



# Toolkit to Support the Implementation of Quality-Based Procedures

# Forward

The Ontario Hospital Association (OHA) has been a strong supporter of the *Excellent Care for All Act* (ECFAA) and associated strategy since their introduction, because they are important to the continuous quality improvement efforts underway in Ontario's health system. In particular, we support initiatives which optimize value and quality for patients through evidence-informed care. We are seeing this through Ontario's Health System Funding Reform – a process of system-wide transformation which seeks to change how health care providers are reimbursed for their services – of which Quality Based Procedures (QBP) are an important component.

The successful implementation of QBPs is integral to this transformation, and the OHA is doing its best to support hospitals during implementation, including the development of educational resources such as this toolkit. I am pleased to present the *Toolkit to Support the Implementation of Quality Based Procedures*, which I hope will serve as a roadmap for hospitals to support them with the application of the Clinical Handbooks and the QBP implementation process.

No journey is without its challenges. However, we can learn from each other and benefit from the lessons and successes of other jurisdictions that have gone down this path. I would like to acknowledge the tremendous work of Health Quality Ontario (HQQO), the Clinical Expert Panels, and the Ministry of Health and Long-Term Care (MOHLTC) for the development of the Clinical Handbooks, which were designed to guide providers through the clinical implementation and evidence driving each QBP. They are a rich and valuable resource for hospitals.

I would also like to take this opportunity to recognize Ontario's hospitals for their commitment to the successful transformation of the system. The planning, mobilization, and leadership required to bring about such a significant change cannot be underestimated.

Finally, I would like to thank all OHA members and system partners who have generously provided their insight during the development of this toolkit.

As we continue on this journey, I firmly believe that ECFAA's principles of integration and its primary focus on quality must remain a strong foundation and driving force for change – our success and the care of our patients depend on it.



Anthony Dale  
Interim President and CEO  
Ontario Hospital Association.

# Disclaimer

This toolkit has been prepared by the Ontario Hospital Association (OHA) to be used as guidance when implementing the *Congestive Heart Failure (CHF)*, *Chronic Obstructive Pulmonary Disease (COPD)* and *Stroke* Quality-Based Procedures (QBPs). Sections of the toolkit can also be used to guide the implementation of future QBPs. Through the work of the OHA's QBP Implementation Advisory Group, members of the QBP Clinical Expert Panels reviewed this toolkit including the implementation tools included herein. Any revisions and/or additions to this document will be vetted by the Clinical Expert Panels.

The materials in this toolkit are for general information purposes only and should be adapted to the circumstances of each hospital. The OHA recognizes that individual hospitals will have unique circumstances for each type of clinical procedure, as well as different clinical team composition and staffing capacity related to support functions, such as decision support, project management and information technology. As such, the OHA advises hospitals to seek their own advice and opinion when developing their organization's approach and plans for implementing QBPs.

The OHA assumes no responsibility or liability for any harm, damage or other losses, direct or indirect, resulting from any reliance on the use or the misuse of any information contained in this toolkit.

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# Acknowledgements

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The OHA also acknowledges the contribution of the hospitals that were interviewed in the process of developing the toolkit. These are:

- Brockville General Hospital
- Grey Bruce Health Network
- Hamilton Health Sciences
- London Health Sciences Centre
- Norfolk General Hospital
- Orillia Soldiers' Memorial Hospital
- St. Michael's Hospital

All stakeholders interviewed are listed in [Appendix B](#).

# Table of Contents

Chapter 1: The Need to Understand QBPs	1
Chapter 2: Structuring Your Organization for Success	6
Chapter 3: Roadmap to Implementation	11
Chapter 4: Monitor and Adjust	26
Chapter 5: Considerations for Boards	28
Appendices	30

## Objective

To provide an overview on:

- The background and expected objectives of QBPs
- Why the toolkit was developed
- The information included in the toolkit

## Target Audience:

- Senior management and/or QBP project teams

# Chapter 1: The Need to Understand QBPs

## Background to QBPs

Ontario's Excellent Care for All Strategy has initiated a greater focus on healthcare quality and quality improvement in Ontario. This provincial strategy is based on four central principles intended to improve the quality of care across the system:

- Care is organized around the person to support their health
- Quality of care is supported by the best evidence and standards of care
- Quality and its continuous improvement are critical goals across the health care system
- Payment, policy and planning **support quality and efficient use of resources**

These principles reflect the key attributes of successful improvement in high-performing health care systems described in Dr. Ross Baker's influential book, "High Performing Healthcare Systems – Delivering Quality by Design (2008)." In his book, Dr. Baker analyzed seven health care systems – including two in Canada – that have successfully used quality improvement tools and knowledge management strategies to transform their health delivery.

The common attributes of these systems include leadership; incentives and accountability; an engaged clinical workforce; a quality culture that supports learning, strategy and policy; and strong information and data to drive improvement.

Introduced in June 2010, the *Excellent Care for All Act* (ECFAA) is a landmark piece of legislation that underpins the Excellent Care for All Strategy. The legislation helps "define quality for the health care sector, reinforces shared responsibility for quality of care, builds and supports boards' capability to oversee the delivery of high quality care, and ensures health care organizations make information on their commitment to quality publicly available".<sup>1</sup> Under ECFAA, quality is defined as a system that is accessible, appropriate, effective, efficient, equitable, integrated, patient-centred, population health-focused, and safe.

The creation of this legislation and strategy are meant to more closely link quality and evidence-based care, and to strengthen the relationship between the delivery of high-quality care and fiscal sustainability through Health System Funding Reform (HSFR).<sup>2</sup> The goal for HSFR is to promote quality and improved outcomes and create a more equitable allocation of resources. Many countries around the world, including Australia, Germany, Denmark and the United Kingdom (U.K.), have used funding as a lever for change. Over the past two decades, these models have been associated with successes in decreasing wait times/ improving access to care, reducing unit costs per admission, reducing variation in both costs and clinical practice and, most importantly, improving quality.

<sup>1</sup> Ontario Ministry of Health and Long-Term Care.

<sup>2</sup> Ibid.

As part of this reform, funding is tied more directly to quality of care and uses evidence to determine what the best care is for patients. It aims to enhance the system by linking funding, policies and accountability, in order to provide more patient-centred care.

In Ontario, there are two key components to HSFR:

- **Health Based Allocation Method (HBAM)**, which will be leveraged to provide organizational-level allocations informed by case-mix utilization and aggregate cost, volume and types of patients and providers.
- **Quality-Based Procedures (QBPs)**, wherein health care providers are reimbursed according to the types and quantities of patients they treat, using evidence-informed rates that are associated with the quality of care delivered.<sup>3</sup>

QBPs are specific clusters of patient services that offer opportunities for health care providers to share best practices and will allow the system to provide even better quality care, while increasing system efficiencies. By promoting the adoption of clinical evidence-informed practices, clinical practice variation should be reduced across the province while improving patient outcomes to ensure that patients receive the right care, in the right place, at the right time.

These clusters, which are comprised of clinically related diagnoses or treatments, have been identified by an evidence-based framework as providing opportunities for:

- Process improvements;
- Developing innovative care delivery models;
- Clinical redesign;
- Improved patient outcomes;
- Greater standardization in care;
- Enhanced patient experience; and
- Potential cost savings.

QBPs are currently being implemented by the Ministry of Health and Long-term Care (MOHLTC) in annual phases spread over three years. The MOHLTC has begun with acute episodic and transition phases, with the vision to include community and long-term care over the coming years through the work of the Quality in Community Care Reference Table. To-date, a total of 10 groups of patient services have been launched as QBPs.

- **2012:** The first phase focused on the implementation of four QBPs: primary unilateral hip replacement; primary unilateral knee replacement; chronic kidney disease; and cataracts.
- **2013/14:** The second phase includes GI endoscopy; chemotherapy-systemic treatment; vascular (non-cardiac), including elective repair of lower extremity occlusive disease and elective aortic aneurysm repair; congestive heart failure (CHF); chronic obstructive pulmonary disease (COPD); and stroke.
- **2014/15:** The third full stream has yet to be fully confirmed.

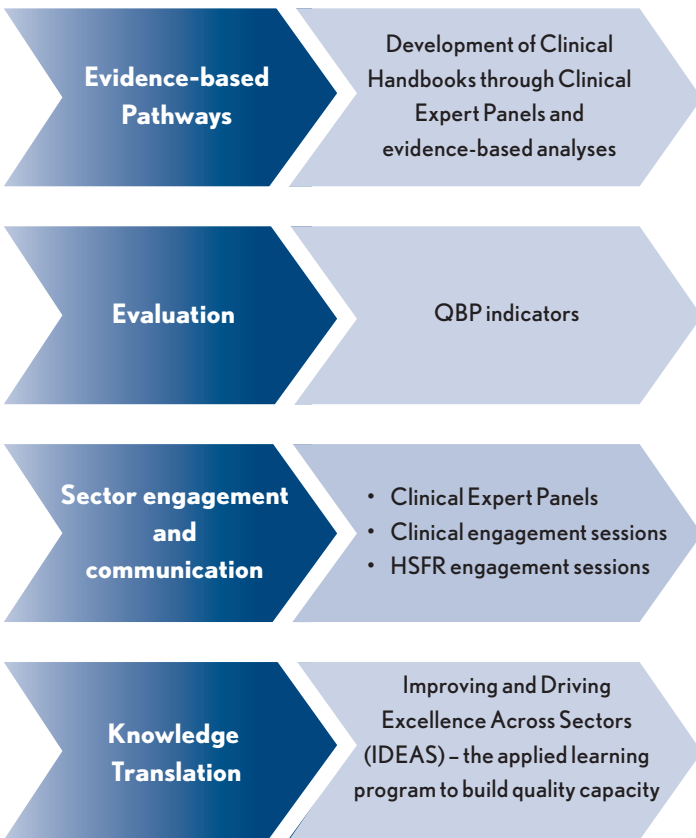
The multi-year QBP implementation is being supported by a number of enablers and resources, including a series of QBP Clinical Handbooks developed by Health Quality Ontario (HQO), Cancer Care Ontario (CCO), and the Cardiac Care Network (CCN) through Clinical Expert Panels. The handbooks are based on the most recent clinical evidence and research, and have been supported by specialized Expert Panels comprised of physicians and other clinicians who are recognized for their experience and knowledge in their respective clinical fields. The handbooks provide detailed information on the pathways that should be implemented to ensure the consistent application of care delivery. The Expert Panels will review and, where required, update the recommended practices, evidence and policy applications, at least every two years.

