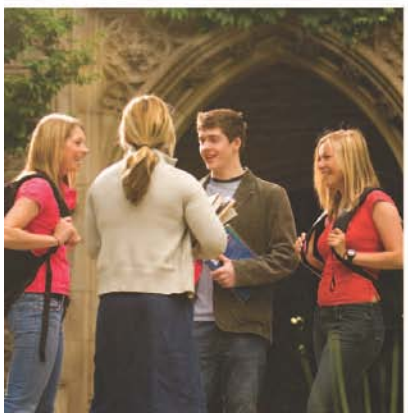




DIALOGUE  
SUMMARY



21 JUNE 2010

EVIDENCE >> INSIGHT >> ACTION

**Dialogue Summary:  
Supporting Quality Improvement in Primary Healthcare in Ontario**

21 June 2010

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 the regional/provincial level 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.

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Conflict of interest

The author declares that he has no professional or commercial interests relevant to the dialogue summary. Select staff of the Quality Improvement and Innovation Partnership reviewed a draft dialogue summary, but the author had final decision-making authority about what appeared in the dialogue summary.

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Dialogue

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## **SUMMARY OF THE DIALOGUE**

Most dialogue participants agreed that Ontario, while having witnessed significant improvements in access to primary healthcare over the last decade, lacks a system-wide and sustained approach to supporting quality improvement in primary healthcare. A number of dialogue participants pointed out that efforts to understand and address the problem should be based on projections of the nature of primary healthcare practices/organizations in five years, and on the practice patterns of and insights from primary healthcare providers early in their careers. A few dialogue participants noted that an important piece of the context within which the problem needs to be understood is the “tsunami” of initiatives coming towards primary healthcare providers and teams right now. These dialogue participants argued that if those providers and teams who need “consolidation time” are given it, and those providers who are “ready for change” are provided with the supports (e.g., tools and coaching) to make changes, and their first few quality improvement efforts truly do help them to do their jobs better or more efficiently, they will likely embrace quality improvement efforts.

Before working through implementation considerations and next steps, most dialogue participants supported the development of coordinating structures and processes to support quality improvements in primary healthcare in Ontario, and a smaller number of dialogue participants supported the development of a coordinating structure for the strengthening of primary healthcare in the province. After working through implementation considerations and first thoughts about next steps, dialogue participants began to shift in their views. They started to see the development of a strategic plan for the strengthening of primary healthcare in the province as being important, and perhaps essential to the success of quality improvement efforts. Throughout the deliberations, dialogue participants continued to see the collaborative development of principles for quality improvement, and support for the scaling up of existing quality improvement initiatives, as work to be done in the context of the development of quality improvement structures and processes.

Dialogue participants generally agreed that “there’s an appetite” for quality improvement right now, but they emphasized the importance of any next steps including a public-engagement strategy, and an effort to engage all primary healthcare practices/organizations (not just those in select funding/delivery models). A few dialogue participants expressed concern that without a mandate and funding from the Ontario Ministry of Health and Long-Term Care to support this work, any progress would need to be made “off the corner of our desks.” These participants observed that the absence of a coordinating structure created a vicious cycle in which it was hard to take even preliminary steps towards the creation of a coordinating structure.

Dialogue participants concluded that two parallel initiatives should be pursued: 1) a small planning group should draft and build consensus on a strategy for strengthening primary healthcare in Ontario, and plan a summit at which the strategy would be debated, finalized and approved by a broad-based group of key stakeholders, including citizen and patient groups, and representatives from Local Health Integration Networks and from public health units; and 2) the Quality Improvement and Innovation Partnership should convene one or more meetings to discuss the need and a plan of action for a strategic alliance focused on supporting quality improvement in primary healthcare, and then provide leadership and support to the strategic alliance.

## SUMMARIES OF THE FOUR DELIBERATIONS

### DELIBERATION ABOUT THE PROBLEM

Most dialogue participants agreed with the general statement of the problem – Ontario lacks a system-wide and sustained approach to supporting quality improvement in primary healthcare – and with the more detailed description of the multifaceted nature of the problem as described in the issue brief. In particular they agreed that: 1) quality improvement programs in Ontario’s physician-led primary healthcare practices are fragmented and limited in coverage, whereas the initiatives in Ontario’s community-governed primary healthcare organizations are more coordinated and broader in coverage, but less specifically focused on quality improvement; and 2) many health system arrangements to support the delivery of high-quality primary healthcare, but especially electronic health records and the information technology supports needed for meaningful performance measurement, are not yet fully in place. As one dialogue participant observed: “there’s lots of innovation in quality improvement out there, but it’s based on personal interest and on volunteers.”

