# McMaster University

DIALOGUE SUMMARY

OPTIMIZING CLINICAL PRACTICE IN ONTARIO BASED ON DATA, EVIDENCE AND GUIDELINES

6 MARCH 2015

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**Dialogue Summary:**
**Optimizing Clinical Practice in Ontario Based on Data, Evidence and Guidelines**

6 March 2015

McMaster Health Forum

> For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

Authors

> Michael G. Wilson, PhD, Assistant Director, McMaster Health Forum, and Assistant Professor, McMaster University
>
> John N. Lavis, MD PhD, Director, McMaster Health Forum, and Professor, McMaster University

Conflict of interest

> The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

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Dialogue

> The stakeholder dialogue about optimizing clinical practice in Ontario based on data, evidence and guidelines was held on 6 March 2015 at the McMaster Health Forum in Hamilton, Ontario, Canada.

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# SUMMARY OF THE DIALOGUE

Dialogue participants generally agreed that the problem can be understood in relation to the five themes presented in the evidence brief: 1) clinical practice in Ontario is not consistently being optimized based on data, evidence and guidelines; 2) yet Ontario is home to some of the world's best data, evidence, guideline and implementation 'shops'; 3) these 'shops' support optimal practice with different perspectives and little coordination; 4) health-system arrangements also aren't being effectively harnessed to optimize clinical practice; and; 5) no big initiatives appear to be on the way to systematize and scale up efforts to optimize clinical practice. Participants focused in particular on how a lack of coordination (i.e., the third theme) limits system-wide practice-optimization efforts. However, they also pointed 'upstream' to two key contributors to the problem, namely limited long-term planning (particularly in terms of clearly articulating goals and sustainably allocating the resources needed to achieve those goals), and the lack of a clear governance model and accountability for practice optimization.

During the deliberations about the three elements of a potentially comprehensive approach to addressing the problem, participants generally agreed with one participant who stated that "where we want to get to is for all patients to get the highest quality of care. What we need is a roadmap for how to get there." However, while there was agreement with the overall goal of creating a roadmap for practice optimization in Ontario, participants expressed mixed views about what the roadmap should look like. Most participants ended up converging on support for what some called a 'mixed economy approach' to optimizing clinical practice, which would mean defining a set of practical goals in the short and medium term, and aspirational goals in the long term. Participants also generally agreed on the need for developing a 'toolbox' that supports the use of a manageable number of promising processes to optimize clinical practice. Participants also consistently emphasized that the activities included in each of the approach elements will require meaningful stakeholder engagement to ensure that priorities reflect local realities, and that approaches to addressing them are adapted accordingly.

Participants articulated four priorities for moving forward: 1) pursuing opportunities to foster the cross-sectoral collaboration required to have an impact on optimizing clinical practice in Ontario; 2) promoting greater local engagement and generating public awareness of progress made towards optimizing clinical practice as ways to foster the necessary cultural change; 3) focusing on identifying key barriers that are likely to hold up progress and targeting the investment of resources accordingly; and 4) collaborating on several research priorities, such as making tools that support optimal practice more usable for real-life settings, developing a 'simplified Ontario framework' for practice optimization, and taking coordinated action to better support initiatives that are designed to provide healthcare professionals and patients with access to the knowledge needed to narrow the evidence-to-practice gap.

# SUMMARIES OF THE FOUR DELIBERATIONS

## DELIBERATION ABOUT THE PROBLEM

Dialogue participants generally agreed that the problem can be understood in relation to the five themes presented in the evidence brief that informed the dialogue:
1) clinical practice in Ontario is not consistently being optimized based on data, evidence and guidelines;
2) yet Ontario is home to some of the world's best data, evidence, guideline and implementation 'shops';
3) these 'shops' support optimal practice with different perspectives and little coordination;
4) health-system arrangements (i.e., governance, financial and delivery arrangements) also aren't being effectively harnessed to optimize clinical practice; and
5) no big initiatives appear to be on the way to systematize and scale up efforts to optimize clinical practice.

Participants focused in particular on how a lack of coordination (i.e., the third theme) limits system-wide practice-optimization efforts. However, they also pointed 'upstream' to two key contributors to the problem, namely limited long-term planning (particularly in terms of clearly articulating goals and sustainably allocating the resources needed to achieve those goals), and the lack of a clear governance model and accountability for practice optimization.