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<sup>3</sup> Ontario Ministry of Health and Long-Term Care. Available [[here](#)]

The illustration below depicts several key enablers which are driving the provincial QBP implementation strategy:

Figure 1.1: Enablers Driving QBP Implementation



## Why was this toolkit developed?

### 1. To support implementation of the Clinical Handbooks

The Clinical Handbooks can serve as an invaluable resource for hospitals as they consider their approach to the implementation of QBPs. They provide the “evidence based rationale and clinical consensus”<sup>4</sup> associated with each QBP.

<sup>4</sup> Quality-Based Procedures: Clinical Handbooks for COPD, CHF and Stroke. January 2013.

The purpose of this toolkit is to provide a suggested roadmap along with several tools and resources to support Ontario hospitals with QBP implementation and the application of the Clinical Handbooks. The toolkit includes and builds on the guidelines developed by the Clinical Expert Panels with regards to the QBPs, and focuses on the process – the “how to” – for adapting the guidelines to local circumstances.

Although this toolkit is focused on three of the 2013/14 QBPs, namely COPD, CHF and Stroke, it is intended to be broadly applied to the implementation of future QBPs.

### 2. The second wave of QBPs is more complex than the first wave of QBPs

The second stream of QBPs is considered less interventional and episodic in nature, and as a result, hospitals may require additional guidance and support with their implementation. Stroke, CHF and COPD are complex chronic diseases/conditions that require multiple types of health care services across many provider groups/organizations. These factors will have to be carefully considered as an organization develops its approach to successful implementation.

### 3. To share approaches and learn from their peers

A great deal of learning can be gained by sharing information between hospitals and hearing from “peer” experiences and insights. Therefore, the toolkit was developed to share peer learning and includes case studies demonstrating how different sized hospitals have approached the implementation of QBPs to date, which can offer hospitals additional guidance and support.



## How was this toolkit developed?

Through a formal Request for Proposal, the OHA engaged KPMG LLP and PatientOrderSets.Com (POS) to develop the toolkit and associated Regional Sessions. An external QBP Implementation Advisory Group was formed (see [Appendix A](#) for membership) to provide guidance and input into the development of the toolkit and the Regional Sessions. In addition, KPMG and POS conducted a number of interviews with a range of hospital representatives to gather their perspectives on success factors and lessons learned related to previous and current QBP implementation (See [Appendix B](#)).

During these interviews, hospitals identified key success factors in the implementation of the first phase of QBPs including the need to:

- Compare current clinical practices to leading practices;
- Standardize procedures; and,
- Understand cost drivers related to each QBP.

In addition, hospitals emphasized the importance of considering the unique clinical, change and project management approaches to QBP implementation. These two approaches are illustrated in Figure 1.2 below:

To complement the interviews, a number of case studies were put together to outline these key success factors and lessons learned. These are included in [Appendix C](#), [D](#) and [Appendix E](#).

The OHA has committed to reviewing and sharing ongoing QBP updates with members. Please refer to the [OHA HSFR website](#) for on-going updates and information.<sup>5</sup>

## What information will I find in the toolkit?

The toolkit:

- Provides a sequential approach to the implementation of QBPs. For example what are the suggested steps for transforming clinical practices in order to meet leading practice standards? This includes the different roles and responsibilities required within the organization for successful implementation;
- Features a number of case studies that provide information on how a number of Ontario hospitals have approached the implementation of QBPs; and
- Includes a summary of considerations for hospital boards when faced with strategic decisions or approaches with respect to QBP implementation.

Figure 1.2: Clinical, Change and Project Management Approaches to QBP Implementation



5 OHA HSFR Education

## Implementation Considerations for Hospitals

The OHA is aware that there are a broad range of health care organizations in Ontario that are at different stages of their QBP implementation efforts. To reflect the provincial variation in implementation efforts, this toolkit suggests one QBP implementation approach. The material is not meant to be prescriptive, and should only be viewed as a general guide to implementation.

As noted in the Clinical Handbooks:

*“It should be recognized that the practices recommended in this clinical handbook have been defined at an aspirational provincial level to guide all hospitals across the province. This is not intended to be an operational care pathway – individual providers will have to implement these best practices based on their own local circumstances and available capacities. In many cases, the implementation of these recommendations will be challenged by local arrangements or the availability of services.”<sup>6</sup>*

Hospitals will need to make refinements and revisions to the approach based on their unique situation and available resources. For example, some organizations may choose to leverage existing committees to support implementation efforts as opposed to structuring new committees. Some organizations may be able to draw on the expertise of in-house staff in their departments such as Finance, Decision Support, Health Records, etc., while other organizations may not necessarily have these dedicated capacities.

Frequently, single individuals assume responsibility for multiple functions within hospitals, and are, as such, confronted with numerous competing priorities. Senior leadership in these hospitals should remain sensitive to this fact, and be more involved in carefully assessing the requirements associated with successfully implementing the selected QBPs. In such cases, it may be appropriate to engage additional assistance to provide the necessary support. For instance, many local health integration networks (LHINs) may have already taken steps to support QBP implementation among hospitals within their catchment area. It is important that health care providers take advantage of these resources. In situations where QBP implementation may benefit from regional coordination, LHINs may bring together the appropriate health service providers or utilize their Local Partnership Committee, which is part of the MOHLTC’s HSFR Committee Structure.

Despite these differences, every hospital’s approach should ensure that project objectives and timelines are clear from the outset and monitored on a regular basis throughout the course of implementation.

To provide additional insight into the different approaches and various strategies for success, three case studies are featured in [Appendix C](#), [D](#) and [Appendix E](#).

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<sup>6</sup> Quality-Based Procedures: Clinical Handbook for Chronic Obstructive Pulmonary Disease, page 59

# Chapter 2: Structuring Your Organization for Success

## Objective:

### To provide:

- An overview of the structures that will support the successful implementation of QBP
- A proposed team structure and associated roles and responsibilities for team members
- A series of tools and templates to support the organizational structure and set-up for QBP implementation

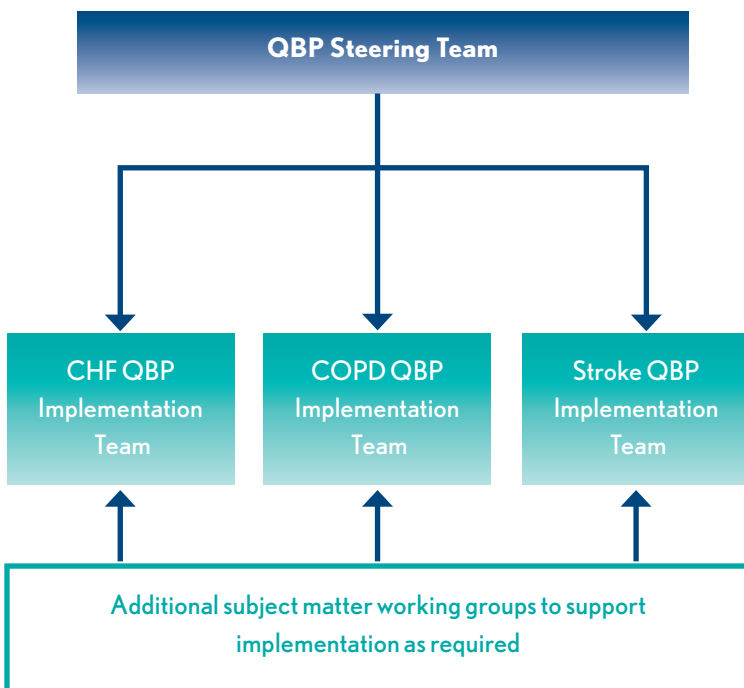
## Target Audience:

- Senior management and/or QBP project teams

## QBP Implementation Structures

The following approach is proposed as a way to structure the organization's implementation process. Organizations may need to make modifications to this approach based on their staffing mix and resource capacity.

Figure 2.1: QBP Implementation Structure



## The organizational structure requires:

1. A steering team, and
2. QBP-specific implementation teams

These are illustrated below:

- **Team leader/executive sponsor:** Senior executive accountable to the CEO with an understanding of clinical issues
- **Other team members:** representatives from clinical programs, finance, decision support, health records, quality and professional practice

- **Team leader:** experienced clinical leader (e.g., program lead)
- **Other team members:** multidisciplinary and interdepartmental (where appropriate) subject-matter experts (e.g., physicians, nurses, other clinicians, finance, decision support, IT) and allied health partners

## Associated Roles, Responsibilities, Tools and Supports for the Steering Team

### Roles and Responsibilities of the Steering Team:

- Govern and support the pace of all QBP
- Provide leadership and direction to the QBP strategy and implementation teams
- Champion the organization's implementation and transformation of QBP
- Develop a corporate approach to the implementation process, including identifying the relationship between the steering team and all related QBP-specific implementation teams
- Steward and support the QBP-specific implementation teams
- Prioritize the QBP implementation process
- Remove barriers to implementation and manage unique challenges
- Establish timelines and accountabilities for the implementation teams
- Ensure that the necessary resources are available to the implementation teams
- Monitor the performance of the implementation teams

#### Steering Team considerations:

*"Through what lenses do we approach this change (for example, quality, funding, standardization, sustainability)?"*

*"What should the role of executives/senior leadership or management be in the implementation of QBP?"*

*"Who, how, and when do we engage the right people and how do we manage any resistance to this engagement?"*

*"Is the quality and availability of the data sufficient to support the QBP implementation?"*

- Facilitate the appropriate communication with all stakeholders, both internally (i.e., report to the senior leadership and board on progress) and externally (i.e., Local Health Integration Networks (LHINs), Ministry of Health and Long-Term Care (MOHLTC), unions, professional associations, and allied health partners)

### Tools and Supports:

- a) **Terms of reference:** Includes the mandate of the group, team roles and responsibilities, key milestones, timelines, and a communication strategy.