A few dialogue participants disagreed with one or more aspects of the problem description, including: 1) the emphasis accorded to the primary healthcare systems’ need to adjust to the burden of chronic disease in Ontario (and specifically to provide more proactive and coordinated prevention and management of chronic diseases); and 2) the focus on shortfalls in the degree to which cost-effective primary healthcare programs and services are being consistently delivered with a high degree of quality and safety and with a high degree of patient-centredness and efficiency (and the lack of attention to the significant improvements in access and other domains over the last decade). Another dialogue participant noted that the issue brief focused on only two groups as illustrative examples of equity considerations arising in the available data and research evidence about the problem, whereas many other groups warrant explicit consideration from an equity perspective as well.

A number of dialogue participants pointed out that the primary healthcare system continues to change rapidly. To use physicians as just one example, there is a steady increase in the number working in teams, using electronic health records, and being paid using a blended-remuneration model. These dialogue participants argued that defining the problem based on old data and research evidence will be much less

#### **Box 1: Background to the stakeholder dialogue**

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in Ontario;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three options (among many) for addressing the policy issue;
- 4) it was informed by a pre-circulated issue brief that mobilized both global and local research evidence about the problem, three options for addressing the problem, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders and researchers;
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed”; and
- 10) it did not aim for consensus.

Participants’ views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participated in the dialogue, and by those who review the dialogue summary and video interviews with dialogue participants.

helpful than doing so based on projections of what will likely be the case in five years. Several dialogue participants also pointed out that those training for or starting careers in primary healthcare are very different from those who went before them. Defining the problem based on data and research evidence from and interactions with mid-to-late career primary healthcare professionals will be much less helpful than doing so based on the practice patterns of and insights from those just beginning their careers.

A few dialogue participants noted that an important piece of the context within which Ontario's lack of a system-wide and sustained approach to supporting quality improvement in primary healthcare needs to be understood is the "tsunami" of initiatives coming towards primary healthcare providers (especially family physicians) and teams. These initiatives include electronic health records, performance targets and related financial incentives, a push to support self-management among patients, and coordination of care within the system, among others. These dialogue participants indicated that if quality improvement is seen as one more "add on," it will likely fail (and some teams may collapse and some providers may move to more urban environments or to environments with fewer citizens and patients with greater healthcare needs). On the other hand, these dialogue participants argued that if those primary healthcare providers who need "consolidation time" are given it, and those providers who are "ready for change" are provided with the supports (e.g., tools and coaching) to make changes, and their first few quality improvement efforts truly do help them to do their jobs better (e.g., provide a better experience for their patients) or more efficiently, they will likely embrace quality improvement efforts. On a related note, one dialogue participant argued that more emphasis needed to be placed on celebrating successes in quality improvement at the practice/organization level. Another dialogue participant noted that another important piece of the context is that many of the savings generated in primary healthcare do not accrue to the sector, but rather to the hospital sector, among others.

One dialogue participant pointed out that the issue brief and the title of the stakeholder dialogue used the phrase "primary healthcare," which in the view of this dialogue participant meant that the dialogue would focus on the social and environmental determinants of health, and not just on healthcare. This could mean both that primary healthcare providers consider a determinants-of-health perspective in all aspects of their work (both clinically and in their advocacy roles), and that sectors other than healthcare need to be engaged. This participant felt that the term "primary care" would be more appropriate to describing the focus of the dialogue, given the working definition of primary healthcare introduced in the issue brief. Dialogue participants agreed that the focus should remain on improving the quality of healthcare at the practice/organization level and not on the social and environmental determinants of health. However, for consistency with the issue brief, the term "primary healthcare" will be used in this dialogue summary.