*Lack of coordination limits system-wide practice-optimization efforts*

Having acknowledged that Ontario is home to some of the world's best data, evidence, guideline and implementation 'shops', many agreed with one participant's observation that "Ontario is resource rich and collaboration poor." Specifically, many participants pointed to there being a lack of knowledge about who is doing what in different 'layers' of the health system. One participant specifically pointed out that this not only limits the opportunities for learning from one another, but also constrains our abilities to leverage one another's strengths to "scale up and have a real impact."

Several participants attributed the lack of collaboration, at least in part, to the sheer number of different initiatives, approaches and tools that are being used by different groups to optimize clinical practice. For example, one participant noted that the participant's group had found, in a recently conducted environmental scan, close to 120

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initiatives to engage primary-care providers in optimizing clinical practice. Similarly, another participant indicated that because of a lack of coordinated and systematized approach to the process of producing guidelines, there are "too many players that cost too much money," resulting in confusion in clinical practice because of several guidelines coming out on the same topic. Many agreed that the result for providers is frustration, which contributes to them not using the guidelines in practice.

More generally, another participant pointed out that many working in the field of 'implementation' (i.e., supporting the use of data, evidence and guidelines) have their own favourite tools, which makes it difficult to engage in efforts to look at a broad array of tools, select those that make the most sense to address a specific problem, and then to foster collective approaches to achieve economies of scale where possible. Building on this, another participant highlighted that in the area of guidelines, developers are inadvertently forced to work on implementation as well, and many feel they are supposed to take on everything rather than fostering collaborations and building on the strengths of different groups.

Another participant suggested (and many agreed) that a big factor contributing to the lack of coordination is not having an integrated information technology (IT) infrastructure across the health system. This participant further emphasized the point by suggesting that the Ontario health system has to be the only multi-billion-dollar enterprise with no coordinated IT system, and that the opportunity to accrue significant long term savings is being lost.

*Limited long-term planning contributes to the problem*

There was general agreement with one participant's comment that optimizing clinical practice in the province cannot be a short-term commitment and, instead, is something that needs to be sustained over the long term. One participant who agreed with this assessment indicated that long-term planning has been done well in other government ministries, but it has not been successfully replicated in the health ministry, which this participant attributed to the complexity involved in "getting everyone to row in the same direction" in the health system. Beyond general statements about the lack of long-term planning, participants specifically emphasized gaps in long-term planning in the context of articulating goals and sustainably allocating the resources needed to achieve those goals.

With regard to goals, several participants shared the view that too often approaches to addressing complex problems are selected before goals are clearly articulated. Others pointed to the difficulty of setting goals in the area of practice optimization because of the confusion about whether the goal is to improve patient experience and outcomes, change clinician behaviour (e.g., by reducing practice variation), spur system change (e.g., by accelerating the scale-up of processes to optimize clinical practice) or reduce costs. Some participants indicated that these goals are intertwined and sometimes at odds with each other, such as when patient preferences might be far removed from what is recommended based on the best available evidence and guidelines. Other participants pointed to the lack of sector-wide governance as an underlying contributor to why clear goals have not been articulated in this area yet (which is a subject to which we return below).

Turning to sustainable resource allocation, participants generally agreed with a point made in the evidence brief: despite being home to some of the world's best data, evidence, guideline and implementation 'shops', many of these shops have insufficient funds to achieve the necessary reach and impact, and/or insecure funds that preclude long-range planning. One participant stated that optimizing clinical practice "requires an investment, sustained and long-term commitment, and planning as well as infrastructure, all of which seem to be lacking."

*Lack of a clear governance model and accountability for practice optimization further contributes to the problem*

Several participants agreed with the notion that without a clear governance model, efforts to optimize practice will continue to struggle with a lack of coordination and limited long-term planning. One participant noted

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that having so many different groups and stakeholders involved in practice optimization, without a clear governance model, results in a diffusion of responsibility and a lack of clear leadership and accountability. Emphasizing this point, other participants noted that much of what needs to be done requires a solid foundation of governance, but that what is currently in place is either "shaky or sand-based" or barely resembles a system given how groups and organizations operate in silos. One participant questioned whether there was anyone in Ontario who is ultimately responsible for ensuring quality in clinical practice. The same participant then spoke passionately about the need for accountability, highlighting that there are millions of Ontarians who are not receiving the care that they should be getting, indicating that "this seems to be something that is everyone's responsibility, but no one has accountability."

