

Health Quality Ontario

The provincial advisor on the quality of health care in Ontario

June 2017

Establishing the Ontario Quality Standards Committee: Summary Report



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Background

The Context

On December 7, 2016, the Ontario government passed the *Patients First Act*,¹ with the stated goal of increasing the coordination and consistency of health care services in the province. A key component of the *Patients First* plan involves the creation of a new committee at Health Quality Ontario through an amendment to its legislation, the *Excellent Care for All Act (ECFAA)*.

Health Quality Ontario's amended legislation now specifies that one of its functions is:

*“to promote health care that is supported by the best available scientific evidence by making recommendations to health care organizations and other entities on clinical care standards, and **making recommendations to the Minister concerning... clinical care standards and performance measures relating to topics or areas that the Minister may specify.**”*

Many organizations in Ontario currently offer guidance on optimal clinical care in a variety of forms, including practice guidelines, clinical pathways, decision tools, and accreditation standards. Though these products often vary in terms of intended audience, use, or specificity, they share a similar goal: supporting clinicians in the provision of high-quality care to patients. In spite of the proliferation of different forms of clinical guidance, care quality in Ontario continues to vary across settings, among different populations, and between regions.

Health Quality Ontario initiated its own [quality standards](#) program to address this issue of variation in care. Quality standards are concise statements based on evidence and expert consensus. The goal of the program is to become a go-to resource for evidence-based standards that promote high-quality care—a recognized and accessible repository used by clinicians, patients, and health care organizations.

With the passing of the *Patients First Act* and the introduction of additional recommendation-making powers in the *Excellent Care for All Act*, Health Quality Ontario embarked on a process of establishing a new committee to support its revised mandate. Beyond guiding Health Quality Ontario's own quality standards work, this committee will play a broader strategic role in realizing the goals of Patients First. This includes working with others to prioritize and coordinate the development, adoption, and monitoring of clinical care standards across the health care system, with the goal of a more centralized, integrated, and systematic approach to improving health care for Ontarians.

The Approach

Health Quality Ontario worked with a project team of internal and external stakeholders to design this new committee. The interdisciplinary team included internal Health Quality Ontario representatives, leadership from Local Health Integration Networks and the home and

¹ Ontario Government. “Ontario Passes Legislation that Delivers Better Health Care for Families.” <https://news.ontario.ca/mohltc/en/2016/12/ontario-passes-legislation-that-delivers-better-health-care-for-families.html>

community care sector, key stakeholders from the Ministry of Health and Long-Term Care and patient representation (see Appendix 1). In consultation with external advisors, this team developed the mandate, scope, governance model, and membership of the new committee.

Key Findings

Environmental Scan

Health Quality Ontario conducted an environmental scan and key stakeholder consultation to identify potential governance models and best practices; to understand Ontario's current standards environment; and to inform where the committee could offer highest value to Ontarians and the health system.

Through its scan of Ontario's current standards environment, the project team identified almost 30 organizations, agencies, and bodies in Ontario alone that develop guidance to clinicians and patients on clinical care. This number does not include private sector or industry organizations, national or international bodies, or journal publications. The rapid proliferation of clinical guidance results in an often overwhelmingly complex environment for clinicians and patients to navigate. One study has suggested that a primary care physician would require an estimated 620 hours—or 20 hours a day—to evaluate the volume of relevant medical literature published each month.²

These materials also vary according to a number of important factors, including the evidence on which they are based, the degree of clinical judgment required to use them, the intended audience, the level of detail, and the corresponding metrics or performance measures associated with them.

Further complicating the landscape, the terms used to refer to these products are not consistently applied or defined. As the project team embarked on the process of evaluating the Ontario landscape, they agreed upon several working definitions of key terms (see Appendix 2). Though not intended to be comprehensive or definitive, these definitions aided the team in articulating the scope of the new committee's work.

Health Quality Ontario currently uses the term “quality standards” to refer to its approach to clinical guidance. Quality standards are “concise sets of easy-to-understand statements based on the best evidence.” However, the *Excellent Care for All Act* uses the term “clinical care standards” to refer to this aspect of the organization's mandate. No definition of the term is offered within the Act, and it is not used by any other Ontario bodies. This presented a challenge to the project team as it worked to define the scope of the new committee's mandate.

Given the stated goal of *Patients First*—enhancing integration in the system and improving the consistency of care, regardless of where it's provided or by whom—the project team felt that clinical care standards should not be too granular or specific in focus. This would allow them to

² Alper et al. How much effort is needed to keep up with the literature relevant for primary care?
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC521514/>

remain applicable across all manner of providers, settings, and regions. They should describe high-quality care, but do so in a way that accommodates variation based on context, clinical judgment, or patient preference. A definition close to that used by the quality standards program was adopted:

Clinical care standards are concise sets of evidence-based, measurable statements that establish the important elements of high-quality health care for patients with specified conditions.

