2007).

8. There are many internal and external knowledge mobilization mechanisms underway that use various strategies (e.g., newsletters, websites, academic posters, papers). Some of these knowledge mobilization mechanisms are tied to individual research dissemination efforts and others to system-embedded QI programming and expertise development. The lack of website maintenance (updating) related to many identified QI-PHC activities is a barrier if the knowledge is to be shared across stakeholders in a timely manner. A provincial strategy for advancing QI-PHC should tap into these existing knowledge mobilization mechanisms.
9. There is tremendous breadth in primary care as a component of PHC (Kringos, Boerma, Hutchinson, van der Zee, & Groenewegen, 2010). There are many models of PHC in Ontario each with different strengths and weaknesses (Dahrouge, Hogg, Russell et al., 2009; Dahrouge, Hogg, Tuna et al., 2010). This diversity needs to be carefully factored into any provincial planning, especially where governance; professional, geographical and organizational jurisdictions; and differing mandates are considered within a provincial PHC plan.
10. Although there has been recent growth in QI-PHC investment by the MOHLTC as of late, the scan findings suggest that there is not a Ministry lead coherent QI-PHC policy directive and related plan for the province. Although pilot projects have their place in determining best practices, a string of pilots suggests that the issue of QI-PHC within PHC renewal is not a strategic priority. The nonintegrated collection of pilots does not constitute a coherent, sustained and strategic program. This presents a significant barrier to QI-PHC that must be addressed if the PHC renewal agenda is to be advanced (McPherson & Shamian, 2010; Reinertsen et al., 2008).

Final Conclusions

This QI-PHC scan is one piece of the puzzle that can help to provide insight into the complexity of PHC renewal within Ontario's multidimensional health care system. The scan contributes by identifying a spectrum of recent innovative QI-PHC activities and their related capacities. The scan logged many local pilot projects and research activities to support QI-PHC initiatives that are not strategically informing subsequent and broader scale initiatives. Accelerating the desired aspects of QI-PHC will likely require increased engagement and leadership from government, professional organizations, and other QI-PHC stakeholders, particularly front-line practitioners and staff.

> **Within the scope of this exercise, the scan affirmed that there is no province-wide, integrated, and measured QI program for the entire PHC sector in Ontario. The MOHLTC needs to bring some coherence to the work by developing a coordinated plan, an accompanying accountability framework, and an appropriate sustainable funding envelope for QI-PHC.**

Moving towards equitable and accessible health care, fundamental tenets of PHC renewal, will require increased attention to patient-centred QI that flows from consistent leadership and commitment to the issue at all levels and in all PHC locations within the health care system. Health system strengthening though PHC renewal will require a QI-PHC governance system that operates from an integrative accountability framework and towards a common vision. Several key elements required to continue to shift and build a QI-PHC culture and its related capacity appear to exist within the Ontario. The supportive elements need to be scaled up for full system implementation and QI-PHC practice integration. The potential exists within the 43 identified activities (and likely many that were unidentified) to launch a coherent and collaborative province-wide program of QI-PHC. The challenge is for provincial governmental leadership, in partnership with PHC system leaders, to seize the opportunity to use this potential and effectively advance QI-PHC within the health system strengthening and PHC renewal agenda.

APPENDIX A

List of Acronyms

AHAC	Aboriginal Health Access Centre
AFHTO	Association of Family Health Teams of Ontario
AOHC	Association of Ontario Health Centres
BHO	Building Healthier Organizations, Accreditation Program of COHI
CACHA	Canadian Alliance of Community Health Centre Associations
CCAC	Community Care Access Centre
CCO	Cancer Care Ontario
CFHT	Community Family Health Team
CHC	Community Health Centre
CHQI	Centre for Health Quality Improvement
CIHI	Canadian Institute of Health Information
COHI	Community Organizational Health Inc.
CPSO	College of Physicians and Surgeons of Ontario
EBRI	Elisabeth Bruyère Research Institute
ECR	Electronic clinical record
EMR	Electronic medical record
EQPHC	Enhancing quality in primary health care, MOHLTC program
FFS	Fee for service
FHG	Family health group
FHT	Family health team
FHN	Family health network
FTE	Full time equivalent
HSO	Health service organization
ICES	Institute for Clinical Evaluative Sciences
IHI	Institute for Healthcare Improvement (Boston, MA)
IHSP	Integrated Health Service Plan
LHIN	Local health system integration network
NAPCRG	North American Primary Care Research Group
OCFP	Ontario College of Family Physicians
OHQC	Ontario Health Quality Council
OICR	Ontario Institute of Cancer Research
OMA	Ontario Medical Association
PCCC	Primary and Community Care Committee, Ontario Medical Association
PHC	Primary health care
PHCS	Primary Health Care System Program
PMC	Performance Management Committee of AOHC
QI	Quality improvement
QIIP	Quality Improvement and Innovation Partnership
RNAO	Registered Nurses' Association of Ontario
NPAO	Nurse Practitioners' Association of Ontario
SELHIN	South East Local Health Integration Network

APPENDIX B
Table 1: PHC Models Covered in Scan[1]

Type	Priorities	Comments
Aboriginal Health Access Centres (AHAC)	Similar to CHCs while offering a blend of traditional Aboriginal approaches to health and wellness and contemporary PHC in a culturally appropriate setting.	10 AHACs under AOHC Salaried Model [2]
Community Family Health Teams (C-FHT)	Some of the 150 FHTs funded under May 2004 provincial plan to expand access to PHC were funded as C-FHTs, borrowing several of strong features from the CHC model	20 CFHTs under AOHC Salaried Model [2]
Community Health Centres (CHC)	Designed to meet the needs of a defined community and to provide accessible PHC services to underserved populations within their catchment area; multidisciplinary, prevention & health promotion programs, social determinants of health focus, community governed	74 CHCs under AOHC (54+ new ones started up in last year or so); Currently one nurse practitioner led team in Sudbury (approx 20 in Ontario now, 19 from other sectors); Salaried Model [2]
Family Health Groups (FHG)	Offer comprehensive PHC services to their enrolled patients; Regular office hours plus extra After Hours blocks of office time and on call to a ministry funded Telephone Health Advisory Service (THAS); Accessibility focus	121 in Ontario as of Oct 2009[3] Fee-for-service Model [2]
Family Health Network (FHN)	Accessibility, comprehensiveness, doctor-nurse collaboration, use of technology	33 in Ontario as of Oct 2009[3] Blended Capitation Model [2]
Family Health Teams (FHT)	Expected to improve access to PHC for more than 2.5 million Ontarians in 112 communities; Focus on reducing wait times and emergency dept visits	Since April 2005, 150 FHTs have been created in both urban and rural parts of ON; 50 more being planned to bring total to 200 [4] Blended Salary Models [2]
Family Health Organizations (FHO)	Represents the alignment of Primary Care Networks and Health Service Organizations into one model. FHOs are groups of physicians who provide comprehensive primary health care services to their patients with a focus on illness prevention.	75 in Ontario as of Oct 2009[3]

[1] Adapted from table presented in Russell, G.M., Dahrouge, S., Hogg, W., Geneau, R., Muldooon, L., & Tuna, M. (2009). Managing chronic disease in Ontario primary care: The impact of organizational Factors. *Annals of Family Medicine, 7*(4), 309-318

[2] Source: Health Force Ontario (2010). *Family Physician Practice Compensation Models.* Retrieved February 15, 2010 from http://www.healthforceontario.ca/Work/OutsideOntario/PhysiciansOutsideOntario/PractisingInOntario/FamilyPhysicianPractice.aspx

[3] Source: Province of Ontario (2010b). *Unofficial listing of FHGs FHNs, and PCNs in Ontario as of October 14, 2009*. Ministry of Government Services. Retrieved February 15, 2010 from http://www.onterm.gov.on.ca/ViewRefList_e.asp?list_id=300

[4] Source: Ministry of Health and Long-Term Care (2010). *Family health teams*. Retrieved February 15, 2010 from http://www.health.gov.on.ca/transformation/fht/fht_mn.html

APPENDIX C
Table 2: Interview Participants[3]