#### [See Appendix F for a sample terms of reference](#)

- b) **Project charter:** Defines the mandate and function of the steering team and is an agreement between the steering team members, executive sponsor, and stakeholders. A project charter can be used as a tool to communicate the objectives and scope of the program, and to guide the team members throughout the QBP implementation process. The charter should also define the working relationship between teams.

The project charter may include the following sections:

- i. **Project Purpose and Intent:**
- Overview of the steering team's goals and objectives
  - Alignment of objectives with overall organizational direction
  - Team outcome expectations
  - Measurement of expectations
- ii. **Scope:** determine what is in and out of scope for the steering team

### Sample project purpose and intent:

- Our QBP steering team will provide leadership, direction and support to the QBP implementation teams in our hospital.
- The work of the steering team will ensure that the corporate direction of improving patient outcomes guides the selection, prioritization, communication, and implementation of the QBPs within the hospital.
- The steering team will provide guidance regarding the level of adherence to clinical guidelines and funding formula required in our hospital overall, and with every QBP implementation.
- Our measure of success is the level of satisfaction that the QBP implementation team has with the support we are providing in the areas of project structure, data analytics, priority setting, and roadblock removal that will speed up the successful implementation of the QBPs within our hospital.

### In Scope:

Communications and engagement throughout the hospital on QBPs;

- Identifying risks and opportunities and present these to the executive teams and the hospital board;
- Prioritization of QBPs;
- Resourcing, conflict identification and resolution;
- Timelines for completion;
- Minimum project structure requirements (status reporting, project plans, implementation gates, and communication plans); and
- Recommendations with respect to QBP transfer, if appropriate.

### Out of Scope:

- Decision on QBPs' transfer to other institutions; and
- Decisions on changes to programs and services at the hospital (e.g., closing an ambulatory service).

- c) **Communications plan:** Defines the organization's engagement strategy and may include:
- Organization's short and long-term goals associated with QBPs;
  - Expected and potential impact of HSFR and QBPs on the hospital, including risks and mitigation strategies;
  - Timelines;
  - Key messages;
  - Stakeholders impacted by the change;
  - Relative impact of QBP implementation on the stakeholder groups to determine their communication needs; and
  - Frequency of interactions with stakeholders.

*See Appendix G for a draft communications plan template*

## Associated Roles, Responsibilities, Tools and Supports for the QBP-specific Implementation Team

### Roles and Responsibilities of the QBP Implementation Teams:

- Lead the implementation of QBP
- Work closely with the steering team to communicate roadblocks, needs, successes and other supports, as required
- Facilitate the planning, execution and delivery of the implementation plan including all phases of the design and execution
- Champion the QBP adoption process
- Understand any organizational-wide resource constraints and resource additional workload, as feasible
- Determine, implement and monitor the desired practice changes based on the Clinical Handbooks
- Monitor the QBP implementation plan and related outcomes

*See Appendix H for suggestions regarding the QBP-specific implementation team members*

### Tools and Supports:

The tools and supports to assist the QBP-specific implementation teams are included throughout the toolkit. Examples of these include:

- Current state pathways and process mapping/heat map;
- Identified peer best practices; and
- Sample QBP pathways, clinical order set checklists, and protocols.

### Working Relationship between Steering Team and QBP-specific Implementation Team

The QBP-specific implementation team should expect a commitment from the steering team and executive leadership to provide advocacy, support, and resources. Specifically, the steering team should facilitate the efforts of the implementation team by:

- Staggering QBP teams' work according to organizational priority and resources;
- Removing barriers to implementation and managing unique challenges;
- Facilitating communication with stakeholders; and
- Expediting the approval standards that the QBP team wishes to implement.

The following are few examples of how the steering team supported the QBP implementation team within hospitals using this structure:

- i. Hip material standardization recommended by the QBP team bypassed several layers of administrative approval within a large hospital because adoption was expedited by the steering team.

- ii. The steering team provided additional Lean resources to support the QBP team in analyzing the flow of a complex patient grouping. The resource facilitated the identification of several flow inefficiencies within the different hospital departments.
- iii. The QBP implementation team recognized that a particular element of their practice is a unique provincial resource. The steering team advocated to the MOHLTC and LHIN about this potential resource for funding consideration and future revision of the QBP guidelines.

### Patient Engagement

Organizations may wish to consider engaging patients as part of their QBP implementation process. Patient engagement could help identify process improvement opportunities and more effective ways to design process steps to support implementation and positively impact the patient experience. The importance of understanding the experience from the patient and family/caregiver's perspective should not be underestimated. Patients can provide critical insights on effective discharge planning/hand-off processes and identify opportunities for strengthening links with community providers. Hospitals may want to consider different types of patient engagement processes appropriate to their patient base, such as:

- Engaging patients as a part of rounds and asking the questions, 'How can we make things better?' and 'What has been your experience so far?' Using these questions, the hospital can develop patient stories that are used to educate staff/clinicians on why changes are required.
- Creating clinically specific patient advisory panels to engage in discussion around what can be improved and/or changed.
- Engaging through the patient advisory committee.
- Engaging patients at discharge to ask questions specifically related to discharge experience.

Challenges in engaging patients may include:

- Identifying representatives of the average patient;
- Engaging patients who are currently experiencing a procedure as they are “too close” to the experience; and
- Undue influence by a minority group of patients whose experience does not represent the norm.

# Chapter 3: Roadmap to Implementation

## Objective:

### To provide:

- An overview of change management considerations
- An overview of the key success factors for implementing QBP
- A suggested approach to guide QBP implementation

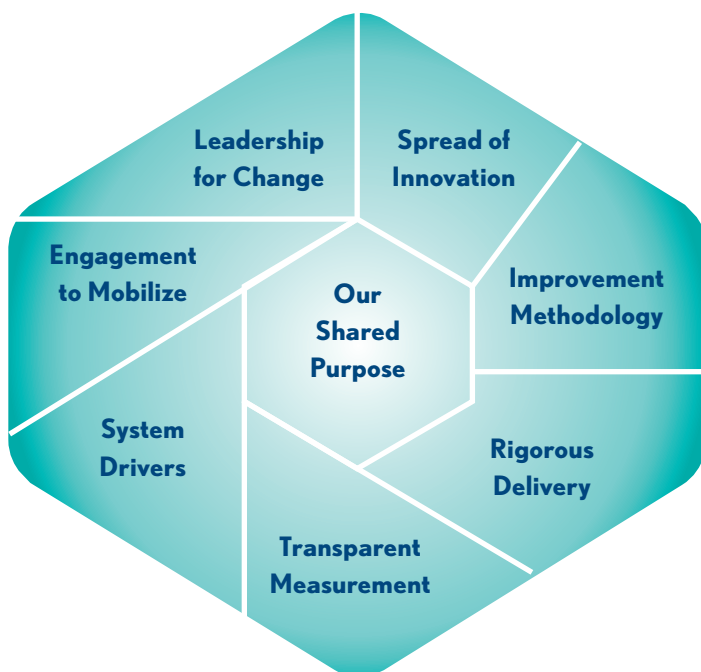
### Target Audience:

- Senior management and/or QBP project teams

## Overview of Change Management Considerations

Change management considerations are particularly significant when implementing an initiative as important as funding reform. The eight components of the United Kingdom's National Health Service (NHS) change model below (Figure 3.1) have been adapted in Ontario to contribute to large-scale improvement in care delivery and to support a shared approach to this significant reform.

Figure 3.1: NHS Change Model



Successful implementation of the QBPs can be facilitated by leveraging these components, in particular:

- Understanding the shared purpose;
- Engaging leadership for change;
- Supporting clinical engagement; and
- Establishing transparent metrics to measure success.

According to this model, hospitals should be able to meet the following change management objectives:

- Articulate a vision of the change;
- Empower administrative and clinical leaders to act as role models by engaging, mobilising and supporting them through all eight components in the model;
- Demonstrate the right behaviours; and
- Bring together the resources needed to enable change.

The process of change is not automatic or built-in. A set of specific organizational processes are required for improvement to occur. Listed below are some of the elements of the organizational infrastructure necessary for improvement:

- The reliable flow of useful information;
- Education and training for staff in improvement theory, methods and techniques;
- Understanding of time and change management necessary to change core processes;



- Alignment of strategic organizational incentives and improvement goals; and
- Leadership to guide and inspire improvement.

In Ontario, improvements are being facilitated through the Improving & Driving Excellence Across Sectors (IDEAS) Strategy. IDEAS is a provincial applied learning strategy, designed and delivered in Ontario for Ontario, to support the health care system in achieving progress on Ontario's system priorities such as QBPs and Health Links.

## Key Success Factors for Organizational Implementation

In approaching the implementation of QBPs, there are a number of key success factors organizations should consider:

1. Senior Leadership Support/Sponsor
2. Clinician Engagement
3. High-quality Data

### 1. Senior Leadership Support/Sponsor

An engaged senior leadership team is a key success factor for effectively implementing QBPs. QBP implementation needs to be a priority for the CEO, as well as other members of the senior team, in order to achieve sustainable change. Evidence suggests that the leadership style and philosophy most likely to deliver large-scale change is one that fosters the commitment to a shared purpose through collaboration.<sup>7</sup> Senior leaders can support the change culture and vision required to create improvement by sharing and cascading this sense of commitment to the rest of the organization. Senior teams should provide clear and consistent messaging about the implications of QBP implementation and the need to focus on clinical aspects and improving quality of care.

<sup>7</sup> National Health Service. Change Model. Available [here]

Across Ontario, different leadership models have been developed to oversee QBP implementation. Potential examples for the senior lead include the CEO, CFO, CIO, or Vice President responsible for clinical programs. Given the need to emphasize the clinical and quality issues associated with the respective QBPs, it is suggested that an individual possessing an *executive role AND clinical knowledge* act as the Executive Sponsor to oversee QBP implementation.

On an ongoing basis, progress regarding QBP implementation should be discussed regularly at senior team meetings. Metrics for gauging success should be developed and used as a framework for assessing progress and to identify potential risks as early as possible. The Executive Sponsor should be clear about their role, responsibility and accountability for the agreed-upon organizational goals.