## **DELIBERATION ABOUT POLICY AND PROGRAM OPTIONS**

Most dialogue participants were drawn to option 2 (developing coordinating structures and processes to support quality improvements in primary healthcare in Ontario), however, a number of dialogue participants positioned option 1 (collaboratively develop principles for quality improvement) and option 3 (support the scaling up of existing quality improvement initiatives) as work to be done in the context of the proposed coordinating structure. Several dialogue participants argued for a broadening of option 2, thereby effectively introducing a fourth option. One formulation of option 4 involved developing a coordinating structure for the strengthening of primary healthcare in the province, while a second involved developing a strategic plan for the strengthening of primary healthcare in the province, which in turn could support the development of a coordinating structure.

### **Option 1 – Collaboratively develop principles for quality improvement in primary healthcare**

Dialogue participants were broadly supportive of the collaborative development of principles for quality improvement in primary healthcare, however, several dialogue participants expressed concern about undertaking such work before developing the coordinating structures that would operationalize the principles. One dialogue participant noted that the process of collaboratively developing the principles would be critical to achieving the buy-in needed to ensure their widespread use in the province.

Most dialogue participants explicitly supported three of the examples of possible principles that had been provided in the issue brief:

- 1) a system-wide orientation that covers the full range of primary healthcare, from physician-led primary healthcare practices on the one hand to community-governed primary healthcare organizations on the other hand;
- 2) the incorporation of quality improvement initiatives (such as learning collaboratives) that have shown promise in rigorous evaluations in Ontario's health system or in other similar health systems; and
- 3) a sustained and coordinated approach to the planning, funding, implementation, and monitoring and evaluation of primary healthcare-focused initiatives designed to support improvements in quality in primary healthcare.

A fourth example of a possible principle – a commitment to transition over time from a dependence on expensive supports designed for and based within other health systems (such as the Institute for Healthcare Improvement) to supports that are purpose-built for and based within Ontario – was considered by some to be a “non-issue” now (i.e., there is no significant reliance on costly out-of-province supports, and good business practices are already being used in procurement of all supports), and by others to be something that would become a “non-issue” as leadership capacity grew within the primary healthcare sector.

A fifth example of a possible principle – a broad definition of quality improvement that incorporates both the primary healthcare programs and services that are delivered (i.e., access to them, their cost-effectiveness relative to one another and to other programs and services that could be offered, and the quality and safety with which they are provided), and how the delivery of these programs and services is organized (i.e., its patient-centredness and efficiency) – was strongly critiqued by one dialogue participant. This individual argued that the definition should remain focused on the quality and safety with which care is provided (which is a second-order priority for citizens overall, but a first-order priority for those who are currently patients), and not include access (which was seen as a first-order priority for all citizens and which would avoid increasing disparities between the “haves” and “have nots”) or cost-effectiveness (which was seen as a third-order priority).

A sixth example of a possible principle – use of public reporting both to support patients in their efforts to navigate the primary healthcare system and to ensure accountability to the citizens who finance the system – was debated in some detail. One participant noted that a form of public reporting is already occurring on independent websites that display patient ratings of their physicians, but not with the rigour that could come from more formalized patient satisfaction surveys. Another participant noted that the newly introduced Excellent Care for All Act placed significant emphasis on public reporting and that, while the act is perceived as having more of an institutional focus than a focus on primary healthcare, the emphasis on public reporting should be taken to be a priority right across the healthcare system. A third dialogue participant commented that it seems odd that quality indicators are publicly available for every daycare facility in Toronto, yet quality indicators are not publicly available for a primary healthcare system that so directly touches the lives of all Ontarians. Responding to this, a dialogue participant argued that Community Health Centres already report on client satisfaction as part of their accreditation process. The participant who made the point about daycare facilities also noted that the public will progressively turn its attention to demanding the best quality care possible (and to having the information and the technological supports, such as those emerging in the



telecommunications sector, they need to feel empowered in making decisions about their care) as its demands to have access to a physician or other primary healthcare provider are met.

Most participants agreed with the goal of public reporting and with a collaborative approach to its roll out (to avoid alienating primary health providers) and a phased expansion of the indicators being reported on (as indicators are shown to be valid and reliable, as well as “stable” at the level at which they are being reported). This refinement of what had originally been a sweeping statement reflected some participants’ concern that some indicators are currently “good enough” to support practice-/organization-based quality improvement, but not (or not yet) “good enough” to provide the public with timely information that they can count on (for example, because they do not adjust for case mix). One participant noted that the choice of indicators to be used in public reporting should be guided by “what patients want to see,” which could include indicators related to whether patients are happy with their after-hours access to care, and whether they are happy with the care they receive once they are able to access it.