Name	Role & Organization
Ben Chan	CEO, Ontario Quality Health Council
Lisa Dolovich	Research Director and Associate Professor, McMaster University, Quality in Family Practice
Philip Ellison	Strategic Plan Implementation Lead, Primary Care Quality, Department of Family and Community Medicine, University of Toronto
Mary Fleming	Director, MOHLTC – PHC, Negotiations and Accountability Management Division, PHC Branch
Doris Grinspun	Executive Director, Registered Nurses Association of Ontario (RNAO)
Mike Green	Associate Professor, Departments of Family Medicine & Community Health and Epidemiology, and Associate Director of Research for the Dept of Family Medicine and the Centre for Studies in Primary Care, and Interim Director of the Centre for Health Services and Policy Research, Queen's University; Adjunct Scientist at the Institute for Clinical Evaluative Sciences (ICES)
Dale Gunter	Associate Professor & Family Physician; Director, McMaster Family Practice; McMaster University, Department of Family Medicine
William Hogg	C.T. Lamont Primary Health Care Research Centre, Élisabeth Bruyère Research Institute; Department of Family Medicine, University of Ottawa; Institute of Population Health, University of Ottawa,
Brian Hutchison	Professor Emeritus, McMaster University; Senior Advisor, Planning, Development and Evaluation, Quality Improvement and Innovation Partnership (QIIP)
Jan Kasperski	Executive Director, Ontario College of Family Physicians (OCFP)
Clare Liddy	CT-Lamont PHC Research Centre
Cheryl Levitt	Provincial Primary Care Lead, Cancer Care Ontario-Provincial Primary Care Cancer Network (CCO-PPCCN)
Jamie Maskill	Regional Decision and Support Specialist, Association of Ontario Health Centres (AOHC)
Kavita Mehta	Executive Director, South East Toronto FHT, Board Member, Association of Family Health Teams of Ontario (AFHTO)
Anjali Misra	Manager of Performance Management, AOHC
Carolyn Poplak	Manager, Education and Capacity Building, AOHC
Jennifer Rayner	Regional Decision and Support Specialist, Southwestern area, AOHC
Fredrika Scarth	Manager, Performance Improvement, Planning and Evaluation, MOHLTC – Health System Accountability and Performance Division, Performance Improvement and Compliance Branch
Moira Stewart	Professor; Director, Centre for Studies in Family Medicine; System Integration and Innovation Network lead; University of Western Ontario, Primary Health Care System (PHCS) Program
David Topps	Professor & family physician, Northern Ontario School of Medicine (NOSM), Family Health Research & Education Team (FHRET)

[3] Names reported with explicit permission from participants

APPENDIX D
Interview Schedule

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Quality Improvement in PHC in Ontario Project

[Environmental Scan & Capacity Map Piece]
February 2010

- **Purpose:** This project involves completing an environmental scan and capacity map of quality improvement activities and quality improvement capacity that target primary health care in Ontario.

- **Quality-related work** definition includes:
  (1) education in quality methods
  (2) quality improvement research & program evaluation
  (3) performance measurement
  (4) quality assessment
  (5) quality assurance and accreditation
  (6) quality improvement practice facilitation
  (7) learning collaboratives
  (8) learning communities

- Time parameters: includes recent, current and planned activities. Recent is defined as: since the year 2000 (first year of federal Primary Health Care Transition Fund)

Opening Questions

1. Please confirm that you are giving us permission to digitally record our conversation.
2. Please tell me your name and current position.
3. Please confirm that we are permitted to use your name in a listing of interviewees, and to quote you anonymously in any materials related to this project and later related publications. If not, then clarify parameters.

Identification of PHC Quality Improvement Activities

1. List the primary healthcare quality improvement activities (QI-PHC) in Ontario that you are aware of.

Then, take each QI-PHC activity separately and respond to the following:

2. What was the timing of the activity (actual or proposed start & end dates)
3. Which aspect(s) of the **quality-related work definition** (see above) did the activity fit under (may include a combination of several)?
4. What role, if any, did you play in the activity?
5. Provide a brief overview of the activity and its objectives.
6. Which sector(s) was engaged in this activity?
7. Who was the lead in the activity? Who were other key players?
8. Was this a primarily Ontario-based activity?

   If NO, then was it a component of an interprovincial, Pan-Canadian, or international project?
9. What was the funding source(s) for the activity?
10. What were the human resources involved in the activity? Specific sets of expertise? (will help to build capacity map for Ontario, so identify individuals, locations, contact info, specific areas of QI and/or PHC expertise)?
11. Were there quality improvement tools associated with the activity (provide copies, links)?
12. Is there any available evidence regarding the impact of the activity? Impact of the tool?
13. Are there any printed or published materials available regarding the activity (and please forward actual copies, links, contact info, etc.)?

Closing Questions

14. Were there key QI-PHC activities in Ontario since 2000 that stand out? Why were they key activities?
15. Are there others involved in QI-PHC activities for Ontario that we should contact?
16. Please add any additional comments that you may have regarding QI-PHC activities and capacity in Ontario.

APPENDIX E
Table 3: Programs for Long Term QI-PHC Capacity Building

AOHC

1. **AOHC QI-Related Training**
2. **A Review of the Trends and Benefits of Community Engagement and Local Community Governance in Health Care**
3. **Building Better Teams: Learning from Ontario Community Health Centres**
4. **CHC Logic Model**
5. **Complexity of Care Project Study**
6. **Eastern Region CHC Performance Management Workshop**
7. **Eastern Region Quality Improvement Workshop Spring 2010**
8. **Implementing Dashboards Across CHCs**
9. **Intraprofessional Data Management Committee at Gateway CHC**
10. **Panel Size Study**
11. **Performance Management**
12. **Quality Assurance & Accreditation**
13. **Quality Oversight in Ontario CHCs**
14. **Regional Data Consortium**
15. **Regional Decision Support Specialist Positions**
16. **Supporting New Leaders in Teams**

CCO

17. **CCO's Primary Care Strategy**
18. **IN-SCREEN**
19. **Quality in Primary Care - Grand Rounds with Dr. Richard Grol**

CPSO

20. **CPSO Peer Assessment Program**

QIIP

21. **QIIP**
22. **Evaluation of QIIP Practice Facilitator Role**

1	AOHC QI-Related Training

Ongoing training (1) Boards in governance, and (2) various workshops regionally and at centres themselves; Large part of training is supporting data management in CHC sector re: data quality; performance management impacting specific deliverables for the professional learning groups

Timelines	Leads	Funder	Tools	KT	Contact
Ongoing for past 5 years	AOHC Performance Management Committee (PMC)	AOHC	Tools available on website	See website for available materials	Carolyn Poplak Manager of Education and Capacity Building

2	A Review of the Trends and Benefits of Community Engagement and Local Community Governance in Health Care

This literature review was commissioned by the Association of Ontario Health Centres (AOHC) to gather information and evidence on the concepts of community engagement and community governance within the context of regionalized health systems. The review presents evidence on the positive benefits of citizen engagement and the value added by inclusion of citizens in local organizational community governance in health care planning and decision-making. This literature review looks at citizen engagement and community governance in Ontario as it is believed to have many benefits for health and health care. The review concludes that enhanced quality of health care, improved individual and community health outcomes, better accountability, and more efficient use of resources are key dimensions of health and health care where engagement of citizens can have a positive impact.

Timelines	Leads	Funder	Tools	KT	Contact
June 2006	AOHC Ktpatzer Consulting	AOHC	N/A	See website for pdf	Carolyn Poplak Manager of Education and Capacity Building; ktpatzer@rogers.com

3	Building Better Teams: Learning from Ontario Community Health Centres

AOHC capacity building initiative for Aboriginal Health Access Centres, CHCs, and Community FHTs; The research sought to define, measure and produce recommendations for improving effectiveness in interprofessional teamwork

Timelines	Leads	Funder	Tools	KT	Contact
August 2004 - 2007	AOHC in collaboration with University of Toronto,	PHCTF; Health Canada	Tools available on website	1. Plain language literature review on interprofessional collaboration 2. Five workshops	www.aohc.org for toolkit Carolyn Poplak Manager of

	ICES, University of Western Ontario, & Lakehead University			held across Ontario; 6 more workshops held in other regions across Canada (Health Canada funded) 3. Presentations at academic conferences 4. Co-investigators to submit papers to peer reviewed journals; Those published will be posted on AOHC website	Education and Capacity Building

4	CHC Logic Model

CHC Logic Model revision currently underway; will be prepared by June 2010; results-based logic model and evaluation framework for CHC sector; CHC Model of Care on website gives indication of logic model direction; other training and capacity building is based on concepts within the model e.g., community governance, team building, cultural competency

Timelines	Leads	Funder	Tools	KT	Contact
Ongoing since 2007 with recent revision underway	AOHC Performance Management Committee (PMC)	AOHC	Under development (not yet available)	See website for updates	Carolyn Poplak, Mgr Education and Capacity Building www.aohc.org

5	Complexity of Care Project Study

Initial pilot of 6 diverse CHCs weighting the client complexity so can compare to other FHTs; measuring who the CHCs see based on co-morbidity data sets from ICES; Aim is to be able to better describe the complex population served by the CHCs and how this relates to complexity and weight of caseloads; Comparing to other primary care provider groups to examine differences and similarities in user population characteristics and thus complexity of care; Supports clinical team accountability through data-driven decision-making at CHC level; Diverse sites included francophone, youth centres, northern, rural and urban; Six CHC pilots finished in March 2010; expanding to provincial analysis of all CHCs this year; regional focus with provincial implementation

Timelines	Leads	Funder	Tools	KT	Contact
Pilot period July 2009-Feb 2010; Initial pilot	AOHC in collaboration with ICES	Absorbed within Rayner's role;	Adjusted John Hopkins ACG, and 6-	Final report co-authored by Rayner &	Contact Jennifer Rayner, London Intercommunity

results presented in Feb 2010; Provincial data collection starts June 2010 and throughout summer, into ICES by Sept 2010 with report by March 31, 2011; ongoing biannual updates & reporting thereafter; possibly reexamine index data every 5 yrs	Co-PIs: Jennifer Rayner (AOHC) Rick Glazier (ICES), Co-PIs	small contract ($2000) with ICES for initial data storage & database access	7 databases from ICES utilization bands, including emergency utilization; internal CHC database from ECG	Glazier not yet released; abstract to be submitted to Data Users conference in Ottawa for Sept 2010	Health Centre 519-660-0874 JRayner@lihc.on.ca