#### Implementation Considerations for Executives

*"What should the role of executives/senior leadership or management be in the implementation of QBPs?"*

*"Who, how, and when do we engage the right people and how do we encourage buy-in for this change?"*

*"Are the quality and availability of the data sufficient to support the QBP implementation?"*

### 2. Clinician Engagement

Strong clinician leadership and governance are critical for quality improvement efforts and for continuously improving the quality of patient care. A common theme in the feedback from hospitals that have implemented QBPs is the importance of effective clinician engagement. Regular and frequent communication with clinicians is vitally important throughout the implementation of QBPs. Plans for improvement must be owned and understood by the chief decision-makers with respect to patient care. This

requires creating teams of physicians (and other clinicians) engaged in patient care who can design and champion improvement.<sup>8</sup>

From the outset, staff, physicians and other clinicians should be provided with sufficient information that will help them understand the importance of this initiative, especially its impact on patient care, and its link to key Ministry of Health and Long-Term Care (MOHLTC) directives. As stated in the Clinical Handbooks, “clinical leaders play an integral role in the [QBP implementation] process. Their knowledge of the patients and the care provided or required represents an invaluable component of assessing where improvements can and should be made.”<sup>9</sup>

*“Building bridges between clinicians and administrators will be the hardest part for hospitals. It must be understood that QBPs are not just clinical, but financial, and they are not just financial, but clinical!”*

*Director of Quality Care, Academic Hospital*

This applies not just to staff associated with specific QBPs, but to all clinical and support staff in the organization. While it is recognized that this may be a challenge, every organization must dedicate resources to communication with staff in a way that ties in with an organization’s unique culture. Organizations that have been largely successful at implementing the first wave of QBPs have dedicated a significant amount of time and resources to the education of clinical staff through workshops, educational sessions, updates at Medical Advisory Committee (MAC), and other clinical professional forums.

The need to focus on clinical engagement cannot be understated because the organizing principle of QBPs is the positive enhancement of the delivery of clinical care.

8 Sawka, C., Ross, J., Srigley, J., Irish, J. The Crucial Role of Clinician Engagement in System-Wide Quality Improvement: The Cancer Care Ontario Experience. *Healthcare Quarterly*, 15 (Special Issue). December 2012.

9 Quality-Based Procedures: Clinical Handbooks for COPD, CHF and Stroke. January 2013.

An organization may consider using QBP champions to enhance and support clinician engagement. These individuals should be well-respected and influential clinical leaders who can support the implementation process, maximize stakeholder buy-in, and help overcome barriers.

While regular reports to the Board, senior management team, MAC and other inter-professional councils will contribute to success, the most critical element is the strength of the clinical groups addressing each of the QBPs. This toolkit has addressed the structure associated with these groups in Chapter 2; however, the linchpin to success is the effectiveness of these groups. Their power and influence is remarkable if they are well-led, focused and given the permission to be open and transparent when reviewing current practice patterns and the desired future state.

The Clinical Handbooks are also key to supporting the implementation of QBPs. The QBP champions, in collaboration with the appropriate medical leaders, should engage clinicians in a critical evaluation of practice patterns, and enforce the message that increasing standardization is not meant to impinge on a clinician’s autonomy to make decisions which are best suited for individual patients. Clinical pathways are meant to be guidelines, and it is understood that variations may occur given specific patient needs. Champions should focus on the extensive work that went into the handbooks which have been carefully reviewed by leading clinical experts. They should also deliver a clear message that this is not a cost-cutting initiative, but a quality initiative.

#### *Dealing with Potential Barriers*

It is important to be sensitive to the responses of those who may feel challenged by changes to their practice and provide the necessary support, while at the same time, being clear and consistent that this change is about continuous clinical improvement in alignment with the MOHLTC’s direction to provide high-quality, safe and effective care to patients.

Nevertheless, feeling hindered by change is normal and should be expected. The graphic in Appendix I illustrates some of the reasons that may contribute to these feelings – for example fear of the unknown or feeling a loss of control, can differ from one stakeholder to another, and should be isolated to help identify appropriate mitigation strategies.

### 3. High-quality Data

The establishment of QBPs provides organizations with the opportunity to bring clinicians and key support departments together with a view to improving **quality of care**, while maximizing the effective use of available resources. In order to make informed and accurate decisions, the importance of high-quality data cannot be emphasized enough. Without good data, working groups will be stymied by the inability to make the necessary progress.

As a first step, organizations should review the quality of their clinical, financial and statistical data, and ensure that they are as robust and as reliable as possible. In some cases, there may be multiple sources of data, which should

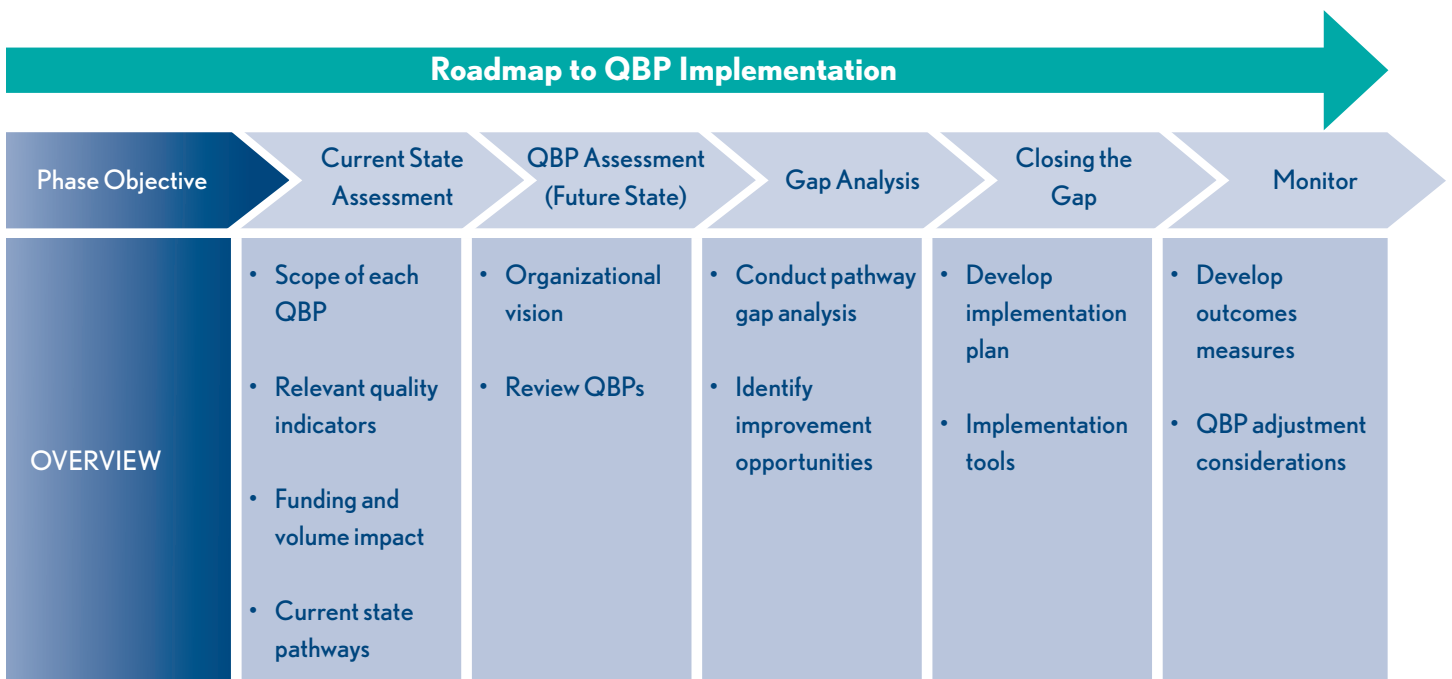
be reconciled prior to any data review (e.g., data from the Discharge Abstract Database vs. data from the acute care census reports). Examples of the type of data to consider may include:

- Types and number of interventions
- Types of medications prescribed
- Patient co-morbidities
- Hospital mortality
- Admission rate
- Staffing models/skill mix

### Suggested Roadmap to QBP Implementation

As noted in Chapters 1 and 2, the Clinical Handbooks provide the detail supporting the leading practices related to each QBP. It is important to recognize that there is no “one” way to address QBP implementation. Within this section of the Toolkit, one approach to QBP implementation is provided (see Figure 3.2). Hospitals may wish to apply the relevant parts of this approach to their organization, and customize it according to their size, capacity, and where they are in their funding reform journey.

Figure 3.2: Roadmap to QBP Implementation



## Current State Assessment

To conduct its current state assessment, hospitals may need to examine the following:

1. Scope of each QBP
2. Current state pathways
3. Relevant quality indicators
4. Funding and volume impact of QBPs

### 1. Scope of each QBP

During the development of the Clinical Handbooks, each Clinical Expert Panel was tasked with defining the inclusion and exclusion criteria for the cohort of patients associated with the QBP based on routinely reported administrative databases.

The Clinical Handbooks for CHF, COPD and Stroke all contain recommended cohort definitions and patient grouping approach, including specific inclusion/exclusion criteria for QBP funding purposes. For example, the CHF QBP defined the patient cohort using the following ICD-10-CA diagnosis codes, diagnosis types, and ICD-10 CCI (Canadian Classification of Health Interventions) exclusion criteria:<sup>10</sup>

- **Age:** Age greater than or equal to 20 years at time of admission.
- **Diagnosis codes:** The ICD-10-CA most responsible diagnosis codes are listed below. I50.x Heart failure, left ventricular dysfunction, etc.
  - I40.x, I41.x Myocarditis
  - I25.5 Ischemic cardiomyopathy
  - I42.x, I43.x Cardiomyopathies
  - I11.x plus I50.x (secondary Dx) Hypertensive heart disease plus heart failure, left ventricular dysfunction
  - I13.x plus I50.x (secondary Dx) Hypertensive heart disease and renal disease plus heart failure, left ventricular dysfunction)

- **Intervention – CHF:** Patients in the pathway are not assigned to an intervention-based HBAM Inpatient Grouper (HIG) cell, given the current methodology. (i.e., Major Clinical Category [MCC] partition variable is not “I”)

As a first step, organizations should review the process for defining the patients in the QBP as outlined by the Clinical Handbooks in order to help define the relevant patient cohorts in the episodes of care pathway.