The first part of the seventh and final example of a possible principle – the incorporation of performance measurement and feedback at the practice-/organization-level – was strongly supported by dialogue participants, but the second part of the example – the explicit setting of performance targets – was contested. Dialogue participants disagreed about whether quality indicators in general and targets in particular should be consistent across all primary healthcare practices/organizations (which facilitates the measurement of impacts of investments at the regional and provincial levels), set independently by each practice/organization (which encourages buy-in and appropriateness to local populations), or selected from a list of approved indicators (with or without some mandatory indicators). One dialogue participant noted that the Quality Improvement and Innovation Partnership provides teams with a choice of the conditions or issues on which to focus, and then the teams use a set of approved indicators that relate directly to their chosen conditions or issues. Some dialogue participants also noted that performance targets have to take into consideration the range of possible achievements for many primary healthcare practices/organizations serving marginalized groups and other populations with significantly greater needs than the general population. One dialogue participant noted that Community Health Centres, which sign accountability agreements with Local Health Integration Networks (unlike most other primary healthcare practices/organizations), have been negotiating population-appropriate agreements about performance targets for some time. One dialogue participant observed that at least some of these targets need to focus on process indicators (e.g., participation in quality improvement activities or in public reporting) and global measures of care (i.e., not just disease-specific indicators). One dialogue participant argued that highly specific quality indicators tend to be highly correlated with global assessments of care. Another dialogue participant noted the importance of at least some indicators addressing current government priorities, such as keeping non-urgent cases out of emergency rooms and reducing avoidable hospital admissions, as well as current Local Health Integration priorities, such as managing chronic conditions.

One dialogue participant recommended the inclusion of an additional principle, namely that an equity lens be taken in all quality improvement initiatives to ensure that the necessary time and resources are devoted to addressing the particular challenges faced when providing primary healthcare to marginalized groups and to others with greater needs. As another dialogue participant noted: “quality improvement is much easier to do in some settings than others.”

## **Option 2 – Develop coordinating structures and processes to support quality improvement in primary healthcare**

Dialogue participants generally agreed that a coordinating structure was needed to support quality improvement in primary healthcare at the practice/organization level. As one participant said: “there are too many little things going on now.” Another said: “we’re a province of little pilots.” One dialogue participant argued for a distributed model that supported many initiatives being run by different organizations, but “under a common architecture.” Dialogue participants also generally agreed that the lead for coordination

efforts should be a strategic alliance among key organizations directly involved in quality improvement, and possibly among key organizations involved in complementary work (e.g., accreditation and continuing professional development) as well. A number of dialogue participants argued that the strategic alliance should ideally be independent of the Ontario Ministry of Health and Long-Term Care, but sanctioned by, funded by and accountable to the Ministry. Several dialogue participants argued that this function could not be led by the Ontario Health Quality Council, but that it should work in close partnership with the Council. Another dialogue participant suggested that a partnership was also needed with accreditation bodies. One dialogue participant argued that the strategic alliance could be comprised of representatives from the provincial professional regulatory bodies and formalized through a memorandum of understanding among these bodies. This participant argued that such an approach would be consistent with the regulatory bodies' interest in moving from finding "bad apples" to supporting quality improvements, as well as their interest in moving from an exclusive focus on healthcare professionals working in isolation from one another to a complementary focus on groups of healthcare professionals working together in teams. Another dialogue participant noted that the regulatory bodies have been starting to work together in supporting the drafting of regulations related to the Regulated Health Professions Statute Law Amendment Act. Several dialogue participants supported the idea of regulatory bodies moving to a team-based orientation, but worried about regulatory bodies' ability to be seen as the lead for quality improvement, and to move away significantly from a focus on their individual members. A few dialogue participants suggested that one of the first tasks of the strategic alliance could be to collaboratively develop principles for quality improvement in primary healthcare. One dialogue participant suggested that the strategic alliance also needs to focus on supporting the incorporation of quality improvement training in health professional and continuing education programs. In responding to this suggestion, one dialogue participant noted that the Quality Improvement and Innovation Partnership is now developing a curriculum on fundamentals in quality improvement.