6	Eastern Region CHC Performance Management Workshop				
Performance management workshop held in eastern CHC region. Capacity building to support other QI strategic objectives.					
Timelines	**Leads**	**Funder**	**Tools**	**KT**	**Contact**
Held October 2008	RDSS eastern region	AOHC & local supports	None identified	See website for resources	Jamie Maskill, RDSS, eastern region

7	Eastern Region Quality Improvement Workshop Spring 2010				
A regional workshop aimed at all levels of staff to showcase QI activities within the region. Peer-reviewed abstracts submitted and reviewed. Keynote speakers not yet confirmed as of march 2010, but aiming to connect well-known QI-PHC experts to the CHC work.					
Timelines	**Leads**	**Funder**	**Tools**	**KT**	**Contact**
To be held in May 2010	RDSS eastern region	Not identified	N/A	Website being developed	Jamie Maskill, RDSS, eastern region

8	Implementing Dashboards Across CHCs				
Dashboards being implemented across all CHCs to assist CHC Board of Directors in setting targets that help improve various measures towards better quality care.					
Timelines	**Leads**	**Funder**	**Tools**	**KT**	**Contact**
Ongoing since 2008	AOHC performance management committee	AOHC	None identified	None identified other than internal documents	Contact Jennifer Rayner, London Intercommunity Health Centre 519-660-0874 JRayner@lihc.on.ca

9	Intraprofessional Data Management Committee at Gateway CHC				
An interprofessional data management committee was developed that cuts across all levels; Developing standard indicators, etc; Data Management and Quality Committee oversees all of work; Running PDSA data and feeding results back to providers					
Timelines	**Leads**	**Funder**	**Tools**	**KT**	**Contact**
2009 - present	Gateway CHC	Gateway CHC	None identified	None identified	Win Wenton, Executive Director and Laura Cassey, Data management Coordinator

10	Panel Size Study				
In Phase I, eastern region contracted with EBRI to examine clinical data at CHCs; Aim was to determine best roster size for NPs and physicians; did not include individual co-morbidity status of clients at time; Phase II to extend the original panel size study connecting it with the Complexity of Care study findings; adding a number of NP teams and case mix into equation; supports clinical team accountability					
Timelines	**Leads**	**Funder**	**Tools**	**KT**	**Contact**
Ongoing with Complexity of Cars Project; initial reporting end March 2010	Simone Dahrouge and Bill Hogg at EBRI were original leads; Jennifer Rayner to	AOHC; Written into Schedule A of agreement, amount not yet determined; Partially absorbed	Adjusted John Hopkins ACG, and 6-7 databases from ICES utilization bands, including	Initial confidential report to CHC Boards and Executive Directors; not shared publically at	Contact Jennifer Rayner, London Intercommunity Health Centre 519-660-0874 JRayner@lihc.on.ca

	lead this second phase	within Rayner's role	emergency utiilization; internal CHC database from ECG	this point	

11	Performance Management

Ontario CHCs' Performance Management Committee Three Year Plan (2009-2012); Performance Management program focuses on the setting of performance and data standards, sector-wide reporting, decision-support, and development of accountability agreements. 3-yr plan outlines 9 main objectives:

(1) To work with the CHC sector to negotiate accountability agreements with the LHINs that continue to entrench the CHC Model of Care, reduces risks to the boards of directors, identifies accountability indicators that reflect the breadth of the model and ensures multi-year funding with regular annual increases.
(2) To position CHCs in maintaining continuous funding, through developing performance indicators which are feasible and acceptable for implementation in Ontario CHCs and that reflect the full CHC Model of Care.
(3) To improve quality of data by developing and improving tools so that informed decisions can be made at the clinical, centre, regional and provincial level.
(4) To enable CHCs and AHACs to demonstrate the effectiveness of their models of care to improve health outcomes for aboriginal, francophone, racialised and minoritised communities, disabled and other vulnerable populations.
(5) CHCs continue to tell their story in order to increase recognition that CHCs are the effective model of care to improve health outcomes of Ontarians.
(6) To support the Model of Care in CHCs, a full set of indicators that reflects the CHC Model of Care is developed and high quality data is produced that illustrates effectiveness.
(7) To ensure community capacity building is recognised as an essential attribute of the CHC Model of Care, data are collected on at least three Community Initiatives indicators and at least one is an accountability indicator in the next M-SAA for 2011-13.
(8) To demonstrate the comprehensiveness of care and the complexity of clients, a methodology to demonstrate complexity of care for CHCs will be developed and endorsed by CHC Provincial ED Network, MOHLTC and LHINs.
(9) To improve the quality of clinical care, relevancy of programmes, and efficiency and effectiveness of service delivery using timely information produced from good quality data and decision-support tools.

Timelines	Leads	Funder	Tools	KT	Contact
2009-2012 plan with 2010-2011 deliverables	AOHC Performance Management Committee (PMC)	AOHC	Workplan and multiple related implementation tools	Internal at this point	Anjoli Misra, Manager, Performance Management, AOHC

12	Quality Assurance & Accreditation

The Building Healthier Organizations (BHO) Accreditation Program of COHI is accessed by AOHC; Performance Management program focuses on the setting of performance and data standards, sector-wide reporting, decision-support, and development of accountability agreements. Accreditation is in collaboration with COHI, some funding to develop; AOHC & COHI collaborate on some initiatives & share membership; modeled after Accreditation Canada; comprehensive website; Accreditation standards and processes are currently being reviewed and revised, focusing in particular on how they could be enhanced to better support organizations in efforts to provide services equitably; measures under consideration include policy/leadership level measures, service accessibility measures and HR measures that impact the promotion of equity. Recommendations currently being solicited from the sector for standards revision.

Timelines	Leads	Funder	Tools	KT	Contact
Ongoing past few years	COHI Barbara Wiktorowicz, Executive Director, COHI	AOHC	Embedded within the accreditation program itself	N/A	www.cohi-soci.ca Barbara Wiktorowicz, Executive Director, COHI

13	Quality Oversight in Ontario CHCs

Project to develop tools to assist CHC Boards with quality oversight

Timelines	Leads	Funder	Tools	KT	Contact
Currently underway	AOHC PMC in partnership with COHI	AOHC & COHI	None yet identified	Not yet identified	Michael Rachlis and Suzanne Ross AOHC PMC ww.aohc.org

14	Regional Data Consortium

South east CHC region; developing indicators and comparing interorganizationally; examining CIHI-PHC indicators; looking at where organizations fall in comparison to others; improving data entry; regional reports to regional executive directors

Timelines	Leads	Funder	Tools	KT	Contact
2008 - Present	AOHC-PMC	AOHC	None identified	None identified	RDSS in Southern region – Jamie

					Maskill Anjoli Misra, Manager, Performance Management, AOHC

15	Regional Decision Support Specialist Positions

Funded by MOHLTC through AOHC; position for each region situated in one CHC administrative home but accountable to all EDs in region; Evaluation of role completed (Lori Zegger); identified gaps with respect to regional-provincial issues; Aim of role is to support evidence-based decision-making

Timelines	Leads	Funder	Tools	KT	Contact
Since 2008	AOHC-PMC	MOHLTC	Multiple examples on website	Example: "Creating Value with Information in a Performance Management Environment" by Data Management Committee Program Learning Group	For ppt & sample work see http://www.aohc.org/aohc/index.aspx?CategoryID=87&lang=en-CA Contact Anjoli Misra, Manager, Performance Management, AOHC

16	Supporting New Leaders in Teams

Ongoing performance improvement package to support QI capacity building for new team leaders.

Timelines	Leads	Funder	Tools	KT	Contact
Ongoing as needed	AOHC	AOHC	Internal tools available	None identified	Carolyn Poplak Manager of Education and Capacity Building

17	Cancer Care Ontario's Primary Care Program

The Cancer Care Ontario Primary Care Strategy is a province-wide QI program. It recognizes that family physicians and nurses play a crucial role in cancer care, greatly influencing patients' participation in cancer screening and providing care and support for patients and their families throughout the cancer journey. To strengthen the connection between family medicine and the cancer system, Cancer Care Ontario created this Primary Care Program in 2008. This program is a key strategy for improving the quality of cancer care in Ontario, as outlined in the *2008-2011 Ontario Cancer Plan*.

Primary Care and Cancer Engagement Strategy: To guide its work, the Primary Care Program developed a Primary Care and Cancer Engagement Strategy. This clear plan of action focused initially on improving screening and detection rates within the ColonCancerCheck program and will eventually expand to other screening programs and the whole cancer pathway.