To assist, HQO has also identified a number of implementation priorities for organizations to consider during the first year of QBP implementation. Equipped with their analysis of their patient cohorts relative to those defined in the Clinical Handbooks, the implementation priorities can greatly assist organizations with their focused implementation efforts. These Year 1 implementation priorities can be found in [Appendix L](#).

### 2. Current state pathways

Another step in completing the current state analysis is the development of a current state pathway or, in other words, an understanding of how patients in the relevant patient cohorts/HIG groups currently receive care in the hospital. Pathways provide an identified continuum of care for a specific population or condition which outlines expected evidence-based outcomes that are likely to be achieved due to the care provided.

Organizations will also need to understand the current state of their pathways including an analysis based on the pathway structure which combines both the administrative (e.g., flow of information, coding) and clinical aspects (e.g., episode of care) of the current state.

The performance information that can be relevant to collect at this stage includes: (a) practice statistics heat map, and (b) episode of care pathway.

<sup>10</sup> Quality-Based Procedures: Clinical Handbook for Congestive Heart Failure, page 28.

### How to develop a current state pathway

The approach typically used to develop a current state pathway is to identify the existing, typical episode of care and document:

1. The workflow process from when a patient presents at the emergency room to their discharge;
2. How care is provided and why specific steps are performed;
3. How decisions about care are being made;
4. The guidelines that inform decisions about care;
5. The resources (technologies, pharmaceuticals) that are available and being used; and
6. The existing metrics for performance analysis.

It is important to have a thorough understanding of the range and degree of care variability that are present for each of the QBP-related diagnoses.

### a) Practice Statistics Heat Map

The heat map can be used as a prioritization tool for an HIG or a particular performance dimension (e.g., length of stay or LOS, can be more important than rate of admission).

The practice performance information can be structured as in Table 3.1. It includes quality performance data and a further breakdown of the QBP HIG. The table highlights the ideal performance relative to a provider’s current performance. The ideal is based upon best known performance as outlined in the QBP Clinical Handbooks. Where the current practice corresponds to the ideal, the cell can be highlighted in green; where there is a small gap between current and ideal, the cell can be highlighted in yellow; performance with larger/more significant gaps can be highlighted in red.

Table 3.1: Sample Current State Assessment Heat Map for COPD

QBP			COPD	
Description			139a - Chronic Bronchitis	39b - Chronic Obstructive Pulmonary Disease
Quality	LOS	Current		
		Ideal		
	Hospital Mortality	Current		
		Ideal		
	Readmission	Current		
		Ideal		
	Admission Rate	Current		
		Ideal		
Funding Impact	Number of Cases			
	Cost per Case	Current		
		Funded		
	Funding Gap			

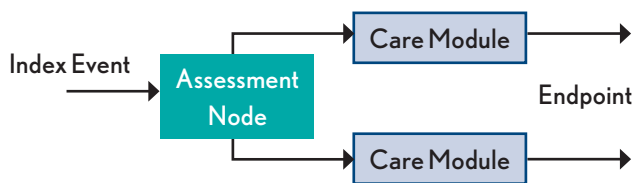
**b) Episode of Care Current Pathway**

Red areas in the current performance heat map can be further analyzed by a more in-depth analysis of the current state pathway. In developing current state pathways, organizations may wish to consider using the definitions which are included in the Clinical Handbooks to define the patient process flow.

Figure 3.3 provides an illustrative example of the episode of care model.

The episode of care pathway model presents the critical decision points and phases of treatment within the episode of care, referred to in the Clinical Handbooks as the clinical assessment nodes and care modules.

Figure 3.3: Episode of Care Pathway Model



<b>Care Pathway:</b>	A schematic representation of an episode of care, including care modules and assessment nodes.
<b>Assessment Node:</b>	A decision point within a care pathway that provides specific criteria to establish the state of a patient and guides stratification down a particular branch of the pathway.
<b>Care Module:</b>	A health service event following an assessment node that is comprised of recommended quality-based practices associated with a particular phase and severity of treatment.

Consider identifying the best performing peer hospitals and define the relative differences in practice, and the factors that may contribute to the gap. Peers can be defined as similarly sized hospitals with a similar practice

within the province or LHIN. MOHLTC resources can be used to identify best performing peers.

**3. Relevant Quality Indicators**

In introducing the QBPs, the ministry has a strong interest in monitoring and evaluating the impact (both intended and unintended) and to provide benchmark information for clinicians and administrators that will enable mutual learning and promote on-going quality improvement. The ministry recognized that reporting on a few system-level indicators alone would not be sufficient to meet the aim of informing and enabling quality improvement initiatives. For that reason, measures meaningful to hospitals and clinicians that are interpretable and have demonstrable value in improving the quality of care provided to patients, were also included.

To guide the selection and development of relevant indicators for each QBP, the ministry, in consultation with experts in evaluation and performance measurement, developed an integrated scorecard based on the policy objectives of the QBPs and a set of guiding principles. This resulted in the creation of a scorecard with the following five quality domains:

- Effectiveness (including safety)
- Appropriateness
- Integration
- Efficiency
- Access

For each of these five domains, a set of evaluation questions was identified and subsequently translated into provincial-level indicators.

The MOHLTC and experts recognized that to be meaningful for clinicians and administrators, it was important to tie indicators to clinical guidelines and care standards. Hence, the advisory groups that developed the best practices were also asked to translate the provincial-level indicators into QBP-specific indicators. Some of these measures are included in Appendix M in draft form. In addition, and for illustration purposes, the table in Appendix N is an example of how key provincial measures were translated into Stroke QBP-specific indicators.

In partnership with its agencies, clinicians and researchers, the MOHLTC is calculating the recommended indicators at the QBP level for which data is readily available. Once calculated and validated by the respective advisory groups and other stakeholders, the results will be shared with hospitals to provide benchmark information. The results will also be summarized at the LHIN and provincial level as baseline information to support the evaluation of QBPs and provide background information to clinicians, administrators and policy decision-makers.

It is prudent for hospitals to review the quality indicators identified in the handbooks as well as the related quality measures that are already accessible within their organizations. Examples of these quality measures may include:

- Risk-adjusted 30-day mortality rate
- Rate of unplanned readmissions within 30 days
- Proportion of patients referred to a heart failure clinic
- Rate of complications
- Discharge destination following acute admission
- Risk-adjusted 90-day readmissions rates
- Time to treatment

Developing an understanding of a QBP’s quality indicators and the organization’s performance against these indicators is critical to ensuring that there is a common understanding of the quality levers that can impact overall performance and cost. In addition, organizations should consider establishing a target for each quality metric based on best practices and/or provincial/LHIN targets. An example of sample quality measures is highlighted below.

Table 3.2: Sample Quality Measures

	QBP level indicator	Actual Performance	Target Performance
<b>Congestive Heart Failure</b>	Length of stay	12 Days	8 Days
	30-day Readmission Rate	5%	1%

The measures included in Table 3.2 are for sample purposes only and intended as examples of how organizations can identify their current performance against a target. The targets included in the table do not reflect any pre-established provincial or LHIN targets.

#### 4. Funding and Volume Impact of QBPs

Each organization will be required to understand the funding and volume impact of QBPs on the hospital.

The MOHLTC provides an interim funding level for each QBP as the product of a Cost per Weighted Case (CPWC) price and the projected volume, which represents the province-wide funding level for each case. Each organization will therefore have to assess its actual costs relative to the CPWC price being funded. The funding surplus or deficit per case implications can be further analyzed by calculating the volume of cases that the hospital performs annually. Multiplying the annual volume and the funding surplus or deficit per case will provide an indication of the total financial impact on the organization.

If there is an estimated shortfall between the actual cost and funding allotted, it is suggested that the organization examine the drivers of this gap (refer to St. Michael’s Hospital case study in [Appendix C](#), to review their response to a potential gap).

In cases of an expected shortfall, organizations can consider the following questions as part of their gap analysis:

- Have we standardized our processes? Are costs impacted by variations in clinical and procedural processes?
- What are the costs of materials? Can we look to group purchasing to drive any discounts?
- Are we coding our data correctly to accurately reflect costs? How do we address any data quality issues?
- Are there too many steps/roadblocks in our processes? Can we apply LEAN methodology to remove “waste” from our processes?
- Is a potential divestment of service required?

The assessment of the potential funding impact may influence the organization’s decision regarding that service. The case studies included in [Appendix C](#), [Appendix D](#) and [Appendix E](#) provide an overview of how different sized hospitals approached a forecasted funding shortfall.

## QBP Assessment (Future State)

Having conducted the current state assessment, hospitals will now be in the position to determine what the future will look like once the QBPs have been implemented. The objective is to build a common understanding of the organization's vision for the future, following implementation of QBPs. As part of the QBP future state assessment, hospitals should consider:

1. Developing the organization's future vision for QBPs
2. Reviewing the Clinical Handbooks and QBP pathways

### 1. Develop the organization's future vision for QBPs

This is the opportunity for the organization to set QBP goals within the context of internal and external realities. To assist, the following questions can be considered:

- For each QBP (e.g., CHF, COPD and Stroke), what are the expected operational and clinical changes to the organization (e.g., in relation to stroke, hospitals may need to reduce practice variations, such as improving transfer processes to integrated stroke centers)?
- What are the overall implications for the hospital in achieving the quality targets of each QBP (e.g., what will we do with the resources that are freed up as a result of a significant reduction in LOS)?
- How will the implementation of QBPs increase collaboration and engagement throughout the hospital and with our wider stakeholders (e.g., multidisciplinary teams or community-based providers)?
- What external changes are expected (e.g., centres of excellence, community-based specialty clinics, designating special care programs, evolving changes in care pathways, demographic changes)?
- What are the requirements of QBP transfers with hospital boards, senior management and LHIN?

