

The Journey toward High Performance and Excellent Quality

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Abstract

Signalling the importance of healthcare quality and quality improvement plans in Ontario, the province's Excellent Care for all act requires all hospitals to publish quality improvement plans, conduct regular patient and staff surveys, and forge a clear link between hospital CEO compensation and quality improvement. The act also clarifies and strengthens links between evidence and quality of care.

The act is an important step toward Ontario's becoming a high-performing healthcare system. Yet as some of the papers in this special issue of *Healthcare Quarterly* discuss, there remains much to be done. Other papers and interviews draw attention to the importance of strategic and system design levers – particularly setting goals, public reporting of results and clinician engagement – to stimulating improvement. Yet other papers present a diverse range of perspectives and ideas on how to pursue improvement and to bridge the knowing–doing gap in healthcare so that evidence informs better practice. Achieving and sustaining high performance in healthcare will require dedicated effort by everyone in every healthcare organization. With a view to the future, the act allows for the expansion of the quality obligations initially applicable to hospitals to other publicly funded health organizations.

Just over two years ago, the Legislative Assembly of Ontario voted unanimously in favour of the Excellent Care for All Act (Legislative Assembly of Ontario 2010). The act signals the importance of quality and quality improvement across hospitals by requiring quality improvement plans, regular patient and staff surveying, and a clear link between hospital CEO compensation and quality improvement. The act also makes clearer and stronger links between evidence and

quality of care. Perhaps most notably, the act enjoyed wide support across the healthcare system, and its provisions can be extended beyond hospitals through regulation.

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The act is not a dramatic departure from previous policies but rather an incremental and inclusive step from earlier efforts to improve quality across Canada. Starting in the early 1980s, a number of academics, policy makers and practitioners worked to advance continuous quality improvement across healthcare organizations. The creation of the 3M Health Care Quality Team Awards, the development of the Ontario Continuous Quality Improver Network (now the Quality Healthcare Network) and the publication of a number of papers, reports and case studies on quality improvement in Canada are some legacies of an era focused on increasing capacity for improvement and the evolution of a quality culture. More recently, improvement methods have expanded to include the breakthrough collaborative approach developed by the Institute for Healthcare Improvement (IHI) in the United States as well as the application of Lean and Six Sigma techniques.

By the 1990s, a growing body of reports from the University of Manitoba Centre for Health Policy, the Institute for Clinical Evaluative Sciences in Ontario, the University of British Columbia Centre for Health Services and Policy Research, and

a range of hospital report cards in Ontario and elsewhere shifted attention to accountability for quality and introduced benchmarking, ranking and other types of comparisons to the quality improvement landscape. The emergence of quality councils in a number of provinces (Dobrow et al. 2006), the establishment of the Health Council of Canada, and a greatly expanded range of performance reports from the Canadian Institute for Health Information facilitated the acceptance of performance reporting as an important element of quality improvement efforts in Canada.

By the early 2000s, a number of papers – most notably the Baker–Norton study on adverse events in Canada (Baker et al. 2004) – helped make the case for change and stimulated widespread efforts to improve the quality and safety of healthcare across Canada. These critical efforts, along with an increased recognition of the importance of governance, have added momentum and focused accountability for improvement in quality and safety. Seen against this historical backdrop, the *ECFA Act* represents a continuation and a synthesis of efforts to improve quality of care.

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Although the act represents an important step forward, it is not the final stop on the journey toward a high-quality health system, let alone a high-performing health system. As the papers in this issue illustrate, there remain a number of important steps yet to be taken in Ontario. Studies of high-performing healthcare systems, including the Quality by Design study (Baker et al. 2008) and work by American (Lukas et al. 2007) and British (Bate et al. 2008) scholars, have emphasized a number of key factors contributing to improved and sustained performance. Some of these factors find reflection in the papers and interviews that follow. This sort of consistency underlines the critical importance of how healthcare institutions are structured and how they organize and maintain a focus on improvement.

However, the papers and interviews in this issue also draw attention to the importance of some strategic and system design levers to stimulating improvement. Three of these levers – goals, reporting and clinician engagement – deserve some attention. The first lever is some form of publicly communicated commitment to improved quality. This commitment can include benchmarks, targets and other aspirational descriptions of better quality. None of the systems referenced explicitly or implicitly throughout this special issue of *Healthcare Quarterly* have begun the quality journey without some form of commitment. The key element seems to be recognition of the importance of improvement and a clear and compelling vision and goal. At their best, these commitments establish a clear and

explicit strategy, and make strong linkages between quality improvement initiatives and this strategy, establishing clear accountability for strategy execution (Baker et al. 2008). The IHI's 100,000 Lives Campaign provides a very clear example of the successful use of goal statements, coupled with a tactical approach to implementation to improve healthcare (Berwick et al. 2006). Although there is some debate about the magnitude of its final outcome, it is clear that over an 18-month period ending in 2006, the IHI campaign helped disseminate evidence of effective practices, mobilized improvement efforts across the United States and stimulated similar campaigns in Canada, Denmark, the United Kingdom and elsewhere. The more recent Triple Aim campaign can be seen in the same vein, although it has a broader set of aspirations.