Provincial Primary Care and Cancer Network: To implement the Primary Care Strategy across the province, regional primary care leads have been recruited in each Local Health Integration Network (LHIN) to act as local contacts for primary care providers and regional cancer programs in Ontario. Together with the provincial primary care lead, they form a Provincial Primary Care and Cancer Network (PPCCN).

CCO is a case study that has developed QI both in KTE and in measuring for all of Cancer; these processes are extending to Renal diseases and Diabetes. CCO has developed specialist and PC networks, guidance, implementation strategies, tools, spread, provider reports.

Timeframe	Leads	Funder	Tools	KT	Contact
Ongoing since 2008	Provincial Primary Care and Cancer Network Management Team: Dr. Cheryl Levitt, Provincial Primary Care Lead Dr. Doina Lupea, Program Manager See website for listing of Regional Primary Care Leads			See website for pdfs: □ Primary Care and Cancer Strategy brochure □ Journal article - *Canadian Family Physician*, November 2009: Provincial primary care and cancer engagement strategy □ Results of Symposium on the Integration of Family Practices and the Cancer Care System	http://www.cancercare.on.ca/pcs/primcare/

18	IN-SCREEN (or Integrated Screening)

Aim is to improve quality in screening for colorectal cancer. Leadership engagement at regional levels seeking to develop a community of practice/network focused on cancer care in primary care. A system developed at CCO combining a series of different administrative databases (billing, laboratory, results data) around colorectal cancer and FOBT screening. Recently completed pilot project with 110 family doctors, where provided them with administrative data from CCO central depository, and asked them to verify its accuracy. MOHLTC has just funded CCO to also include mammography and cervical screening in integrated manner over next year. Plan to develop systems that help CCO provide individual physician level report to guide screening practices; provide with actual profile of each patient and whether they have been screened or not and aggregate data on how they compare to how they were doing before, and on how they compare to their peers and on how they compare to their LHIN, among other items. Goal is to move to 1,000 family physicians and next year to full 9,000 to cover the province, within administrative data limitations. For March-April 2010: external consulting firm to develop

full business plan for the project. Effective knowledge mobilization, focus on priorities, and strict workplan necessary since limited staff time.

Timeframe	Leads	Funder	Tools	KT	Contact
Started in 2007 and is ongoing	Cancer Care Ontario Cheryl Levitt lead; Jill Tinmouth, PI on research side	MOHLTC, portion of $193 million colon cancer sponsorship program, primary care program portion $650,000 annually; CIHR grant application currently under review to extend work	See CCO Toolbox link on website	PHC Summit Jan/10; WONKA; OICR; ICSQ Various sessions, see website	www.coloncancercheck.ca Jill Tinmouth, Clinician Scientist & Assistant Professor, Division of Gastroenterology, Department of Medicine,Sunnybrook Health Sciences Centre & U of T; Adjunct ICES

19	Quality in Primary Care - Grand Rounds with Dr. Richard Grol: A Lifetime Involvement in QI

A high profile event held on February 4, 2010 "Grand Rounds with Dr. Richard Grol: A Lifetime Involvement in Quality Improvement". Aims were to create an opportunity for knowledge exchange by a larger set of primary care and quality stakeholders from across Ontario and to encourage more understanding of the issues and opportunities for expert input and new partnerships. Dr. Grol is an expert in quality improvement in primary care, having led the European Practice Assessment (EPA) program. The overarching objective for this event was to leverage Dr. Grol's expertise to begin to develop indicators for quality improvement for Primary Care & Cancer, beginning with prevention and screening, and later expanding to the cancer journey. This was a face-to-face meeting held in Toronto and was webcast for remote real time access.

Timelines	Leads	Funder	Tools	KT	Contact
Event held Feb 4, 2010 Grant: Jan 1 – Dec 31, 2010	Collaboration among Primary Care Program of Cancer Care Ontario, McMaster University (Department of Family Medicine), University of Toronto (Department of Family and Community Medicine), Ontario College of Family	CIHR: Meetings, Planning & Dissemination Grant: Knowledge Translation		1. Event itself is KT 2. Meeting archived on CCO Primary Care Program website with links on sponsor websites	Cheryl Levitt, MOHLTC, primary care Doina Lupea

	Physicians, Ontario Medical Association, Ontario Health Quality Council, & Quality Improvement and Innovation Partnership (QIIP). Cheryl Levitt, provincial primary care lead + steering committee from all co-sponsoring organizations				

20	**CPSO Peer Assessment Program**

The CPSO Quality Assurance Program develops, establishes and maintains programs and standards of practice to assure the quality of practice of the profession and to promote continuing competence among physicians. Peer Assessment is a CPSO quality assurance program that has been designed to assess and evaluate its members by their own peers—practicing colleagues. The program has been in operation since 1980 and thousands of physicians have been assessed. Each year, most physicians (almost 90%) are found to be practicing in a satisfactory manner and receive useful feedback from their assessor. The program's emphasis is educational and recognizes and acknowledges the professional's and CSO's role our role and responsibility in attaining the best possible patient outcomes. CPSO is committed to developing and maintaining professional competencies and in actively partnering with its members to provide tools and resources, such as the feedback from the Peer Assessment Program.

The 2008-2010 CPSO Strategic Plan focuses on Quality Professionals, Healthy System & Public Trust. This includes Building a Strong Regulatory Foundation as one of its priorities. Under this area, a goal is to significantly increase the number of physician assessments to support the development of a system of continuing professional development and continuing competence. CPSO's strategic plans noted that they will build the capacity to conduct 2,000 assessments on an annual basis by 2010. A proportion of assessments were tied to identified practice indicators of educational need.

Timelines	Leads	Funder	Tools	KT	Contact
Since 1980	CPSO Quality Assurance Committee	CPSO		Links related to aspects of program on website; Bulletins from Quality available on website	http://www.cpso.on.ca/members/peerassessment/

21 Quality Improvement and Innovation Partnership (QIIP)

The Quality Improvement and Innovation Partnership (QIIP) originated as a project within the MOHLTC. In 2009, QIIP formally incorporated as a non-profit organization and has a funding and accountability agreement with the MOHLTC. QIIP is a provincial organization mandated to build ongoing quality improvement capacity in PHC across the province. As part of its core activity in quality improvement, QIIP works with FHTs, CHCs and other models of primary healthcare to through multi-session Learning Collaboratives. Expert subject-matter faculty and QIIP's team of external QI coaches assist the practice teams to learn and apply quality improvement methods including the use of rapid cycle tests of change and performance measurement. Areas of focus for improvement have included chronic disease management (diabetes care), prevention (colorectal cancer screening) and office practice redesign (access and efficiency).To date, QIIP has reached 121 teams primarily involved Ontario's 150 FHTs, but Community Health Centres and Shared Care Pilot projects have also been reached. Plan is to expand into other practice models through the QIIP Learning Community. The goal of QIIP is to advance the development of a high-performing primary health care system. QIIP's strategic objectives include:

• To introduce, integrate and spread quality improvement methods
• To build a learning community among primary healthcare practices to share and spread improvements and innovation
• To advance the use of performance measurement to plan, test and evaluate improvements in the organization and delivery of primary healthcare
• To partner with other quality initiatives and programs related to primary healthcare

Timelines	Leads	Funder	Tools	KT	Contact
2007 - Present	Brenda Fraser: Executive Director Nick Kates: Provincial Lead Brian Hutchison: Senior Advisor + other QIIP staff	100% MOHLTC Approx $6 million/yr; budget negotiated annually	QIIP Learning Community – offering teams a series of action groups to participate in active learning cycles plus the LC gateway (web-based platform) and QI coach support Multiple tools, resources, events & collaborative opportunities available through website	Numerous; QIIP Improvement and Innovation Framework Most recent: 1. Learning Collaborative 1, 2 and 3 Reports 2. QI Showcase 3. Workshop for new FHTs and Nurse-Practitioner Led Teams, Feb 2-3, 2010 4. Presentation at IHI Conference, Washington, DC March 9, 2010	Quality Improvement and Innovation Partnership 2345 Argentia Road, Suite 101, Mississauga, ON L5N 8K4 905-363-0490 905-363-0491 Email: info@qiip.ca www.qiip.ca Brenda Fraser: brenda.fraser@qiip.ca

				(Fraser, O'Brien, Kates) 5. 'Collaborative 3' Congress completed May 10, 2010	

22	Evaluation of QIIP Practice Facilitator Role

An Evaluation of Introducing Quality Improvement and Innovation Partnership (QIIP) Practice Facilitators into Family Health Teams and their Role in Facilitating the Objectives of Learning Collaboratives. Worked closely with QIIP Steering Committee to examine the intention and the role of the practice facilitators. Large amount of data collected re: how the facilitators engaged with the learning collaboratives to support their QI work. Examined issues such as how many teams they worked with, how they did this work (from a distance, face-to-face), kinds of activities they conducted, how they used their time, challenges in working with teams.