### 2. Review QBP Clinical Handbooks

The Clinical Handbooks have been created to serve as a compendium of the evidence-based rationale and clinical consensus driving the implementation approach for each QBP.<sup>11</sup> The handbooks have been prepared for informational purposes only and do not mandate health care providers to provide services in accordance with the recommendations included therein. The recommendations included in the handbooks are not intended to take the place of the professional skill and judgment of health care providers. Using an episode of care model, the handbooks illustrate the pathway of each patient case included in the defined cohort, from initial presentation through segmentation into one of the defined patient groups.

*“While the episode of care model bears some resemblance to a clinical pathway, it is not intended to be used as one for implementation in a particular care setting. Rather, the model presents the critical decision points and phases of treatment within the episode of care.”<sup>12</sup>*

It is essential that organizations review the Clinical Handbooks and the episodes of care in detail. Recognizing that the QBPs are the ideal future state to strive for and that the handbooks were developed by province-wide recognized expert panels, there may be variation at the organizational provider level that needs to be recognized (e.g., unique complex cases not clearly covered, resources not available).

### Example of Future State Pathway

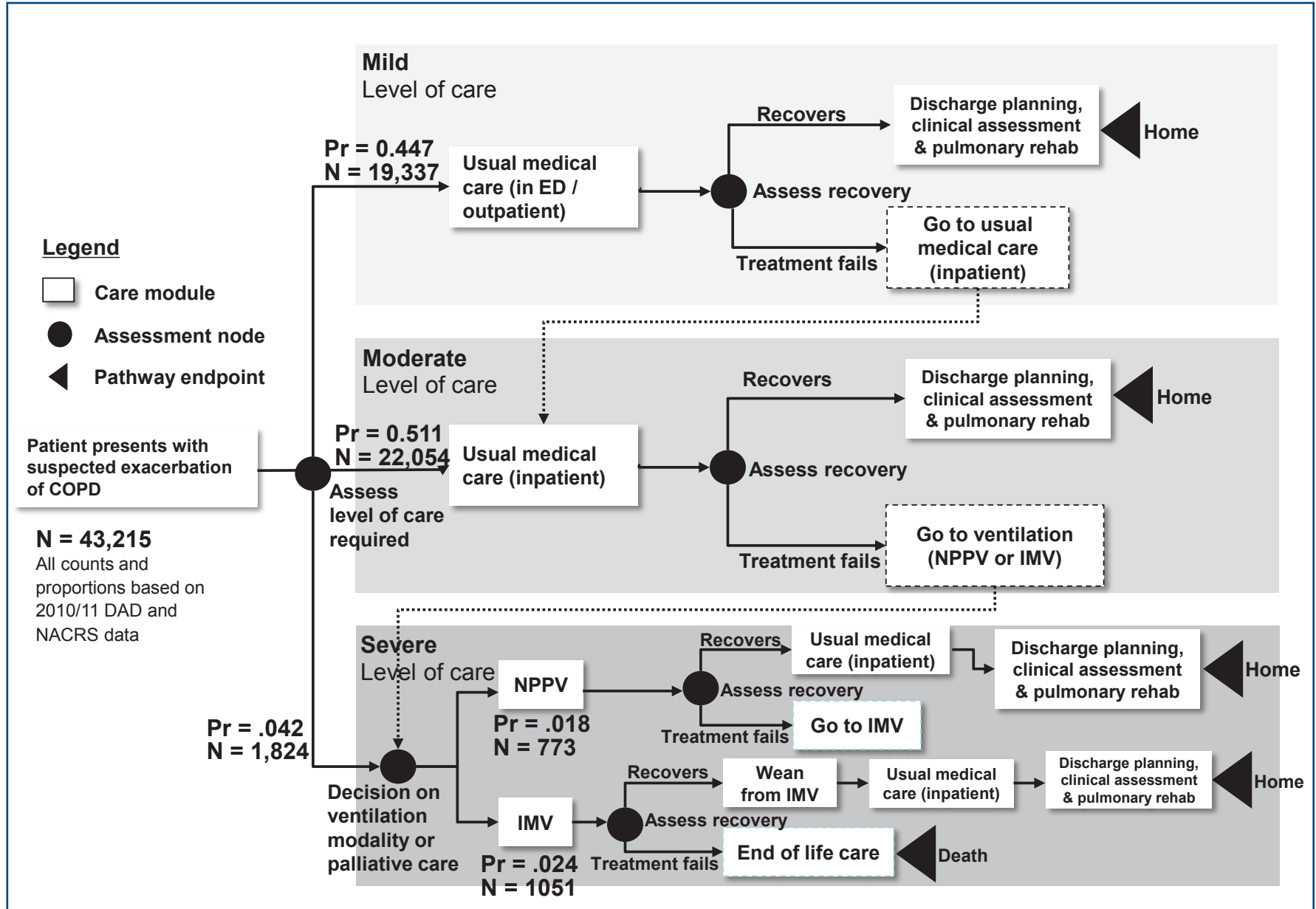
The following episode of care pathways (figures 3.4-6) for COPD, CHF and Stroke have been taken from the Clinical Handbooks.

<sup>11</sup> Quality-Based Procedures: Clinical Handbooks for COPD, CHF and Stroke. January 2013.

<sup>12</sup> Ibid.