Some dialogue participants argued that there was a more pressing need for a structure to support primary healthcare strengthening in Ontario. They argued that an independent organization was needed to: 1) establish the business case for ongoing primary healthcare investments (to avoid witnessing a halt in future investments with less than half of the sector working under new funding and delivery models, as well as to reap the advantages from past investments in these models); 2) propose governance (and funding) arrangements for the primary healthcare sector (to ensure that, among other advantages, the sector's voice could be heard in local, regional and provincial debates); and 3) develop a strategic plan for the sector, monitor its implementation, and evaluate its impacts. These dialogue participants differed in whether they thought that the structure should be an independent agency (possibly called Primary Healthcare Ontario) on par with Cancer Care Ontario, or (given the provincial government's likely focus on cost control over the next decade and its recent challenges with independent agencies) a less costly and more nimble council (possibly called the Primary Healthcare Council). One dialogue participant liked many aspects of the Cancer Care Ontario model, including the engagement of both a provincial/regional leadership council (where administrative expertise is valued and linkages to Local Health Integration Networks can be made) and a clinical council (where clinical expertise is valued and linkages to healthcare providers can be made). Most participants spoke out in favour of the council model over the agency model, however, not all participants expressed a view about this.

Dialogue participants offered a number of additional comments related to the idea of developing a broader coordinating structure for primary healthcare. One dialogue participant pointed out that primary healthcare as a sector has received a disproportionately large share of new provincial funding over the past decade compared to other sectors (in large part to address pressing access challenges that confronted the current governing party when it was elected), and that tough questions would be asked about what more could be achieved as access challenges are being steadily addressed. Related to this point, one dialogue participant argued that a next big challenge would be in enhancing value for money by identifying whether new programs and services should be "added" because of their cost-effectiveness in achieving desired impacts, and whether existing programs and services should be "retired" (as one individual argued should be the case for vitamin D testing). Hearing this, another participant reminded others that there is an important distinction between value for money and cost, and that often doing a better job will cost more. Another dialogue participant

noted that a strong rationale would be needed to convince decision-makers to develop a new structure in a crowded institutional landscape, and wondered whether any new structure should be more focused on supporting integration (e.g., in chronic disease prevention and management) than on further entrenching a separation between sectors. Related to this point, one dialogue participant noted that primary healthcare providers in rural communities don't make a distinction between primary and secondary or tertiary care because they have to provide the full scope of care in many circumstances. These providers are often involved in hospital-based quality improvement initiatives, and would find it difficult to understand why primary healthcare quality improvement initiatives would be treated separately. Another dialogue participant argued that any structure to support primary healthcare strengthening in Ontario would still need to make improvements to access its first priority. This dialogue participant, among others, argued that the coordinating structure to support quality improvement in primary healthcare should in the long run be folded in under this broader structure, but that in the meantime the strategic alliance could focus on achieving a number of measurable "wins" in the more focused domain of quality improvement. Another dialogue participant suggested that any structure designed to support primary healthcare strengthening in Ontario would need to establish strong links with regional health authorities and public health units across the province, and involve people with a rich understanding of front-line primary healthcare in the province (as well as those who understand the realities of specialty care). Finally, one dialogue participant argued that any structure would need to "have teeth" at the policy level. This participant wondered whether initiatives like the Saskatchewan Quality Council which "had teeth", was able to accomplish more than its Ontario counterpart, which played more of a simple reporting role, as well as whether there were broader lessons to be learned from efforts to establish similar organizations in other jurisdictions.

One dialogue participant argued that the first step to promote greater coordination in primary care should be the collaborative development of a strategic plan for the sector, and that the broad-based consultations (with a range of stakeholders, including citizens and patients) required to develop this plan could inform the design of any coordinating structures and processes, both to support primary healthcare strengthening generally and to support quality improvements in primary healthcare more specifically. This dialogue participant suggested that there may be lessons to be learned from how other countries with strategic plans for the primary healthcare sector (such as Australia, Ireland, the Netherlands, New Zealand and the United Kingdom) undertook the development, implementation and monitoring of their plans. However, other participants pointed out the challenge of developing a plan without first having a mandate, funding and accountability arrangement for the "planners" sorted out with the Ontario Ministry of Health and Long-Term Care.