Complicating the issue of governance and accountability is the tension between whether bottom-up governance approaches (i.e., locally driven) or top-down governance approaches (i.e., driven by those with system-level authority) are needed. Many participants argued for practice-optimization initiatives to be based locally given local leaders' ability to foster shared understandings of an issue and to develop collaborative approaches to addressing it. In addition, several participants also emphasized the critical importance of patient engagement in governance, with one participant indicating that the purpose of governance is to represent the 'owner' of the institutions (i.e., patients), rather than providers and organizations, which are the current focus of governance. The same participant who spoke about the lack of long-term planning in the health sector also emphasized the importance of patient engagement in planning and governance, indicating that long-term plans are not viable in the short term or sustainable in the long term without patient engagement. The same participant noted that while patient engagement has been done well in some areas of government, the same has not been true in the health ministry (although this has changed to some extent).

While acknowledging the importance of local knowledge and patient engagement, other participants suggested that assuming bottom-up approaches are best is part of what is driving the problem. For example, one participant highlighted that doing things at the local level assumes that there are rational decisions being made, but in their experience, doing practice optimization at the local level typically means implementing people's 'pet projects'. The same participant asserted that, instead of using either a bottom-up or top-down approach, there needs to be a balance to achieve innovation, while having accountability for quality at a system level. Another participant indicated that building governance that can support the scale up of local processes means bridging the tensions between achieving local improvements and achieving system-level accountability and change. A third participant noted that while local initiatives are critical to innovation, the big challenge is how to support integration across the system from a governance perspective, given how difficult it is to engage players in different parts of the system in order to scale up.

## DELIBERATION ABOUT APPROACH ELEMENTS

During the deliberations about the three elements of a potentially comprehensive approach, participants generally agreed with one participant who stated that "where we want to get to is for all patients to get the highest quality of care. What we need is a roadmap for how to get there." However, while there was agreement with the overall goal of creating a roadmap for how to optimize clinical practice in Ontario, participants expressed mixed views about what it might look like, in particular for the first element, where the focus was on how to identify clinical practices to be optimized and the underlying causes of the problem.

**Element 1 - Support dynamic efforts to identify clinical practices to be optimized and the causes of underlying problems**

Many participants agreed that systematic and transparent approaches should be used to identify key areas of clinical practice to be optimized (or as candidates for optimization) at the system level or below (e.g., areas where there are large evidence-practice gaps). Some also agreed that there is a need to identify and support

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the use of a manageable number of iterative/theory-based approaches to understanding the causes of problems (such as evidence-practice gaps) and the levels where these causes are best addressed (although many didn't speak specifically to this issue). In contrast to this 'key areas' focus, some participants argued that we should optimize all areas of clinical practice. Other participants instead suggested that we should simultaneously pursue practical goals (i.e., identify key areas of clinical practice to be optimized) and aspirational goals (i.e., overall practice improvements). In speaking to the pursuit of both practical and aspirational goals, one participant suggested that "we can't wait for a system revolution." The same participant further explained that this does not preclude articulating what is needed for system change, but that there is also "a need to be realistic and fix the things that we are readily able to within the confines of the existing system."

Many agreed that the prioritization of problems needs to be driven locally to ensure an understanding of the causes of problems at the local level, while others argued that there is value in having some degree of accountability at all levels for action on a reasonable number of sector-specific priorities. For example, one participant pointed out that while there is lots of local activity around optimizing clinical practice, there is not much progress overall, and this participant argued that setting priorities is needed to provide focus and "make some real headway." In addition, most agreed that there needs to be some alignment between the areas where evidence-practice gaps are looked for and the political priorities set by government, the regional priorities set by Local Health Integration Networks, and the local priorities set by communities. For example, one participant indicated that it would be very difficult to engage in priority-setting without some sort of alignment, because otherwise different groups will end up working in isolation and not collaborating with each other.

Virtually all dialogue participants agreed with the need for information, engagement and leadership in setting priorities. First, several participants emphasized that good priority-setting requires high-quality information about evidence-practice gaps, but that existing data systems often don't permit the use of systematic and transparent approaches, so there is a need to work aggressively to improve our data systems. One participant suggested that "we need to focus on fixing the basics first, like having a coordinated and functioning IT system," and another participant similarly indicated that without the right data, it will be difficult or impossible to reliably identify areas of practice that should be optimized. Second, participants supported the need for meaningful engagement with a broad range of patients (including those whose voices are not normally heard) and a broad range of health professionals to prioritize problems and to develop an understanding of the causes of these problems. Lastly, participants agreed that effective leadership will be fundamental both for priority-setting and for pursuing aspirational goals towards overall system change in the long term. One participant suggested that, as compared to other jurisdictions, Ontario has strong health-system leadership that can be drawn upon to pursue a set of aspirational goals towards improving the overall system.