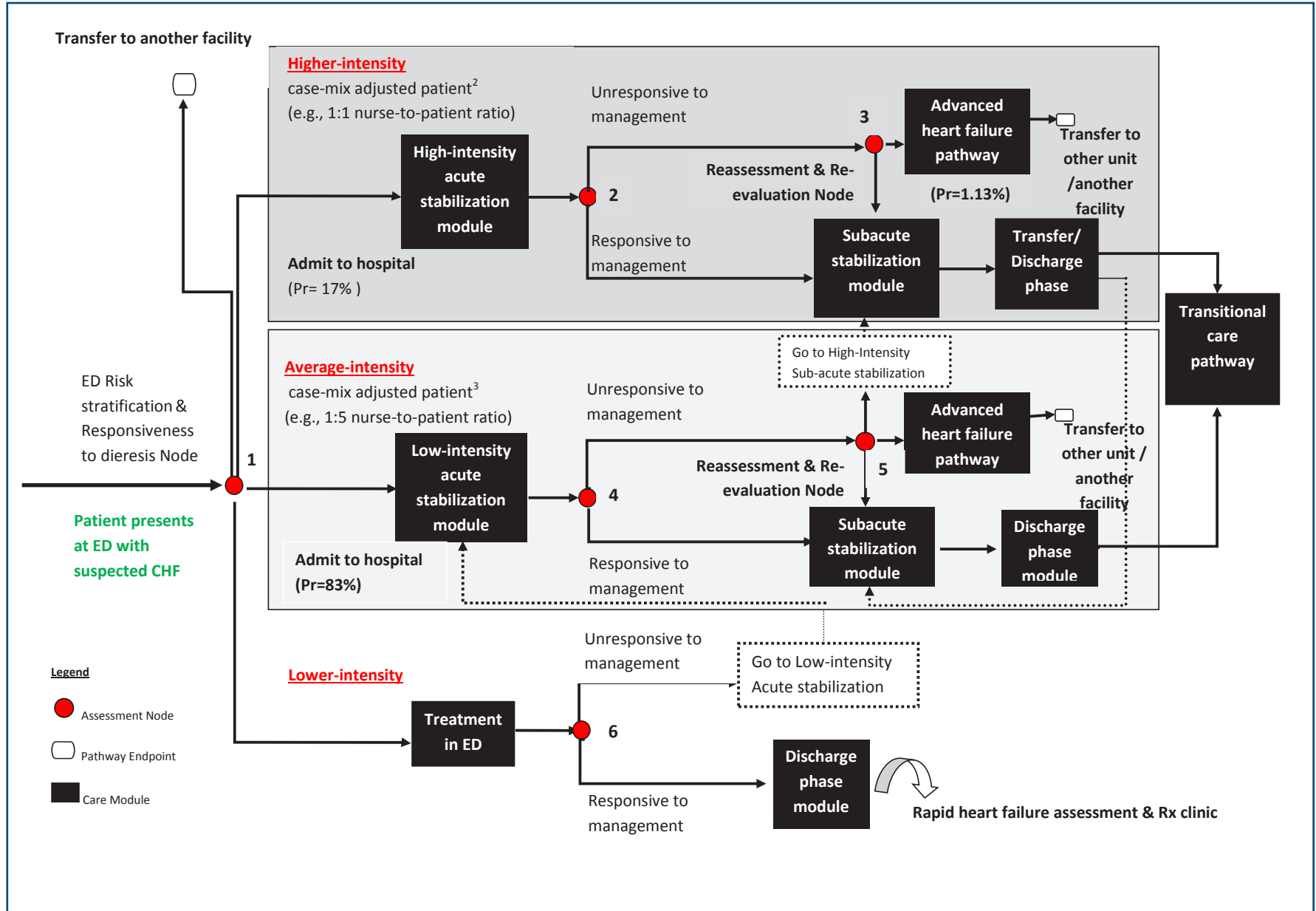


Figure 3.4 – COPD QBP Episode of Care Pathway<sup>13</sup>



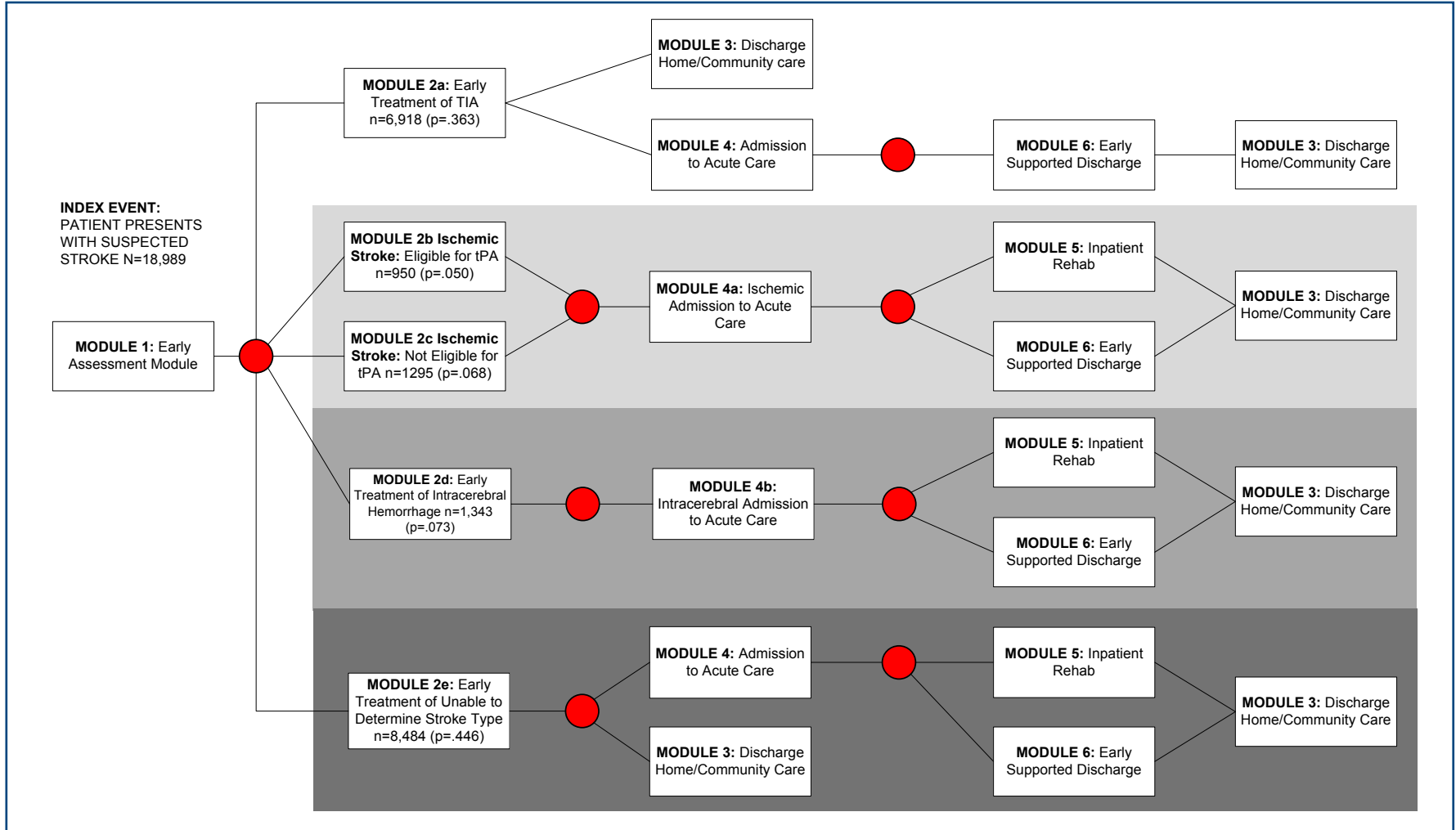
13 Quality-Based Procedures: Clinical Handbooks for Chronic Obstructive Pulmonary Disease. January 2013.

Figure 3.5: CHF QBP Episode of Care Pathway<sup>14</sup>



14 Quality-Based Procedures: Clinical Handbooks for Congestive Heart Failure. January 2013.

Figure 3.6: Stroke QBP Episode of Care Pathway<sup>15</sup>



## Gap Analysis

A gap analysis is performed by the organization after extensive data gathering to assess current state against future state and identify a road map for closing the gaps. To conduct the gap analysis, hospitals may need to complete the following:

1. Conduct pathway gap analysis;
2. Identify improvement opportunities; and
3. Consolidate QBP opportunities.

### 1. Pathway gap analysis

Analysis of the gaps in practice between the current pathway and the QBP episodes of care/desired future state can provide insight into potential improvement opportunities.

A comparison between an organization's current clinical process for each QBP and the clinical pathway outlined in the handbook may reveal a number of gaps that will need to be addressed. For example, the COPD episode of care includes positive pressure ventilation, where appropriate, for treating severe COPD, before more invasive forms of ventilation. Organizations will have to review their current state pathways to identify whether this is part of their clinical processes.

### 2. Identify improvement opportunities

There are two principal areas that need to be analyzed in order to identify improvement opportunities for each QBP:

#### a) Process Flow Efficiency

Process flow assessments can highlight potential opportunities for improving or standardizing patient and information flow. Process flow assessment is relevant to a patient's *episode of care* (e.g., a stroke patient flows through hospital departments from emergency to discharge); and *information flow* (coding information relevant to the patient's condition and treatment).

#### b) Practice Variation

Patients with the similar diagnoses should be treated according to evidence-based protocols. Variation in patient care may produce differences in patient outcomes and in levels of adherence to best practices (e.g., dose and dosing schedule for patients with a similar condition).

### 3. Consolidating QBP opportunities

Clinical variation and pathway opportunities highlighted through the analysis above should be consolidated with opportunities identified through other analysis (e.g., process improvement exercises such as value stream mapping or Kaizen; or quality improvement exercises such as hypothesis generation and testing). Prioritization of these opportunities and implementation timelines will guide the next phase of work.

## Closing the Gap

Closing the gap is the action organizations are required in order to implement the future state. When closing the gap, hospitals may need to complete the following:

1. Develop an Implementation Plan; and
2. Identify Implementation Tools.

#### 1. Develop an Implementation Plan

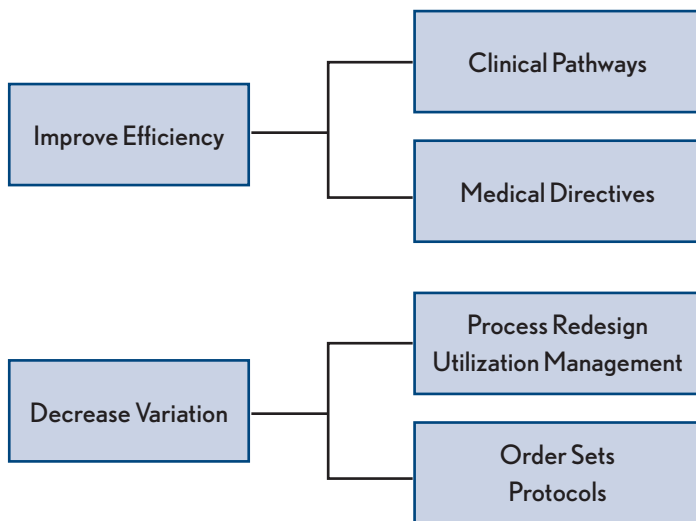
The plan is a tool that can be used for communicating the overall approach to implementation. The plan can be preliminary and can be adjusted as additional information becomes known. The plan is a tool that can be used for communicating the overall approach to implementation. Clarity on timelines provides the structure necessary for successfully implementing multiple QBPs simultaneously and the sequencing for QBP implementation can depend on the relative importance to the organization (i.e., case volume or quality gap), resource availability, and data availability.

A sample QBP Implementation Plan is provided in Appendix J. The main components of the plan are the list of activities, sponsor for each activity, and duration of each activity. In creating this implementation plan, hospitals may wish to consider the implementation priorities created by HQO in Appendix L.

**2. Implementation Tools to improve flow and minimize practice variation**

There are many tools available to hospitals which can assist them in streamlining the delivery of care for each of the respective QBPs. They include clinical pathways, protocols, order sets, medical directives, utilization management tools, and process improvement approaches, to name a few. The QBP checklists included in Appendix O are also an important resource for supporting effective implementation (see discussion below). A number of tools are provided in the appendices to assist with implementation. The use, adaptation, and maintenance of these tools will be at the organization’s discretion.

Figure 3.7: Implementation Tools to Improve Efficiency and Minimize Variation



Reduction of clinical practice variation as well as patient and information flow efficiency can be improved in a number of ways, including the standardization of pathways, protocols, order sets, and the utilization of medical directives. Together, these tools translate guidelines and standards into clinical language that can be acted upon. They bring best practices to the point of care and can empower clinicians to expedite care in critical situations, leading to better patient outcomes and increased operational efficiency. Both the reduction of clinical practice variation and patient flow efficiency have the added benefits of supporting organization-wide quality improvement goals, (e.g., reducing LOS, decreased mortality rates).

Many hospitals in Ontario focus significant attention on the area of utilization management. Tools such as Medworxx and InterQual, for example, allow organizations to review the utilization of their most valuable resource – an inpatient bed – by monitoring LOS and reasons contributing to prolonged stays in those beds. This analysis can be done either retrospectively or concurrently, but is instrumental for understanding reasons that contribute to an increased LOS, and therefore, increased costs. Utilization management tools also support the prompt identification of patients who are designated alternate level of care (ALC) while still in an acute bed, and allow for proactive planning to get the patient into the right facility offering the most appropriate level of care. These tools can support effective QBP implementation by allowing hospitals to understand reasons that contribute to delays in discharge.

The use of process improvement tools can also facilitate effective QBP implementation and support closing identified gaps. The adoption of LEAN principles and tools such as Value Stream mapping, 5S thinking, Kaizen events and root cause analysis can provide hospitals with valuable information with respect to flow in respective clinical units and departments, and identify factors that contribute to bottlenecks and/or delays in the patient process. By streamlining the flow with respect to each of the QBPs, one could expect to see improvements in patient care and reduction of variability.

