

In this issue, we begin our year-long focus on effective primary care systems, opening up critical lines of questioning around a fundamental issue: evaluation. How do we know whether a primary care system is making the grade, getting stronger or falling short? If we build it, what should it yield? There are myriad ways and measures to assess the quality, performance and outcomes of primary care systems (and ample arguments about which are best). What standards should primary care systems meet? What bars should be set, at what height, and to what end? What knowledge, skills and data are required – and available – to evaluate primary care models? Are evaluation results driving primary care quality improvement (QI) big and small?

The first two articles revolve around one approach to assessment – accreditation. Five family practices in the WestView Primary Care Network in Alberta went through an intense process and in 2015 became the first network to earn a Primary Care Accreditation (Moe et al. 2019b). According to the authors who examined the effect of accreditation on QI efforts, benefits include: “improvements in policy and documentation infrastructure, and not in clinical outcomes,” increased pressure and opportunities to implement QI initiatives, and internal and external recognition of excellence.

An accompanying analysis on workload and cost asks if accreditation was worth the expense and effort (described as “enormous” in the previous piece) (Moe et al. 2019a). Total cost for the five clinics was \$963,313, ranging from \$168,669 to \$227,838 for individual clinics. The considerable cost of engaging physicians – key to QI success – was noted, and the article concluded by asking if supporting QI initiatives in general would reap more meaningful returns.

The authors of our third article argue that insufficient evaluation on models such as Ontario’s Family Health Teams fuel debate on optimal models of care (Sibbald et al. 2019). They describe the arrival of FHTs as an infusion of “new vitality” into family medicine, “a proactive step” to improved patient care. Their applause is attenuated, however, by the FHTs’ “lack of built-in evaluation strategies to assess performance.” The authors do acknowledge some exceptional strengths, such as the Data to Decisions (D2D) tool developed to measure quality, and underscore the need for increased resources for the FHTs. They call for more staff to support QI and change management training, vendor requirements to embed evaluation metrics into EMRs, and meaningful, timely practice-level data. The authors assert that better, and more, evaluation of the FHT model will confirm its effectiveness.

International Models of Integration: Part 3

Helen Bevan, chief transformation officer of England’s National Health Service, closes out The Change Foundation’s series on international health service delivery models for integrated systems (Fooks et al. 2019). She offers thoughtful, refreshingly frank advice for achieving a new world order in integrated health and social care. First, shift from “old power” – held by few, jealously guarded, closed – to “new power,” made by many, open, distributing power, not hoarding it. Second, avoid labels that alarm and use language that is meaningful to people. Third, spend less time and energy on structures and more on agency, releasing people to bring on change. To take in the full force of Ms. Bevan’s ideas, we urge you to read the entire article.

Health System Governance

The article by White and colleagues (2019) looks westward to Alberta’s Strategic Clinical Networks™ and to what is known – and unknown – about them. The networks, teams of healthcare professionals, researchers, government stakeholders, patients and families, were created to improve quality and reduce variations in patient outcomes and practice. While some have completed projects showing promising results, the authors’ overarching message is that there is as yet too little, and too limited, evaluation of what this structural shakeup has delivered at the patient, practice and system level.

Managing Effectively

Michael Heenan (2019) presents health quality management as an amalgam of QI areas, discrete but indivisible, with individual goals blended into a single integrated definition that all managers can apply in their health setting. He reviews developments in the literature related to governance, process improvement, performance measurement, patient experience, physician and staff engagement and finance. He defines each area, compares common elements, and arrives at a new definition of health quality management: “safety, accountability cultures committed to zero harm, effectively planned and financed, utilize process improvement and measurement tools that enable operational change and are based on a relentless commitment to continuous learning and knowledge transfer.”

Increasing Efficiency

When talk turns to hospital hallway medicine, one may hear about the need for system-wide change or greater capacity in other sectors. Details about hospital bed turn-over times and patient transfers are generally not part of health reform

discussions. And that's a missed opportunity for implementing small changes that can improve processes and operations, according to the authors of *Time of Transfer of Admitted Patients from the ED: A Contributor to ED Boarding in High-Volume Community Hospitals* (Salehi et al. 2019). They share findings from a retrospective study of three high-volume GTA hospitals and their discharge times of inpatients and transfer times of ED-boarded patients.

Workplace Safety

This issue's last article describes another modest intervention that can yield improvements in an area of growing concern – the safety of health professionals. In this case, the intervention was at Canada's largest psychiatric hospital where a risk-flagging system – embedding alerts in a patient's electronic health record -- was implemented to make health professionals aware of potentially aggressive or violent patients (Paterson et al. 2019). The study found that violent incidents decreased during the implementation of the “alert system” but increased after the end of that phase. The authors advised that risk-flagging – for which, again, there is limited literature – should be complemented with other forms of risk communication.

Improving Services for Vulnerable Populations

In an important contribution to a sparsely populated research area, an ICES study (Brown et al. 2019) on the reproductive health of Ontario women with intellectual and developmental disabilities (IDD) reveals an increased risk for adverse outcomes and identifies practical program changes to mitigate them. Results from a baseline CIHI survey (Costante et al. 2019) on access to palliative care in Canada show a pronounced paucity of services for a particularly vulnerable population, a lack of expertise among health professionals and a compelling need for more community-level data.

– The Editors

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