**Element 2 - Use rigorous processes to select and implement approaches to optimizing clinical practices**

Paralleling the views held by many dialogue participants related to the first approach element, some participants agreed that it is important to support the use of a manageable number of promising processes to optimize clinical practices that align with an understanding of the problem and its causes. Several participants viewed such a 'toolbox' approach as best, given that it would mean that approaches could be developed at scale in a way that would make it easy for those on the receiving end (i.e., those in local settings) to identify processes best suited to addressing the problem they are facing and to adapt the processes to their needs. Some participants also indicated that the toolbox needs to be supplemented with meaningful engagement that includes capacity building for adapting approaches in local contexts (or as one participant called it, "a facilitated approach for using in real life"). Some participants also emphasized that this process needs to be kept simple, with one participant noting: "This isn't rocket science. Keep it simple or it will paralyze people."

Two reasons for why the toolbox approach was viewed as optimal were articulated primarily by one participant, but agreed upon by several others. First, the participant indicated that, as pointed out in the evidence brief, there are many tools available for optimizing practice, and there is a large body of evidence related to each of these tools. This participant suggested that some tools are effective and can be applied in many different contexts to address a range of issues, and the use of these tools needs to be prioritized and locally supported. Second, the participant noted that efforts to change behaviours occur in complex systems, and that "people often develop perfect tools for a perfect world, but the reality is that our world is messy and tools need to reflect this." The participant also noted that "people think about solutions without considering the problem", and good tools prompt them to consider the problem first. Again, the participant suggested that such tools need to be prioritized and locally supported. Most participants agreed that the lack of an existing toolbox that includes considerations about when and how to use specific approaches needs to be addressed.

**Element 3 - Monitor, evaluate and review the approaches selected to optimize clinical practices**

Much of the deliberation about the approach elements focused on identifying clinical practices to be optimized and the causes of underlying problems (element 1), and selecting and implementing approaches to optimizing clinical practices (element 2), with little emphasis on monitoring, evaluation and reviewing approaches to optimize clinical practice. Those participants who did speak to this element generally agreed that there is a need to monitor the use of these diagnostic and implementation processes, evaluate them, and periodically review the toolbox as we learn from monitoring and evaluation efforts. When asked about the potential to commercialize effective and efficient processes beyond Ontario (if and when it is demonstrated that the processes are making a difference), most agreed that it is premature to talk about commercialization given that much needs to be done to operationalize what is being proposed.

**Considering the full array of options**

While all participants shared the goal of achieving high-quality care for all, most of the divergence in opinion about a roadmap for achieving that goal was related to whether the emphasis should be on first prioritizing key areas of clinical practice to be optimized, or whether the goal should be to focus on activities that will optimize all areas of clinical practice. Those who emphasized the former argued that while the system may not be perfect, much can be accomplished by prioritizing key areas. In contrast, participants emphasizing the latter argued that the system is fragmented and more attention needs to be paid to creating a coordinated system, which will result in across-the-board improvements. Most participants ended up converging on support for what some called a "mixed economy approach" to optimizing clinical practice, which would mean defining a set of practical goals in the short and medium term and aspirational goals in the long term. This convergence was largely the result of an acknowledgement that while aspirational goals are important, they require a change in culture that will need to be fostered by achieving practical goals in the short and medium term.

Beyond this, there was agreement among most participants for the toolbox (and related supports) approach outlined in the second element. In addition, participants consistently emphasized that the activities included in each of the elements will require meaningful engagement to ensure that priorities reflect local realities, and that approaches to addressing them are adapted accordingly.

## DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Some dialogue participants viewed a key component of pursuing the elements to be a 'supply-side' approach through a convening authority that would have a mandate to pull much of the work together. To foster demand or buy-in, several participants emphasized the need for effective governance and strong leadership

that is accountable for quality and for engaging other sectors, combined with local engagement (including patient engagement). For the former, one participant highlighted that the common feature among those organizations selected by the Registered Nurses' Association of Ontario to be a Best Practice Spotlight Organization is that they are committed to change, and that this comes from strong leadership. For local engagement, one participant argued that long-term plans are not sustainable without patient engagement, which de-politicizes the process, but that engagement takes time to do well. Related to this, another participant noted another key leverage point for implementation will be patients enabled by technology, and emphasized that having empowered patients who can ask probing questions of their providers will be a powerful tool for implementation.