Health Quality Ontario's quality standards could be considered one example of clinical care standards. In future, other organizations may undertake the development of their own clinical care standards in partnership with Health Quality Ontario and the new committee. The goal over the next three years would be to define a streamlined process for introducing new standards into the field—from topic prioritization through to adoption and monitoring of uptake.

Jurisdictional Scan

Once the Ontario context was established, the project team investigated provincial, national, and international examples of similar committees in order to identify best practices for governance. The scan focused on seven organizations or committees operating in similar structures or with comparable goals. These included the Quality Standards Advisory Committees at the National Institute for Health and Care Excellence; the Australian Safety and Quality Commission standards program; the Agency for Healthcare Research and Quality in the United States; and several Ontario examples.

Thematic findings from the scan are summarized in Appendix 3 of this report. Key observations include the following:

- **Importance of Clinical Partners** – A strong connection to clinical leadership is necessary to support prioritization, development, and adoption of standards; well-documented processes and reputable experts must be involved from the beginning to ensure credibility. The standards must be combined with implementation tools to enable application within the clinical workflow.
- **Value Proposition** – Topics should be identified in close collaboration with clinicians to support improved uptake and address issues that most affect patient care. Committee members must resist delving into technical details of standards—the value of such a committee is in its ability to take a broader systems view.
- **Start-up vs. Operational** – Strong examples of governance recognize the importance of a long-term plan and vision, but also the need to ensure that the “start-up” nature of the first few years is recognized. Early work plans should focus on program design, communication, and process development (i.e. ensuring Health Quality Ontario's existing standards program is functioning in alignment). Following this development phase, a process can be defined and introduced whereby other standards-developing bodies or organizations that support adoption are able to leverage the committee and its processes. The membership and committee support should reflect the start-up focus of the first year; these can be revisited once the committee is operational.

- **Independence** – All examples reviewed demonstrated independence from government oversight or political decision-making, noting this as integral to ensuring a perception of impartiality and maintaining trust.³

Consultation

Key stakeholders and informants for consultation were identified through environmental and jurisdictional scanning and included provincial, national, and international organizations. The team held consultation meetings with over 30 organizations and individuals (see Appendix 4 for complete list). Representation included patients, caregivers, clinicians, associations, standards-developing bodies, regulatory bodies, ministries, and both international and provincial data agencies.

Detailed consultation findings are summarized in Appendix 4. High-level findings include the following:

- **Supports to Clinicians** – Many of the clinicians and clinical groups consulted welcomed a model that would prioritize clinical care standards, ensure appropriate engagement, and make the necessary tools available to support adoption. They expressed concerns about existing burden—both in terms of adopting rapidly proliferating standards and in meeting new performance measures related to them. The project team heard that clinicians and allied health professionals are already required to use best evidence to support care. Rather than working against this professional requirement, many stakeholders felt this committee could represent an opportunity to support clinicians in meeting their professional standards by enhancing clarity related to evidence-based care.
- **Adoption is Key** – Given that support to clinicians is integral to the adoption of standards, the team heard that this should be a key area of focus for the committee. In some cases, this may require a more measured and deliberate approach to the release of standards or a phased process for monitoring performance to allow the field to keep pace.
- **A Worthwhile Risk** – From consultations with Health Quality Ontario’s Patient, Family, and Public Advisors Council, the team heard that patients and the public are very supportive of the objectives of the quality standards program. Patients feel that standards can help to provide them with a better understanding of their care and be used to facilitate difficult conversations with their providers. They suggested that members on the committee would need to be collaborative leaders willing to take on risks, deferring short-term interests for the sake of the long-term vision of improving the system.
- **Definitions** – The team heard variable reactions to the term “standards.” Some interpreted it as referring to a minimum requirement for performance. This could suggest a focus on clinical performance management, which is not the intent. An effective and ongoing consultation and partnership strategy will be necessary to ensure that the concerns of clinicians are addressed and that the intent of the program is clear. The team heard that a focus on integrated care—care that crosses multiple sectors,

³ Report of the Triennial Review of The National Institute for Health and Care Excellence. (2015). UK Department of Health. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/447317/NICE_Triennial_Review_Report.pdf

professionals, and contexts—would be most valuable, since this is an area not currently addressed by other sector- or provider-specific clinical guidance.