### **Option 3 – Support the scaling up of existing quality improvement initiatives**

Dialogue participants had very mixed views about where to start when scaling up existing quality improvement initiatives. A number of dialogue participants supported team-focused quality improvement while others argued strongly for "not leaving anyone behind" (including solo practitioners). One, or at most two, dialogue participants endorsed specific potential starting points, including learning collaboratives, "test cases" (e.g., diabetes) and early adopters (of quality improvement or electronic health records). One dialogue participant spoke out in favour of, and another against, a competition-driven approach whereby primary healthcare practices/organizations could apply for supports for their quality improvement activities.

Several dialogue participants questioned the premise of having to make strategic choices about starting points at all, noting that "some, all or none" of the potential starting points might make sense. These dialogue participants viewed all quality improvement as having to be driven by individual practices/organizations. Following this approach, the strategic choices would be left to each practice/organization and not made at the provincial or regional level using a "one-size-fits-all approach." Other dialogue participants, on the other hand, argued that choices among starting points should always be driven by provincial and regional priorities, even if there is a list of options from which individual practices/organizations can choose. A third group of dialogue participants argued that making strategic choices "need[s] to begin with deciding what you want to accomplish and not with a shopping list."

## Considering the full array of options

Before working through implementation considerations and next steps, most dialogue participants supported option 2 (developing coordinating structures and processes to support quality improvements in primary healthcare in Ontario) and a smaller number of dialogue participants supported one variant of a new, complementary option 4 (developing a coordinating structure for the strengthening of primary healthcare in the province). After working through implementation considerations and first thoughts about next steps, dialogue participants began to shift in their views. Dialogue participants started to see the other variant of option 4 (developing a strategic plan for the strengthening of primary healthcare in the province, which in turn could support the developing of a coordinating structure) as being important, and perhaps essential to the success of quality improvement efforts. Throughout these developments, dialogue participants continued to see option 1 (collaboratively develop principles for quality improvement) and option 3 (support the scaling up of existing quality improvement initiatives) as work to be done in the context of option 2.

## DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Dialogue participants generally agreed that “there’s an appetite” for quality improvement right now from front-line practices/organizations through Local Health Integration Networks and up to the Government of Ontario (as indicated by its speech from the throne and by the Excellent Health Care for All Act). One dialogue participant argued that this “appetite” needed to be translated into concrete demands of the federal government as the Ontario government participates in the re-negotiation of the Canada Health Transfer, which expires in 2014. Most dialogue participants did not object to the summary of potential barriers listed in the issue brief, however, two barriers were touched upon more frequently than others, namely that citizen/patient groups may resist principles that were developed without their active engagement, and that primary healthcare providers may resist strategic choices that “leave behind” some practices/organizations in the short- to medium-term. These potential barriers led dialogue participants to emphasize the importance of any next steps including a public-engagement strategy and an effort to engage all primary healthcare practices/organizations (not just those in select funding/delivery models). One dialogue participant noted that public engagement would generate important ideas that might not have been considered otherwise, enhance accountability within the healthcare system, and have spill-over effects in terms of supporting greater patient involvement in self-management. Several dialogue participants emphasized that any next steps must include a significant push to achieve 100% use of electronic health records in primary healthcare practices/organizations, and significant investments in monitoring and evaluation, and in tools and coaching to allow primary healthcare practices to act upon high-quality performance data. A number of dialogue participants lamented that the historical lack of investments in monitoring and evaluation has meant that it is now difficult to demonstrate objectively the improvements that have been achieved in Ontarians’ access to primary healthcare as a result of sustained investments in Family Health Teams, nurse practitioner-led clinics and other initiatives over the past decade, and hoped that this would not be the case with future investments in quality improvement initiatives.

A few dialogue participants wondered whether the personalities of those representing key organizations and their attachment to their “preferred ways of doing things,” as well as the historical competitiveness (for resources) and rivalries among their organizations, might be leading to a greater focus on areas of difference than on the common good. One of these participants noted that “if we don’t work together, we won’t get there” and that “we each need to let go of our standard way of doing things.” Another of these participants noted that we have to ask “how can we make it happen faster” together. A few other dialogue participants expressed concern that without a mandate and funding from the Ontario Ministry of Health and Long-Term Care to support this work, any progress would need to be made “off the corner of our desks.” These participants observed that the absence of a coordinating structure created a vicious cycle in which it was hard to take even preliminary steps towards the creation of a coordinating structure.