Participants also identified four important barriers to implementation to consider. The first is that the health system often lacks processes to support collaboration, which will be critical for a convening authority in this area to overcome. The second barrier relates to the fact that these processes will need to be committed to over the long term, but, as one participant noted, "we aren't usually very realistic about the amount of time that it takes to create change in the system." This participant suggested that overcoming this barrier will require the type of strong and committed system-level leadership (i.e., top-down governance) described above, as well as local-level engagement (i.e., bottom-up governance) that can facilitate the behavioural and culture changes that will be needed to make it work. The third barrier identified is that long-term commitments are expensive and, as a result, there is a need to make a clear case that the investment will be worth it. One participant noted that with the emphasis in government on evidence-based budgeting, it is important to make the case about what outcomes can be expected for any money spent. Lastly, some participants further emphasized the lack of data and IT infrastructure as a critical barrier, with one participant noting that it will require a big investment, but will save a lot of money over the long term.

## DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

Participants identified four priorities for moving forward. First, some participants spoke to their willingness to work within and beyond their respective networks to foster the needed cross-sectoral collaboration (and avoidance of competition) that will be required to advance this work. For example, some participants indicated that they would like to work towards defining the role of government in this area by clearly articulating priorities at the macro level, as well as related activities and measures of progress towards achieving priorities. This participant stated that the Ontario Ministry of Health and Long-Term Care "has the opportunity to be a powerful facilitator to stop the downstream pressure on the system by working with other sectors." Also related to collaboration, another participant indicated that while the idea of creating a toolbox is a good one, groups such as primary-care providers will still have many different groups coming at them with different resources and approaches, and so suggested that the priority for action was to help spur a more coordinated process. Similarly, other participants spoke to the need to work collaboratively with their communities of practice, organizations and Local Health Integration Networks to determine how to standardize processes. One participant noted that such action would be especially critical for organizations that serve clients across regional boundaries, so that expectations could be consistent. Furthermore, the need to work collaboratively across agencies with needed data (e.g., the Institute for Clinical and Evaluative Sciences and Health Quality Ontario) was also identified as an important part of fostering greater collaboration.

The second priority related to promoting greater local engagement and generating public awareness of progress made towards optimizing clinical practice. One proposed activity was to reward what one participant called "massive quality improvement." Several participants thought the idea of providing incentives to achieve significant progress in quality improvement was a good one, with one participant indicating that incentives should be coupled with frequent public recognition (both locally and provincially) of those who have made the biggest improvement. This idea aligned well with those of other participants who were interested in pursuing greater engagement with providers and patients in their areas, and doing a better job of publicly

promoting the excellent work already being done in the province towards practice optimization. These types of activities were viewed as important for building awareness and cultural change in the system.

The third priority identified was to focus on identifying key barriers that are likely to hold up progress as a way of determining where to best target the investment of resources. Some participants reiterated working towards addressing the IT barriers and the lack of coordination in the system. One participant specifically highlighted the need to address the absurdity of not being able to know what laboratory tests or diagnostic imaging have been done, which results in significant duplication of work and inefficient use of resources. Another participant suggested that taking action on addressing the lack of coordination and resulting fragmented care as well as overuse of health services in the health system will not only save money, but will also clearly demonstrate to patients that they are being heard.

Lastly, several research-related priorities were articulated by some of the participants. First, several participants pointed to the need for leadership to ensure the research community collectively does a better job at making tools more usable in real-life settings. Second, one participant noted that researchers involved in guideline production and/or implementation "need a collaborative research plan to get our ducks in a row", and to move toward a "simplified Ontario framework" for practice optimization by articulating what it is, how it might work, and the types of outcomes that should be prioritized. When asked about who would be best poised to lead the development of such a framework, some participants reaffirmed the notion of needing a task force supported by a convener or secretariat. The Registered Nurses' Association of Ontario was suggested as a candidate for this role. Lastly, one participant noted that "healthcare professionals and patients have lousy access to knowledge", and indicated that while several knowledge refineries exist, they operate with little support. Given this, the participant indicated that their priority is to take more coordinated action in this area, and several others expressed support for this course of action.