Committee Design

Objective

With many organizations producing clinical guidance in the system, keeping pace with that guidance places a significant burden on clinicians, patients, planners, and policymakers. Often these products are sector- or provider-focused, and it can be difficult to determine how they relate to one another or where focused, system-wide attention is required to see improvement.

Based on the overwhelming feedback gathered through consultations, and on lessons learned from other jurisdictions, the project team determined that a centralized, coordinating function for clinical care standards is needed in the province. The new committee's value proposition lies in its ability to enhance integration and promote coordination across Ontario.

The following committee objective was articulated:

Improve outcomes and reduce unwarranted variation in care quality through a coordinated provincial approach to standards prioritization, development, adoption and measurement.

All subsequent considerations for the setup of the committee were based on this goal. A name for the committee was chosen to signal the committee's broader system-wide focus—the Ontario Quality Standards Committee (OQSC).

An articulation of the vision, objective, activities, principles, and enablers of the proposed committee can be found below.

Committee vision and objectives



Mandate and Scope

Given its broader, system-wide focus, it was determined that the committee would not develop clinical care standards itself. Clinical care standards will continue to be developed by experts—both clinicians and patients or caregivers with lived experience. A single committee, particularly one populated with the goal of addressing issues at the level of the whole health system, would not be appropriately equipped to evaluate the evidence associated with the diversity of health conditions and patient populations for which clinical care standards will be developed.

Rather, the committee will accomplish its objective in two ways:

1. By providing advice to Health Quality Ontario on its quality standards program, including on opportunities to enhance the adoption and impact of its quality standards; and
2. In alignment with the mandate set out in the *Excellent Care for All Act*, make recommendations directed to health care organizations, the Minister of Health and Long-Term Care and other entities. As a committee of the board, all recommendations are submitted to the Health Quality Ontario Board for approval.

Health Quality Ontario has always had a mandate to make recommendations to health care organizations on clinical care standards. Its new power, making recommendations to the Minister, could be approached in several ways, including proposed funding, policy, resource, or structural changes to enable the uptake of clinical care standards.

The committee's role in prioritizing or coordinating clinical care standards activities taking place outside of Health Quality Ontario must be explored and developed gradually through close consultation and collaboration with system partners. There may be circumstances in which a

standard for a topic already exists in the system and, provided the methods by which it was developed are sufficiently rigorous, the committee may choose to recommend that the Health Quality Ontario Board endorse this standard and develop recommendations associated with its adoption. In other cases, a clinical care standard might be needed in a topic area that aligns with the expertise of an existing organization in Ontario, and the committee may play a role in referring out the development of that standard. Organizations may also choose to partner with Health Quality Ontario in the development of a clinical care standard or collaborate on approaches to supporting adoption and uptake.

One of the committee's first activities will involve the development of a partnership strategy for the alignment and coordination of clinical care standards with other clinical guidance in Ontario. The committee's mandate will not replace that of existing bodies currently tasked with producing standards for professionals (e.g. the Health Regulatory Colleges) or facilities (e.g. accrediting bodies). Rather, it will work in partnership with these organizations to coordinate and align efforts.