Timeframe	Leads	Funder	Tools	KT	Contact
1 year ending summer 2009	Rick Birtwhistle Mike Green Jyoti Kotecha Grant Russell	MOHLTC competitive research grant $223,400	Contact project manager for details	Report with MOHLTC; papers underway	Jyoti Kotecha, Project Manager kotechj@hdh.kari.net

APPENDIX F
Table 4: Time Limited QI-PHC Activities

1. **Better Innovations Group (BIG)**
2. **CHAP**
3. **CHQI**
4. **Collaborative Mental Health Care Network Mainpro© C Program**
5. **CQIO**
6. **e-Learning to Enhance Quality Assessment Competencies**
7. **Group Health Centre**
8. **IDOCC**
9. **IMPACT**
10. **IMPROVE**
11. **Improvements in Pain Management Project**
12. **Partnership for Health – A Diabetes Prevention and Management Demonstration Project**
13. **Primary and Community Care Committee (PCCC) OMA**
14. **Quality Improvement Strategic Pillar: University of Toronto, School of Family Medicine**
15. **Quality Indicator Project**
16. **Quality in Family Practice Project**
17. **Resident First Initiative**
18. **Violence Reduction Project**
19. **The Change Foundation Projects**
20. **Using Computerized Decision Support in Primary Care**
21. **Web-based Patient Self-Management**

1	Better Innovations Group (BIG)

Department of Family Medicine, Queen's University; Major committee created within the Dept 2-3 years ago in response to the development of the FHT and some initial performance measurement work that suggested that there was readiness to move on accountability, measurement and reporting. The group undertook an extensive series of consultations with the department. Committee make up of whole clinical group, all the allied health professions, physicians, residents—all took several days to develop the team and its workplan. Covers entire team—approx 15 FTEs with 22 – 24 physicians + 68 staff and 50 residents per year. Now integrated into departmental culture; weekly "BIG Briefs" updates before grand rounds, standard item on departmental meeting agendas, quarterly planning meetings, integrating residents' audit project into BIG planning. Doing a number of projects, e.g. interdisciplinary team functioning proposal to MOHLTC through Health Force Ontario to examine best practices in interdisciplinary team work

Timeframe	Leads	Funder	Tools	KT	Contact
2007 - Present	Karen Hall Barber	Internal to Dept	Tools available; different tools for 3-4 working groups	Summary reports	Karen Hall Barber kphb@queensu.ca

2	CHAP

The Cardiovascular Health Awareness Program (CHAP) is a community-based program that brings together local family physicians, pharmacists, other health professionals, public health representatives, volunteers, and health and social service organizations to work together to promote and actively participate in the prevention and management of heart disease and stroke. Largest RCT ended in 2006; analyzing data for this now; BP and self-reported cardiovascular factors using ICES administrative data; helping 22 communities 16,000 patients 19 control communities; large initiative involving 250 physicians, 130 pharmacists and 600+ volunteers

Timeframe	Leads	Funder	Tools	KT	Contact
ongoing since 2000 with several phases	UBC, McMaster University, EBRI	Canadian Stroke Network; MOHLTC; ICES	multiple teaching aids; see website for details	Website publications & newsletters posted up to fall 2009; Main publication available related to the intervention: Carter, M., Karwalajtys, T., Chambers, L., Kaczorowski, J., Dolovich, L., Gierman, T., Cross, D., Laryea, S. (2009). Implementing a standardized community-based cardiovascular risk assessment program in 20 Ontario communities. Health Promotion International	www.chapprogram.ca

3	CHQI

In July 2008 the MOHLTC Ontario Health Performance Initiative chose to join The Change Foundation to create The Centre for HealthCare Quality Improvement (CHQI) at The Change Foundation. Operating arms-length from government, CHQI's commitment to improving the quality of health care through on-the-ground projects across the province aligns perfectly with the Foundation's new strategic directions focused on supporting the integration of health services and improving the quality of health services in the community. The partnership shares a focus on accelerating the pace and widening the scope of quality improvement in health care in Ontario. CHQI operates at arms-length from the provincial government. The initiative was established in 2006 to accelerate quality improvement in Ontario to improve system-level outcomes in areas of provincial strategic priority.

Timeframe	Leads	Funder	Tools	KT	Contact
Ongoing since 2006 with org shift in 2008	MOHLTC with The Change Foundation	MOHLTC at the Change Foundation	See website for avail resources	See website for avail resources	www.chqi.ca

4	Collaborative Mental Health Care Network Mainpro© C Program

The Collaborative Mental Health Care Network (CMHCN) program links family physicians from across the province with a GP Psychotherapist and Psychiatrist mentor in a collaborative relationship to support easy access to case-by-case support and ongoing continuing professional development regarding mental health care. The program is supported by the MOHLTC. The CMHCN connects family doctor mentees to psychiatrist and GP-Psychotherapist mentors through telephone, email and fax. Mentees may contact their mentors on an informal basis for guidance and support. Formal CME workshops, small group teleconferences and sessions take place regularly in order to foster group cohesion. These tools help to support and augment the case by case mentoring program. Advice in the areas of diagnosis, psychotherapy and pharmacology is provided to mentees who are matched with mentors based on clinical interests and/or geographic location.

Timeframe	Leads	Funder	Tools	KT	Contact
Established in 2001; now permanent program	OCFP & MOHLTC	MOHLTC, Mental Health Division grant initially	Innovative tool development; see website	National & international recognition for work; Evaluation overview on website	http://dl.dropbox.com/u/49189/CMHCN1/Collaborative%20Mental%20Health%20Network%20Web%20Home.html Eilyn Rodriguez, Assistant Executive Director, Research and Educational Services, 416-867-9646 Ext: 24

5	CQIO: Celebrating Quality Internationally & in Ontario

The McMaster Quality in Family Practice Team organized this knowledge transfer and exchange week in Hamilton, Ontario to Celebrate Quality Internationally and in Ontario (CQIO) in primary care/family practice. Co-sponsored by the McMaster Quality in Family Health Team, CCO, CPSO and OCFP. Quality. The CQIO Week encompassed a broad spectrum of strategic and tactical knowledge exchange meetings throughout March 2 to 6, 2009. It helped to bring many stakeholders together to discuss a provincial QI framework for family practices. A summary of the CQIO Week culminating in the key event—the Quality Initiatives Knowledge Exchange Workshop on March 6—is available as an online webcast, and the full Proceeding are available on this site. As well, documents related to the Practice Manager Workshop are available and a summary of the Workshop is documented in the Proceedings.

Timeframe	Leads	Funder	Tools	KT	Contact
March 2-9, 2009	McMaster Quality in Family Practice Team, CCO, CPSO & OCFP			See website for: CQIO Proceedings: download the full Proceedings, as well as presentation slides from the Conference Webcast: View the online webcast of the CQIO Conference Practice Manager Workshop: download the workshop agenda, a summary of the workshop, and other relevant documents. CQIO Photo Gallery: view images of the CQIO events	http://www.qualityinfamilypractice.com/recent-events1/cqio-conference-march-2-6-2009

6 e-Learning to Enhance Quality Assessment Competencies

The Ontario College of Family Physicians, under the leadership of Jan Kasperski (Principal) and David Price (co-investigator), received funding for this project that developed the electronic infrastructure and support to enable the effective use of the Quality in Family Medicine tool (see Quality in Family Practice project description). The official project name was: Enhancing Competencies in FHT's using Quality Improvement as a driver for Learning, Team Building and Innovation.

The goals of this project were to 1) adapt some of the existing outreach presentations/training workshops materials, develop additional training resources on the Quality Assessment Tool and develop them into an Internet-based e-learning program and 2) to facilitate training on how to utilize the Quality in Family Practice program and thus dissemination and uptake of the Quality project objectives, in particular use of the Assessment Tool through the web-based medium.

The project was designed to support 7+1 practices in using the Quality in Family Medicine tool to improve and/or develop effective and efficient structures and organizational and clinical process in Family Health Teams. This program focused on the structure and processes that are needed on an organizational and clinical basis to support all team members in a FHT to work together to provide efficient and effective team-based care. Key members of the Quality Assessment Tool project team worked with McMaster's Division of e-Learning Innovation to adapt existing workshop materials and resources to create:

- A standalone Web-based interactive presentations that outline some of the key messages that are currently delivered in face-to-face presentations; and
- An embedded (or reference-based) 'help' resources that can be accessed 'on demand' as people are using the Assessment Tool.

The team reviewed and tested the tool, assembled practice tool kits and developed an interactive distance-learning program to support the uptake of the program in family practices. It was anticipated that this program would have the potential to provide the underpinning for the launch a province-wide program to enhance the quality of practices throughout Ontario and Canada.

Timeframe	Leads	Funder	Tools	KT	Contact
Jan – Dec 2009	Jan Kasperski (Principal) David Price (co-investigator),	Ministry of Health & Long Term Care	FHT specific tools on the website. -Web-based educational program to support the use of the tool. -Feedback on the effectiveness of the web-based education vs. facilitator supports for the use of the quality tool. -Proof of concept with "new" FHT successfully using the online tool and resources to facilitate development of the FHT and practice.		http://www.qualityinfamily practice.com/about-quality/e-learning-quality-tool

7	Group Health Centre

Group Health Centre in Sault St. Marie. Serves approximately ½ the population of Sault St. Marie. Strong evidence-based leadership among team that developed and implemented innovation Health Promotion Initiatives (HPI) Program and numerous research projects that have contributed to the Primary Care Excellence Model at the GHC. Developed programs targeting improvements in care for people with congestive heart failure, diabetes, osteoporosis, HIV/AIDS and many other conditions. Recently launched vascular intervention program (VIP). (No individual breakdown of projects available at this time.)