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In this special issue of *Healthcare Quarterly*, Cancer Care Ontario and the Cancer Quality Council of Ontario provide examples of the importance of goals. Cancer Care Ontario's first three-year Ontario Cancer Plan established a comprehensive strategy and goals for improvement. These efforts have been followed up with annual updates that publicly report progress toward measurable targets for each stated goal (Duvalko et al. 2009). The importance of a commitment to quality and improvement finds clear reflection in the interviews with Richard Ernst and Joe Mapa about how to make measurable improvements in the patient experience. In her paper on what makes care patient-centred, Barbara Balik (2012) references the Triple Aim goals and makes it clear that a key first step is the articulation of expectations. Speaking to the importance of conversations at all levels of an organization to move toward partnerships with patients, she states: "Facilitated conversations can reveal what all participants expect and what behaviours are needed to transition to partnerships."

The second element is effective performance reporting. Although typically drawn from observational studies, data suggest that public reporting of results can be a powerful tool for motivating change, establishing accountabilities and creating transparency. Done well, public reporting can draw the attention of clinicians to areas of deficiencies and motivate positive change. For example, reporting of cardiac surgery outcomes in New York State and California prompted surgeons to rethink how they care for certain groups of patients, particularly those who are at high risk (Hannan et al. 1994; Harlan 2000). Likewise, British performance results improved only in England, where

results were reported publicly; they did not improve in Scotland, where they were reported privately (i.e., back to each institution individually); or in Wales, where they were not reported at all (Alvarez-Rosete et al. 2005). In Canada, a cardiac report card by the Institute for Clinical Evaluative Sciences for treatment of patients who had suffered a heart attack prompted over half of clinicians surveyed to launch one or more quality initiatives at their hospital (Tu and Cameron 2003). Public reporting has also been shown to motivate healthcare administrators to make necessary changes to improve care. Examples of administrative responses to publicly reported information include improvements in recruitment practices and performance monitoring, and increased investments in quality improvement (Bentley and Nash 1998).

It is often unclear whether the improvements stimulated by public reporting stem from the effect of competition on patient decision making or concerns over reputational damage on staff decision making. A recent study, however, highlights the importance of a simple and much more complementary driver: a staff culture oriented toward improvement. Veillard and colleagues (2012) show that private reporting of results – strongly linked to evidence-based guidelines and a theory of improvement – were also associated with increased quality improvement activity. Thus, it is reporting that captures attention that matters, perhaps because it is public or it is useful to clinicians and managers. This sort of reporting may touch on the intrinsic incentives faced by providers and managers, their desire to do right by their patients and the growing recognition of how evidence, including performance data, shapes providers' and managers' decisions. Once again, each of the systems referenced in this report have some form of public performance reporting. Perhaps, not surprisingly, in their survey of what other jurisdictions have done around quality legislation, Veillard and colleagues (2012) note that performance reporting is a common element of these laws.

The third element contributing to better quality is strong clinician leadership for improvement efforts that are aligned to meet improvement goals.

The third element necessary to better quality is strong clinician leadership for improvement efforts that are aligned to meet improvement goals. Strong clinical governance has been demonstrated as an important ingredient for continuously improving the quality of patient care (Scally and Donaldson 1998). The importance of clinical governance has been highlighted in the United Kingdom's National Health System reform (Scally and Donaldson 1998; Halligan and Donaldson 2001). Plans for improvement must be owned and understood by the chief



decision makers in patient care. This requires creating teams of physicians (and other clinicians) engaged in patient care that can design and champion improvement plans. A number of papers and interviews draw out the importance of clinician engagement at every step of the improvement journey, starting with the articulation of shared goals. In their interviews, both Levinson and Flemons speak to the importance of a genuine supported engagement with physicians and the potential for strong clinical leadership on quality improvement. Papers by Sawka and colleagues (2012) on Cancer Care Ontario and by Cochrane and colleagues on British Columbia point to the necessary, but not sufficient, role of structures for engaging physicians in the quality journey.

Despite these common themes, the papers in this special issue also present a diverse range of perspectives and ideas on how to pursue improvement and to bridge the knowing–doing gap in healthcare so that evidence informs better practice. Waldner's paper (2012) on hospital design is one novel reflection of this trend, but most of the papers and interviews touch one way or another on the importance of increasing the use of evidence. For example, Laupacis and Born (2012) discuss the potential of engagement to shape and monitor improvement goals; the papers on the Ontario quality improvement plans, the BC General Practice Services Committee and the Saskatchewan Health Quality Council talk to the importance of effective co-creation between policy makers and providers of the strategies, tools and tactics to improve quality.

The paper by Kutty, Ladak, Paul and Orchard (2012) notes that most hospitals found that preparing the quality improvement plans required under the *Excellent Care for All Act* was a positive experience and helpful in terms of promoting quality. But Baker and MacIntosh-Murray (2012) report that some leading institutions found the increased requirements limiting and at times detrimental to their quality improvement efforts. This finding highlights the challenge that any systemic approach faces. New initiatives need to motivate and assist low performers while facilitating continued progress for organizations at more advanced stages of their quality improvement journey.

This last point – that different organizations perform variably and need different tools at various points in moving toward high performance and excellent quality – highlights the importance of capacity building. The *Excellent Care for All Act*, and many other strategies across Canada, have emphasized stronger accountability and an increased focus on quality. In the novel *Shoeless Joe*, later adapted into the film *Field of Dreams*, W.P. Kinsella imagines a fantasy world where building a baseball diamond in an Iowa cornfield is sufficient to lure famous baseball players to emerge. However, securing high performance in healthcare will require dedicated and sustained efforts by every healthcare organization to develop the capacity for improvement, engaging clinicians, managers and leaders across the system. Happily, the *ECFA Act* allows for the expansion of the quality obligations initially applicable to hospitals to other publicly funded health organizations. **HQ**

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