## **DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES**

Dialogue participants concluded that two parallel initiatives should be pursued:

- 1) a small planning group should draft and build consensus on a strategy for strengthening primary healthcare in Ontario, and plan a summit at which the strategy would be debated, finalized and approved by a broad-based group of key stakeholders, including citizen and patient groups, and representatives from Local Health Integration Networks and from public health units; and
- 2) the Quality Improvement and Innovation Partnership should convene one or more meetings to discuss the need and a plan of action for a strategic alliance focused on supporting quality improvement in primary healthcare, and then provide leadership and support to the strategic alliance.

Dialogue participants agreed that: 1) the small planning group should be comprised of representatives of a small number of organizations (Association of Ontario Health Centres, Ontario College of Family Physicians, Ontario Medical Association, Registered Nurses Association of Ontario, and Ministry of Health and Long-Term Care); 2) the representatives need to be able to speak on behalf of their organizations and to contribute resources (staff time, money or both) to the initiative; and 3) the strategy should address key issues like: a) the business case for primary healthcare investments; b) governance in the primary healthcare sector; c) goals related to improving access and quality within primary healthcare and activities to achieve the goals; and d) a monitoring and evaluation plan to monitor progress against the goals and to evaluate the impacts of investments and activities. Several dialogue participants argued that the strategy should use language that resonates with citizens and patients (e.g., family physicians, not primary healthcare providers), not just with experts in the field. One dialogue participant also noted that the planning group would need to be supported by a secretariat that could draft and iteratively revise the strategy, plan and execute the engagement plan to support the strategy's development, and plan and execute the summit.

Many dialogue participants agreed that the strategic alliance would need to have a clear mandate, a clear division of labour among key organizations directly involved in quality improvement and among key organizations involved in complementary work (e.g., accreditation and continuing professional development), clear accountabilities and committed funding. One dialogue participant suggested that the strategic alliance, with support from the Quality Improvement and Innovation Partnership, could: 1) conduct a gaps analysis to identify who is not already at the table but needs to be; 2) collaboratively develop principles for quality improvement in primary healthcare; 3) establish (and periodically revise) quality improvement priorities and targets in light of provincial and regional priorities and targets; and 4) support the identification, measurement and analysis of quality improvement indicators that would be used by or offered for use by primary healthcare practices and organizations. One dialogue participant noted the importance of engaging with the Ontario Health Quality Council while its new memorandum of understanding with the Ontario Ministry of Health and Long-Term Care is being negotiated.

Many dialogue participants also agreed that both the planning group and the Quality Improvement and Innovation Partnership should engage dialogue participants in establishing the terms of reference for both the planning group and strategic alliance, and at key junctures in the evolution of their work.

**DIALOGUE PARTICIPANTS**

The McMaster Health Forum does not normally publish the list of dialogue participants. Participants in this dialogue, however, consented to have their names listed.

Adrianna Tetley, Executive Director, Association of Ontario Health Centres

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Doris Grinspun, Executive Director, Registered Nurses Association of Ontario

Geoffrey Bond, Elected Professional Member, District 5 (Simcoe, Muskoka, Durham, Peel and York), College of Physicians and Surgeons of Ontario

Ivan Silver, Chair, Continuing Professional Development – Ontario

Jan Kasperski, Chief Executive Officer, Ontario College of Family Physicians

Karen Patzer, Senior Planner, Champlain Local Health Integration Network

Karl Stobbe, Past President, Society of Rural Physicians of Canada

Linda Dietrich, Regional Executive Director, Central and Southern Ontario, Dietitians of Canada

Lynn Wilson, Chair, Department of Family and Community Medicine, University of Toronto

Michael Green, Associate Professor, Department of Family Medicine, Queen's University

Paula Carere, President-Elect, Nurse Practitioners Association of Ontario

Peter Deimling, Member, Board of Director, Association for Family Health Teams in Ontario

Scott Wooder, Treasurer, Ontario Medical Association

Stewart Harris, Professor, Department of Family Medicine, University of Western Ontario

Susan Fitzpatrick, Assistant Deputy Minister, Negotiations and Accountability Management, Government of Ontario