Timeframe	Leads	Funder	Tools	KT	Contact
Over past 5 years	Various team members depending on initiative. Strong leadership in past from Dr. Lee	Various funders depending on project	None identified	See website	http://www.ghc.on.ca Lewis O'Brien Obrien_1@ghc.on.ca

8	IDOCC

The Improved Delivery Of Cardiovascular Care (IDOCC) Program is a voluntary regional program designed to assist primary health care providers in the Champlain District improve the delivery of evidence-based prevention and management strategies for heart disease, stroke and diabetes within their practice.; A five-year Cardiovascular Disease Prevention Strategy for the Champlain District (Champlain LHIN serves 1/15th population of ON 1.4 million people; 1,000 family physicians offer primary care services in this LHIN). Out of University of Ottawa, part of research program looking to best understand ways to improve service delivery by physicians through sustained changes in primary care practices. The first phase of the strategy includes the roll-out of six key initiatives to improve CVD prevention in the Champlain District, one of which is the IDOCC Program. The IDOCC Program uses an Outreach Facilitation Model in which skilled health professionals serve as an expert resource to primary care practices.The Outreach Facilitators work with practices to implement evidence-based guidelines for the following risk factors and conditions associated with the prevention and management of CAD, Stroke and Diabetes:

* hypertension (blood pressure)
* dyslipidemia (cholesterol)
* smoking
* weight management/ physical activity
* management of patients with coronary artery disease (CAD) or peripheral vascular disease (PVD)
* management of TIA/stroke
* management of diabetes

Outreach Facilitators support practices with:

* organizing work so that prevention and chronic disease management are integrated into routine operation
* structuring and implementing specific care improvements identified by your practice

* increasing the use of evidence-based guidelines
* integrating practice activities with other services, including specialists and community resources

Timeframe	Leads	Funder	Tools	KT	Contact
Three phases: 2007-8; 2009-10, 2010-11; by end of Phase 3 will have been rolled out across entire district	Champlain Cardiovascular Disease Prevention Network (CCPN), a collaboration of 15 partner organizations. Coordinated by the Élisabeth-Bruyère Research Institute in collaboration with the: University of Ottawa, Faculty of Medicine; University of Ottawa Heart Institute; Champlain Regional Stroke Program; Champlain Local Health Integration Network; Pfizer; William Hogg & Clare Liddy, co-leads + several co-investigators	MOHLTC $4 million; Joint funding through grants: Champlain LHIN; and sponsored in part by Pfizer Canada Inc.(a Founding Industry Partner of the Champlain CVD Prevention Network)	See toolkits on website; Facilitators use IDOCC Program tools made available to them through the primary care practice, as well as their own resources and tools from other established health organizations. Some tools include: 1) Champlain CVD Prevention Guideline: provides summary of latest evidence-based guidelines for heart, stroke, and diabetes, as well as key risk factors (e.g., smoking, hypertension, dyslipidemia) and a comprehensive list of community programs and services. 2) Decision Aid and Risk Factor Management Tools: Integrated Risk Factor Screening Tool and Guide for Comprehensive Risk Reduction coupled with the CV Risk Flowsheet	Published economic analysis: 40% positive return on 1st year of investment Growing body of evidence; accepted paper in Canadian Family Physician journal; Presented at CDC-Centres for Health Services; NAPCGR 2009	whogg@uottawa.ca T: 613-562-4262 ext. 1431 cliddy@scohs.on.ca T: 613-562-4262 ext. 1514 www.idocc.ca

9 IMPACT

Integrating family Medicine and Pharmacy to Advance primary Care Therapeutics (IMPACT) was a large-scale provincial demonstration project supported by the Ontario PHCTF (2004-2006) and is now a MOHLTC funded program. IMPACT aimed to improve drug therapy using a collaborative care model that integrates pharmacists into the primary health care team. The pharmacists' main service was individual patient assessments to identify, prevent or resolve drug-related problems. Quantitative and qualitative methods were used to evaluate the process of integration, pharmacist service uptake, drug-related patient outcomes, and the costs associated with program set up and implementation for sustainability. This multi-site project involved 7 pharmacists, approximately 70 physicians and cover approximately 150,000 patients. Within each practice site, a pharmacist with special clinical training worked 2.5 days per week for 1 year and coordinated a multifaceted intervention aimed at optimizing drug therapy to improve patient outcomes (blood pressure, cholesterol, diabetes, pain control, constipation, etc.) The family physicians and other

members of the practice worked closely with the pharmacist in implementing these strategic interventions. Family physicians from a range of practice models (Ontario Family Health Networks, Primary Care Networks, and other types of family physician group practices) participated in this project. Quantitative and qualitative methods were be used to evaluate the process of integration, pharmacist service uptake, drug-related patient outcomes and the costs associated with program implementation for sustainability. The integration of the physicians and pharmacists at the practice sites was evaluated with the aim of generating a practical and transferable practice model.

Timeframe	Leads	Funder	Tools	KT	Contact
PHCTF pilot 2004-6; ongoing MOHLTC program now	MOHLTC (currently) Large team of investigator & co-investgators; Lisa Dolovich & Kevin Pottie, McMaster Co-I; Team membership details: http://www.impactteam.info/impactTeam.php	PHCTF $2.5 million 2004-6 and then extended and funded as a regular program of MOHLTC	See website for resources	Main publication in Clinical Pharmacy and Therapeutics; see website for numerous conference abstracts	Lisa Dolovich www.impactteam.info

10	IMPROVE

Improving Practice Outcomes VIA Electronic Health Records built on previous work: "Primary health care measures on quality and comprehensiveness – estimation, validation and generalization." The objectives were to:

1. Retest previously created health administrative (HA) data measures against electronic health record (EHR) measures. This comparison will allow conclusions about the strengths and gaps of HA data for use in province-wide indicators of primary health care (PHC);
2. Add new measures relevant to Ontario's evolving Family Health Teams that will be tested for validity and generalizability; and,
3. Assess a tool, particularly developed by this project, to provide feedback to family physicians and other PHC providers regarding its impact on improvements in the quality of service provided. This tool can then be used more widely to support and enhance best practices in PHC generally; Information sheet with bar graphs available

Timeframe	Leads	Funder	Tools	KT	Contact
April 2007 - May 2008; the quality of care outcomes are currently being	MOHLTC under funding program Enhancing Quality in Primary Health Care	MOHLTC; ICES	toolkit book in pdf available	Inaugural conference Electronic Medical Records (EMR) in Primary Care	Moira Stewart: moira@uwo.ca Doug Manuel: doug.manuel@ices.on.ca

tracked and analyzed	Moira Stewart & Doug Manuel			Research: International Perspectives held March 25, 2008 in Toronto; posters with results available in pdf	

11	Improvements in Pain Management Project

Project initiated before real QI in PHC work started in Ontario, so not nested explicitly in QIIP; Multidisciplinary team including an OT with expertise in pain management, and physicians, pharmacist, social worker; enormous menu ofand tools: questionnaires to measure outcomes previously developed validated; not available publically yet to be presented in near future

Timeframe	Leads	Funder	Tools	KT	Contact
2007-ongoing (incl earlier pilot before funded project)	Dale Gunter, PI McMaster FHT	Dept of Family Medicine, McMaster University $100,000 over 2 yrs	2 kinds tools - research side and intervention side: SF36 Quality of Life; Cage D Questionnaire for etoh and drug use; Kehler-10; + developed own tools around medication use for research side; on intervention side: Materials that participants read, self-care, self-management, exercise etc	No presentations of pilot work yet	Dale Gunter McMaster University

12	Partnerships for Health – A Diabetes Prevention and Management Demonstration Project

South West LHIN and the South West Community Care Access Centre launched Partnerships for Health – A Diabetes Prevention and Management Demonstration Project; 3 year pilot in south western Ontario launched with the full support and funding from the Ministry of Finance's *Strengthening Our Partnerships* program, in partnership with MOHLTC. This project represents

an $8 million dollar investment into the prevention and management of diabetes and, ultimately, of other chronic diseases. The demonstration project will bring together a wide range of health care partners, including:

- South West CCAC
- Brockton Family Health Team
- Clinton Family Health Team
- Strathroy Medical Clinic
- South Bruce-Grey Health Centre, Walkerton Site
- Thames Valley Family Practice Research Unit, University of Western Ontario
- Huron Perth Healthcare Alliance – Clinton Site
- South West Local Health Integration Network

There are three key elements to the plan:

- Stronger partnerships between family doctors, CCAC case managers and other health care providers to support people with diabetes
- Resources to empower and support patients in managing their own diabetes
- Information Technology systems to support communication and integration among primary health care providers, specialists, hospitals and patients.