Table 3.3: Defining Order Sets, Protocols and Medical Directives

<p><b>What are Order Sets?</b></p>	<p>Order sets are medical checklists used by clinicians to provide high-quality, safe health care. They:</p> <ul style="list-style-type: none"> <li>• Include comprehensive best-practice interventions for a particular population condition.</li> <li>• Reflect the latest and most reliable evidence-based practices.</li> <li>• Present specific recommended interventions (e.g., specific dosing, frequencies).</li> <li>• Are formatted to present information clearly in an organized and standardized structure - clear and accurate order lines reduce the likelihood of errors and improve patient safety.</li> <li>• Must remain current to support clinical advances and clinical judgment.</li> </ul>
<p><b>What are Protocols?</b></p>	<p>Clinical protocols are a type of order set that:</p> <ul style="list-style-type: none"> <li>• Contains only default orders.</li> <li>• May not need to be signed by the practitioner.</li> <li>• May or may not be placed on the paper chart depending on local workflow considerations.</li> </ul> <p>Clinical protocols are made up the following modules:</p> <ul style="list-style-type: none"> <li>• Patient Population: outlines the patient population for which the clinical protocol is intended. It will provide specific criteria for inclusion and exclusion of patients into the clinical protocol orders.</li> <li>• Implementation Considerations: contains specific conditions and considerations that must be met before proceeding with the clinical protocol.</li> <li>• Clinical Protocol Orders: contains the orders implemented as part of the patient’s plan of care.</li> <li>• Termination of Clinical Protocol: outlines the criteria for the clinical protocol to be discontinued.</li> </ul>
<p><b>What are Medical Directives</b></p>	<p>Medical directives can be used to improve efficiency of patient flow. A medical directive is a written order by a physician(s) to other health care providers that pertains to any patient who meets the criteria set out in the medical directive (CPSO Delegation of Controlled Acts, policy #5-12).</p> <p>The purpose of medical directives is to eliminate and/or reduce any delay in the management of patient care and to ensure standardization of therapy. Note that responsibility for a delegated controlled act always remains with the delegating physician(s).</p>

### QBP checklists

To support organizations in understanding and implementing the QBP episode of care pathways, the QBP checklists included in [Appendix O](#) provide a comprehensive list of the expert panel recommendations outlined in each Clinical Handbook. The checklists take the handbook material and present them in a standardized format to facilitate the gap analysis process.

A checklist has been created for each phase of the episode of care and is organized in accordance with the modules and assessment nodes outlined in the handbooks.

In addition to reducing/mitigating process inefficiency and practice variation, there are several other standards and tools that can be help to improve quality and safety. The tools are available in [Appendices P-AF](#).

# Chapter 4: Monitor and Adjust

## Objective:

### To provide:

- Examples of process and outcome measures that can be tracked to ensure implementation success
- An approach to monitoring QBP adjustments

### Target Audience:

- Senior management, Steering Teams and/or QBP project teams

As part of the implementation process, the organization will have to identify and communicate performance metrics to monitor progress. Ideally, the measures should be a balance of both process and outcome, where possible. In addition to any relevant pre-existing measures, organizations are also encouraged to monitor progress by using the metrics that are being recommended by the respective QBP clinical advisory groups described in Chapter 3 (see Appendix M for draft recommended indicators).

An organization may wish to identify a series of metrics over the course of two or three years to monitor improvement. Table 4.1 is an example of the types of metrics organizations can consider. Organizations may choose to use their own pre-existing metrics, those included in the Clinical Handbooks, and metrics currently under development. Hospitals should also draw upon a number of available national and provincial resources such as [Health Quality Ontario](#) and the [Canadian Institute for Health Information](#), which can provide support in developing an approach to the collection of data for QBP implementation process.

Resource models, templates used, and frequency and type of communication may need to be adjusted over time. Organizations will also need to ensure that unintended consequences from the QBP implementation are identified and managed (e.g., increase in readmission rate, increased inappropriate referrals to CCACs).

Table 4.1: Monitoring Progress for QBP implementation

Timeframe	Metrics
<b>By end of Year 1</b>	<ul style="list-style-type: none"> <li>• Reduction in unplanned readmissions within 30 days rate by x%</li> <li>• Reduction in acute LOS by x%</li> <li>• Diuretic management (frequency)</li> <li>• Pre-discharge functionality (walkability test)</li> </ul>
<b>By end of Year 2</b>	<ul style="list-style-type: none"> <li>• Reduction in unplanned readmissions within 30 days rate by x%</li> <li>• Reduction in LOS by x%</li> <li>• 30 day stroke/TIA risk adjusted mortality rate</li> <li>• % reduction in time from referral to home care visits</li> <li>• % patients admitted to LTC within 1 year of stroke/TIA inpatient hospitalization</li> </ul>
<b>By end of Year 3</b>	<ul style="list-style-type: none"> <li>• Reduction in unplanned readmission rate within 30 days by an additional x%</li> <li>• Reduction of inpatient mortality rate by x%</li> <li>• Reduction in LOS by x%</li> </ul>

## Monitoring QBP adjustments

Additional changes to QBPs will likely be necessary overtime. There are three broad conditions that will drive adjustments:

1. Advancements in clinical guidelines: revised best practice guidelines.
2. Continuous quality improvement: opportunities for greater flow efficiency, recommendations from quality improvement team, revision of QBP targets etc.
3. HOO Clinical Handbook and evidence review: HOO is planning a review of the handbooks every two years. Therefore, the gap analysis and implementation plan may have to be reviewed in order to align with any changes made to the handbooks.

## Assessing the success of QBP implementation

The successful implementation of QBPs will require significant change in any organization. However, these changes have the potential to significantly improve the quality of health care for Ontarians. This is what the ECFAA and strategy are all about.

The success of the implementation process will depend on the ability of a hospital to sustain and maintain the changes required in clinical practices and processes, and to realize the improvements that have been targeted. Making quality improvement in patient care the main focus, and communicating this goal effectively during QBP implementation, will yield demonstrable results and benefits.

Organizations should consider reviewing and measuring adherence to new standards, and attempt to understand the factors that contribute to the standards being met. Implementation teams should also maintain a high-quality educational plan beyond the point of implementation to ensure that any new personnel are aware of the organization's commitment to QBPs and are trained and practicing up to the established QBP standards.



## Objective:

- To provide considerations for directors related to QBP's and their impact

## Target Audience:

- Hospital board directors

# Chapter 5: Considerations for Boards

QBPs are an integral part of Health Services Funding Reform (HSFR) and play a key role in transforming Ontario's health care system into one that is more person-centered, evidence-based and focused on quality and value. The environment in which hospitals operate is changing and directors will be required to make decisions related to funding reform. Proactive consideration of this change will help hospitals to be nimble and responsive in their approach to any QBP-specific decisions. It is suggested that hospital board chairs develop an understanding of the potential strategic and operational impacts of HSFR and QBPs on their organization.

Suggestions specifically for board chairs:

- Board chairs may wish to include funding reform as a standing item on board agendas. QBPs could also be discussed at the appropriate board committee (e.g., quality committee, finance committee).
- Board chairs can consider a specific and focused discussion with their board on the relationship between QBPs, the government's strategic goals for the health system, and the goals of the organization ([www.ontario.ca/healthfunding](http://www.ontario.ca/healthfunding)).

The following items are included as further considerations for board chairs and directors with regards to QBP implementation. These are included as suggestions to recognize that different hospital boards will have varying knowledge of HSFR and QBPs.

## 1. Do we understand QBPs and its link to HSFR, as well as how reform supports the government's vision as described in Ontario's Action Plan for Health Care?

Boards can ask: "Do we understand how QBPs support HSFR and what the potential effects may be?" To ensure that boards can answer this question, education (as part of regular board education processes) should be provided on QBPs and on the principles of the *Excellent Care for All Act* (ECFAA), and reinforce quality and quality improvement as the primary driver behind improved patient care and system sustainability.

Directors should be encouraged to engage in ongoing discussions on the impact of funding reform on quality, cost and value. Directors should familiarize themselves with the core benefits of HSFR for the long-term viability of the system: to use funding as a way to drive better value for money by spreading best practice, improving quality, and lowering costs within the system.

Armed with this knowledge, hospital boards may wish to revisit their strategic directions and planning documents in light of funding reform. Questions to consider are:

- Are our strategic objectives still relevant given the current environment? Do we need to course correct?
- What will be the effect of QBPs on our services and programs?
- What is the current state of our quality improvement processes and what impact will QBPs have on our approach?
- Should we be using QBPs to focus our efforts towards continuous quality improvement? What do we need to do to achieve this?

- How can the Quality Committee, established under ECFAA, support the QBP journey and ensure that “best practices information supported by available scientific evidence is translated into materials that are distributed to employees and persons providing services within the health care organization, and to subsequently monitor the use of these materials by these people.”<sup>16</sup>

## **2. Have we engaged with our LHIN and other hospital boards to understand their approach to QBPs and any implications for our organization?**

Board chairs may wish to use existing governance forums or seek LHIN support to facilitate new forums to explore how QBPs are being implemented. There will be a need to understand, as a regional health system, the challenges and opportunities associated with QBPs. The Ministry of Health and Long-term Care (MOHTLC) is publishing stories from hospitals and other health service providers on its [website](#).

## **3. Have we engaged our communities in discussions regarding the impact of QBPs on care and services offered?**

Hospital boards are accountable to their local communities and should ensure that the public has a high-level understanding of funding reform. Boards should provide public messaging developed in collaboration with the MOHTLC and their local LHIN as to how potential changes may impact patients. Boards can use existing communication channels or consider developing specific opportunities for community education. In the event there is a change in service, proactive community engagement will likely enhance “buy-in” for this change.

## **4. What information do we require from our management about the hospital’s approach to implementing QBPs?**

Directors should require management, who will lead the implementation of QBPs, to provide an organization-wide overview of the approach to implementation.

Questions to probe include:

- How are we identifying, understanding, and managing our costs?
- How wide is the “gap” between what we are presently doing and what is expected through implementation of the QBPs? Can the gap be closed? Do we want to close the gap? What is the impact on services if we close the gap or if we choose not to?
- What is management’s approach to closing this gap?
- What resources and supports are currently available for implementation?
- How is the organization approaching the implementation? What are the reporting relationships between the Steering Teams and the Board/Board Quality Committees?
- What is our approach to changing the culture of our hospital to one of continuous quality improvement?
- What are the risks if we are unable to meet certain aspects of the clinical guidelines?
- Are there mitigation strategies?
- What are the Key Performance Indicators that will inform us about our performance?

Additionally, it is likely that hospital boards will be presented with decisions for approval by their management teams on QBPs. For example, whether to “stay in the business” of a specific QBP or how to approach a potential deficit situation if the actual cost of a procedure is significantly more than the funding allowance.

Boards and senior management may decide to proactively plan for these types of scenarios and to spend time on generative discussions about the impact QBPs will have on the services they deliver. These discussions can be supported by a decision-making framework (with specified criteria) or a set of questions that can be used to manage difficult decisions when they arise.

<sup>16</sup> *Excellent Care for All Act*, 2010. Available [\[here\]](#)