Project will be carefully evaluated and based on final outcomes, could provide a model for other chronic diseases; Will include four distinct phases that clearly identify deliverables and milestones that ensure governance and accountability throughout life of project. Comparing 3 different intervention approaches using facilitators; assesses IT readiness of sites; Care algorithm using CDA, CHR algorithm, workflow processes and standardized forms. Involves more than 50 practices; Many are demonstrating positive results, with patients showing improved A1Cs, blood pressures and blood lipids, and fewer low blood sugar incidents.

Timeframe	Leads	Funder	Tools	KT	Contact
3 yr pilot project launched Feb 2008 – Jan 2011	Stewart Harris evaluating the program Linkage to South West LHIN activities is through South West LHIN Chronic Disease Prevention and Management (CDPM) Committee See Feb/10 list: http://www.partnershipsforhealth.ca/Partnership_docs/CDPM%20Member%20List%20-	Ministry of Finance $8 million over 3 years (Strengthening Our Partnerships Program) + MOHLTC	See project website for resources	See project website for resources	http://www.partnershipsforhealth.ca/ Annabelle Mackey South West LHIN (519) 672-0445, ext. 2573 1 866 294-5446 annabelle.mackey@lhins.on.ca Sandra Coleman Executive Director South West CCAC 519 641-5496 sandra.coleman@sw.ccac-ont.ca Tommasina Conte South West LHIN 519 672-0445, ext 2566 1 866 294-5446 tommasina.conte@lhins.on.ca Mike Hindmarsh hindsighthealthcare@rogers.com

	%20updated%20Feb%2010.pdf				

13	Primary and Community Care Committee (PCCC)

Joint committee of OMA and MOHLTC. Ministry funded group to improve interprofessional education (IPE) among FHTs. Started in Northeast ON June 2009. Focus on (1) engaging the residents in QI work within the interprofessional team environment and (2) The FHT itself as an IPE environment that requires supportive processes. Multiple IPE activities, such as workshops, related to interprofessional team building.

Timelines	Leads	Funder	Tools	KT	Contact
2009-present	OMA & MOHLTC David Topps + 2 other physician colleagues	MOHLTC & OMA	Strong qualitative approach to development initially to lay groundwork; workshop materials focusing on IPE; Evaluations built into activities	Final report related to workshops	David Topps David.topps@normed.ca Northern Ontario School of Medicine (NOSM), Family Health Research & Education Team (FHRET) Tammy McKinnon tmckinnon@fortwilliamfhn.ca

14	Quality Improvement Strategic Pillar: University of Toronto School of Family Medicine

Adopted Quality Improvement and Research & Evaluation as strategic pillars based on internal environmental scan. Will guide activities for next 3 years. Developing a curriculum for Family Medicine that includes quality improvement. Considers the standard for a resident in Family medicine to complete a quality project as part of their residency requirements.

Timelines	Leads	Funder	Tools	KT	Contact
2009 – 2012; planning now with implementation in 2010-2011 academic year	Lynn Wilson	Internal planning	Survey developed & available; Considering IHI.org internet-based modular program	Some poster presentations	www.qualityinfamilypractice.com

15	Quality Indicator Project

Comprehensive data collection, calculation of quality indicators and feedback process in 7 FHTs in Ottawa and Kingston. Provided teams with detailed custom reports + one hour facilitated feedback session on the FHT performance in different areas. Wanted to examine the challenges in measurement, the possible tools that could be used, and how feedback can be provided to teams. Consent obtained from both the providers and patients to do a fully linked study where providers did questionnaires; practices had their staff fill out a single tool, collecting information about the context of the practice, and then patients did individual pre- and post-visit surveys. Comprehensive chart audit done and included any of their administrative data that was housed at ICES to link at the individual level. Data set for 1000 patients.

Timelines	Leads	Funder	Tools	KT	Contact
2 year project 2007-9	Phase I: Mike Green & Bill Hogg, co-leads Phase II: Mike Green & Sharon Johnson	MOHLTC	Providers tool completed re: context of practice; Qualitative evaluation interviews	Preliminary findings reported I posters at NAPCRG 2009; CIHR Summit 2010; Final report at MOHLTC; Drafts of papers underway	Mike Green mg13@post.queensu.ca

16	Quality in Family Practice Project

Quality in Family Practice is a project of the Department of Family Medicine at McMaster University. This was designed as a province-wide project similar to the national accreditation programs in Australia, New Zealand and Europe. The vision of this project is that ALL Family Practices in Ontario will provide safe and high quality Primary Care. The mission is to implement a comprehensive and integrated continuous quality improvement program in Ontario that promotes and celebrates excellence in Family Practice. The project is an evidence-based undertaking designed to recommend an interdisciplinary assessment program for family practice in Ontario. Based on extensive research, environmental scan, and information gathered from visiting sites in Australia, New Zealand, and Europe, a set of Quality assessment indicators / tools were developed. They have been piloted (Phase 2), and field tested (Phase 3) with a number of FHTs in Ontario. Since this work was completed in 2008, a Delphi study was initiated to validate and fine-tune the Quality tool / indicators. This process was finalized in June 2009, resulting in a re-write of the indicators and re-grouping them into categories that are better aligned with the CIHI and the OHQC quality definitions. An updated version of the tool will be available in early 2010. The Quality Project now has four concurrent projects underway: Delphi study, Strategic Planning, Quality in McMaster Family Practice implementation within the FHT Collaborative Initiative, and Quality e-Learning Project. Phase 5: OCFP has taken lead to develop educational template to help with better understanding and management of the indicators.

Timeframe	Leads	Funder	Tools	KT	Contact
Ongoing since 2000 (started with 1999 visited by Ronald McFitter)	McMaster University, Department of Family Medicine in collaboration with OCFP Cheryl Levitt, has been Project Leader and PI until recently when taken over by David Price Phase V: OCFP taking lead in developing educational template (Anthony Levison & Linda Hiltz)	Originally was $250,000 MOHLTC funding (through PHCTF); Now $500,000 shared between MOHTC & OCFP Phase I: 2003-2005 PHCTF (with OCFP) Phase II: 2005-2006 MOHLTC Phase III: 2007-8 MOHLTC 2008-2009: MOHLTC – Health Force Ontario Recent: David Price has received about a $500,000 from MOHLTC to expand the Quality project into the six academic sites and develop capacity in those sites to run an assessment within their own units	Hamilton Quality Assessment tool (see website); Rewritten tool will be available on the web for download + purchase as a book through McMaster Express Printing	Extensive library of Quality presentations, publications, newsletters, & other documents on website; Annual reports to MOHLTC; Canadian Family Practice journal March 2010 (David Price); Quality Book of Tools: Cheryl Levitt lead with co-author Linda Hiltz	www.qualityinfamilypractice.com

17	Resident First Initiative

This is one of the Ontario Quality Health Council's responses to the long term care sector to engage a number of stakeholders in meeting the public reporting piece on quality care in the sector. Developed in response to a ministerial request to report on QI; Focused on QI skill development and Improvements in variety of different clinical areas; 15 improvement facilitators hired with goal of developing a cadre of QI facilitators for LT care sector

Timeframe	Leads	Funder	Tools	KT	Contact

Starting in 2010	Ben Chan, OHQC	Multi-year MOHLTC	advanced access QI Guide for LT care Homes Check website for QI tools in near future	Website not available yet	Ben Chan

18	Violence Reduction Project				
Web-based program being developed by the OCFP in response to recommendations made by an inquest into the workplace death of an RN in Windsor, ON. Comprehensive literature review and collaboration with an architect examining ideal workplace design to minimize violence in the workplace. Will include focus groups with staff re: workplace redesign. Secondarily, will provide a web-based program to help staff identify patients whose behaviour may pose a risk.					
Timeframe	**Leads**	**Funder**	**Tools**	**KT**	**Contact**
Starting in 2010	OCFP in collaboration with Dept of Family Medicine, McMaster University + # of other FHTs throughout ON	MOHLTC Workplace Safety envelope $250,000 + in-kind from OCFP	To be determined, including web-based interactive educational programming	forthcoming	OCFP

19	The Change Foundation Projects				
The Change Foundation is an independent health policy think tank that supports health system integration and quality improvement in home and community care in Ontario. The quality improvement research agenda includes initiatives to improve the continuity of care among health-care sectors and to contribute to evidence-based decision-making home/community care, one of several areas of concentration committed to in the Foundation's strategic plan for 2007-2010. For more on Change Foundation research agenda on home and community-care as of June 2009, see http://www.changefoundation.ca/docs/QIResearchAgenda.pdf					
Timeframe	**Leads**	**Funder**	**Tools**	**KT**	**Contact**
Current & ongoing	The Change Foundation	internal	n/a	See website	www.changefoundation.ca

20	Using Computerized Decision Support in Primary Care

Based on the COMPETE project; computerized decision support tracker integrated into EMR; COMPETE is the original electronic health research group in Canada and has the largest experience with implementation and evaluation of electronic decision support for patients and providers in the country. COMPETE I focused on successful implementation of Electronic Medical Records (EMRs) in small, community-based primary care offices. COMPETE II developed a decision support tool (CII Diabetes Tracker) for the high priority and costly chronic disease, diabetes, then tested it combined with automated telephone reminders, in a large randomized trial.COMPETE III built on the research initiated in COMPETE I and II. This next stage of investigation was broadened to vascular risk— diabetes, hypertension, cholesterol, previous heart attack or stroke. The electronic health care network was also expanded beyond patients and primary care providers to include specialists and Clinical Care Coordinators. The focus was to optimize patient-clinician interactions with the support of the technology to enhance the quality, safety and efficiency of care.

Timeframe	Leads	Funder	Tools	KT	Contact
COMPETE dates back to 1997; 10 year project with different phases	Multiple agencies; Anne Holbrook, PI with 11 co-investigators (see website for details)	Multiple Funders: Health Canada, Ontario MOHLTC, CIHI; peer-reviewed grant support for each phase	multiple see website for details	see website for multiple publications list accurate 1998-2007	www.compete-study.com

21	Web-based Patient Self-Management

Uses a patient-controlled health record module (MYOSCAR) to enhance QI in cardiovascular care; ran pilot with 50 people randomized to use tool or not to determine feasibility, ability to use tool, BP records; overall very happy with tool but no changes in BP recorded

Timeframe	Leads	Funder	Tools	KT	Contact
2008-2009	MOHLTC Lisa Dolovich, co-lead	MOHLTC $200,000 under Enhancing Quality in PHC (EQPHC)	the MYOSCAR program itself is the tool	no publications yet; abstracts NAPCRG; systematic review done for the project and overview of pilot work	www.myoscar.org

APPENDIX G
Table 5: QI-PHC Capacity Map for Ontario

Table 5

Project	FTE & Role	Location	Funder
Programs for Long-Term QI-PHC Capacity Building			
1. AOHC QI-Related Training Decision Support in Primary Care	4.0 FTE AOHC Education and Development team	Toronto	AOHC/MOHLTC
2. A Review of the Trends and Benefits of Community Engagement and Local Community Governance in Health Care	# FTEs not identified; written by Ktpatzer Consulting	AOHC & Ktpatzer Consulting in Toronto	AOHC
3. Building Better Teams: Learning from Ontario Community Health Centres	# FTEs not identified; Collaboration between Canadian Alliance of Community Health Centre Associations (CACHA) and AOHC;	AOHC Toronto CACHC Ottawa	AOHC & CACHA
4. CHC Logic Model	Unidentified portion of AOHC performance management staff roles	Toronto	AOHC
5. Complexity of Care Project Study	0.4-0.5 FTE of South West Region RDSS role	London	AOHC
6. Eastern Region CHC Performance Management Workshop	Unidentified portion of eastern RDSS position	Ottawa	AOHC In collaboration with partners
7. Eastern Region Quality Improvement Workshop Spring 2010	Unidentified portion of eastern RDSS position	Ottawa	AOHC In collaboration with partners
8. Implementing Dashboards Across CHCs	Unidentified portion of AOHC staff & all 4 RDSS roles	Toronto	AOHC
9. Intraprofessional Data Management Committee at Gateway CHC	Unidentified portion of Eastern RDSS role + Gateway CHC Executive Director & Data Management Coordinator roles	Tweed	Gateway CHC
10. Panel Size Study	0.3 FTE of South Western Region RDSS role	London	AOHC
11. Performance Management	1.0 FTE Manager, Performance Management AOHC	Toronto	AOHC
12. Quality Assurance & Accreditation	Unidentified portion of AOHC Manager, Performance Management + Manager, Education & Capacity Building roles	Toronto	AOHC
13. Quality Oversight in Ontario CHCs	Unidentified portion of AOHC staff roles	Toronto	AOHC
14. Regional Data Consortium	Unidentified portion of AOHC Manager, Performance Management & RDSS roles	Toronto	AOHC

Table 5

Project	FTE & Role	Location	Funder
15. Regional Decision Support Specialist Positions (RDSS)	4.0 FTEs of RDSS positions (1.0 FTE position vacant at present)	Provincial in 4 CHC regions: northern, eastern, southern & western	Funded by MOHLTC through AOHC; Amt not identified
16. Supporting New Leaders in Teams	Unidentified portion of AOHC Education & Capacity Building Team	Toronto	AOHC
17. CCO's Primary Care Strategy	Not identified specifically; 2.0 FTE staff leads in partnership with 13 volunteer regional leads as of April 2010	CCO in Toronto with province-wide partnerships	CCO
18. IN-SCREEN (or Integrated Screening)	Not identified	Not identified	MOHLTC, portion of $193 million colon cancer sponsorship program; primary care program portion $650,000 annually
19. Quality in Primary Care - Grand Rounds with Dr. Richard Grol: A Lifetime Involvement in QI	No assigned FTEs	webcast	Hosted by cancer Care Ontario
20.CPSO Peer Assessment Program	Not reported	CPSO in Toronto with peer assessors province-wide	CPSO
21. Quality Improvement and Innovation Partnership (QIIP) Learning Collaboratives and Learning Community	1.0 Director, QI 1.0 Manger, QI Initiatives and Coaching 16.0 FTE QI Coaches 1.0 FTE Co-leads QI and Clinical Integration	Active learning cycles/learning sessions and regionally based support to PHC teams across the province	MOHLTC
22. Evaluation of QIIP Practice Facilitator Role	1.0 FTE Project Manager + unidentified FTEs for Research support staff	Kingston (Queen's University)	MOHLTC $223,400
Time-Limited QI-PHC Activities			
1. Better Innovations Group (BIG)	unidentified	Kingston (Queen's University)	Internal, Dept of Family Medicine
2. CHAP	4.0 FTE researchers; 10.0 FTE in communities for program delivery	Hamilton (McMaster) & Ottawa (EBRI)	Not identified

Table 5

Project	FTE & Role	Location	Funder
3. CHQI	No FTEs identified; roles include: 1 executive Director 1 Senior QI Consultant 1 Office Manager ! Admin Assistant 12 QI Consultants	Toronto	MOHLTC; The Change Foundation
4. Collaborative Mental Health Care Network Mainpro© C Program	Now absorbed within OCFP staffing roles	Toronto (OCFP)	MOHLTC, Mental Health Division grant initially; program of OCFP now
5. CQIO	Not reported; short term event	n/a	Not reported
6. e-Learning to Enhance Quality Assessment Competencies	Unidentified (under Quality in Family Practice project—see # 18)	Hamilton (McMaster)	unidentified
7. Group Health Centre	No projects in particular detailed; ++ capacity within center staff for multiple QI projects	Sault St. Marie	n/a
8. IDOCC	3.5 FTE facilitators + IDOCC project manager, project coordinator and research associate; remainder of HR provided by the practice as part of day-to-day work	Champlain LHIN area; Ottawa	MOHLTC $4 million; Champlain LHIN; and sponsored in part by Pfizer Canada Inc.
9. IMPACT	4.0 FTE research staff; 3.5 FTE Pharmacists	Hamilton (McMaster); Ottawa (EBRI); Vancouver (UBC)	$2.5 million PHCTF 2004-6; MOHLTC now as program
10. IMPROVE	Not identified	London	MOHLTC Enhancing Quality in Primary Health Care Program; ICES support
11. Improvements in Pain Management Project	0.1 FTE project design staff; most work absorbed by existing staff (2 physicians, 1 pharmacists, 1 OT, 1 social worker); 1.0 FTE existing Occupational Therapist specializing in pain management	Hamilton	Dept of Family medicine $100,000
12. Partnership for Health, Southwest LHIN	Not clearly identified; involves program staff, research staff	London; Southwest LHIN	Ministry of Finance in partnership with

Table 5

Project	FTE & Role	Location	Funder
			MOHLTC
13. Primary and Community Care Committee (PCCC)	Not identified	Not identified	MOHLTC & OMA
14. Quality Improvement Strategic Pillar: University of Toronto School of Family Medicine	Absorbed internally in regular staffing	Toronto	U of T
15. Quality Indicator Project	Not specifically identified other than research assistants	Kingston (Queen's University)	MOHLTC
16. *Quality* in Family Practice Project	1.0 FTE admin assistant since 2006; 1.0 FTE Quality Project planning Coordinator since 2008; Main research supports provided through faculty FTEs	Hamilton (McMaster)	Originally was $250,000 MOHLTC funding (through PHCTF); Now $500,000 shared between MOHTC & OCFP
17. Resident First Initiative Ontario Health Quality Council (OHQC) work with long term care	15 FTEs QI facilitators	Throughout province	Not provided
18. Violence Reduction Project	Not identified (2010 start)	Not identified	MOHLTC Workplace Safety envelope $250,000 + in-kind from OCFP
19. The Change Foundation Projects	Not identified (project-specific)	Not identified	Not identified
20. Using Computerized Decision Support in Primary Care	Not identified; varied depending on phase	virtual	Multiple Funders: Health Canada, Ontario MOHLTC, CIHI; peer-reviewed grant support for each phase
21. Web-based Patient Self-Management	2.0 FTEs to run project; 0.2 FTE for system support	virtual	MOHLTC $200,000 under Enhancing Quality in PHC (EQPHC)

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