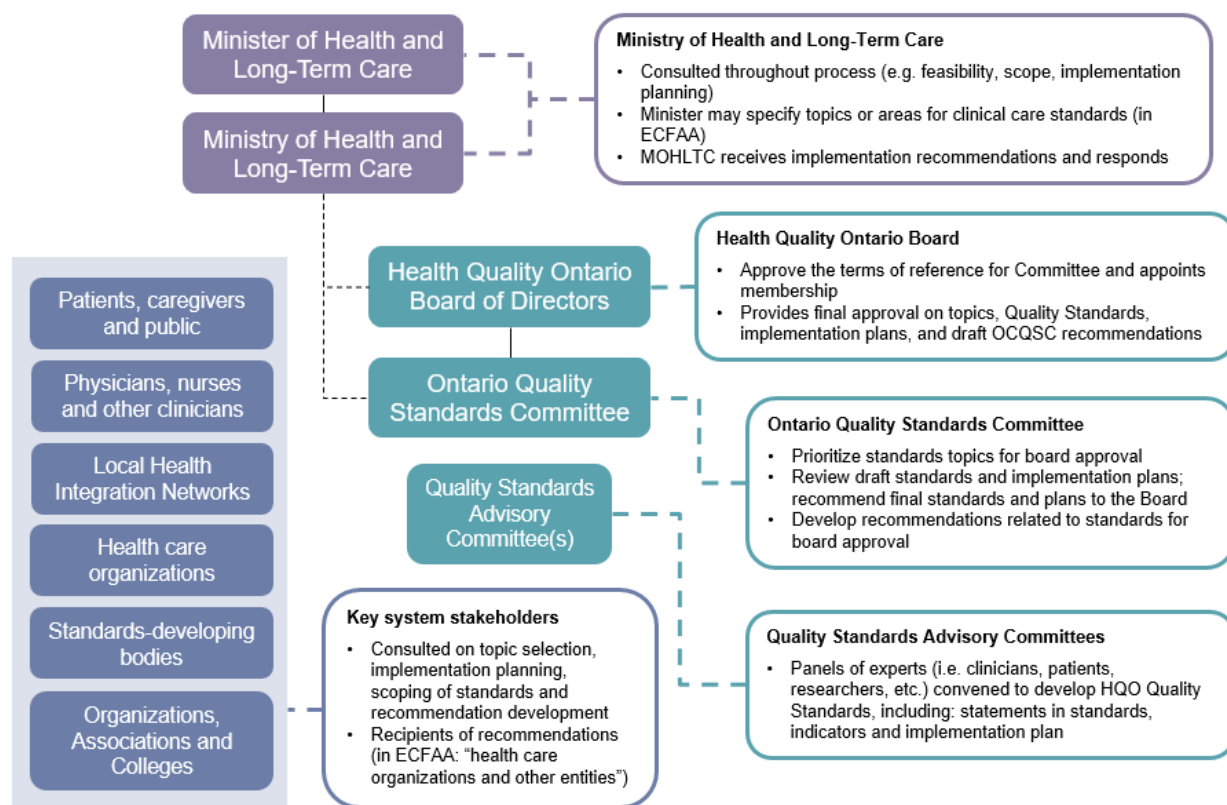
Governance and Role

In accordance with changes in Health Quality Ontario's legislation, the new committee will be a committee of its Board of Directors. Once proclaimed, the *Patients First Act* gives the Health Quality Ontario Board the ability to delegate certain legislated functions to the new committee. In the initial year of committee operation, decisions will go to the Health Quality Ontario Board of Directors for approval. The organization will continue to explore which activities could be delegated to the committee versus retained; it is anticipated that this approach to delegation may change over time as the committee becomes more established.

In terms of its role in Health Quality Ontario's quality standards program, the Ontario Quality Standards Committee will have four specific touch points:

1. Input on topic selection, scoping, and membership of Quality Standards Advisory Committees to develop each quality standard. The committee will submit prioritized topics to the board for approval;
2. Advice on implementation and adoption considerations and on communications related to quality standards;
3. Review of final quality standards and adoption plans, including development of recommendations to health care organizations, the Minister, and other entities, all of which will be presented to the Health Quality Ontario Board of Directors for approval;
4. Ongoing monitoring of uptake and system-wide impact, including input on refreshing quality standards as needed.

The proposed governance relationships for the committee are depicted in detail below.



Given the complexity of the environment and the need for ongoing consultation, the committee's role external to Health Quality Ontario's quality standards program will be designed and articulated in a partnership strategy to be developed during its first year of operations.

The following table describes the roles anticipated related to the committee's activities.

Role	Responsibilities
Health Quality Ontario staff	Receive suggestions for standards topics and support OQSC in the topic prioritization process; complete evidence reviews and support QSACs to develop standards; manage production of quality standards clinician and patient guides; develop implementation/knowledge translation plan for quality standards
Ontario Quality Standards Committee (OQSC)	Prioritize quality standards topics for board approval; review draft quality standards and draft implementation plans; recommend final quality standards and implementation plans to the Health Quality Ontario Board of Directors for approval; develop recommendations related to quality standards for board approval.
Quality Standards Advisory Committees	Guide the development of quality standards, including the drafting of quality statements based on evidence review, clinical expertise, and patient engagement (each standard has its own QSAC).
External stakeholders (e.g. clinicians, researchers, associations, regulators, colleges and universities, industry, patients, caregivers)	Submit topics; provide feedback on draft quality standards; collaborate on implementation plans; align with implementation supports; inform draft recommendations

Role	Responsibilities
Health Quality Ontario Board of Directors	Approve the terms of reference; appoint the membership; provide final approval of topics, quality standards, implementation plans, and the draft OCQSC recommendations
Ministry of Health and Long-Term Care	Submit topics and review topic lists; review draft quality standards and provide feedback on implementation plans; receive OQSC recommendations; use quality standards and recommendations to inform policy development and decision-making

Based on feedback heard during consultation, the committee’s Terms of Reference will be revisited following its first year of operations. This will ensure that any revisions to its governance, role, or membership can be made once it is fully operational.

Membership and Recruitment

Feedback heard over the course of consultation with partners and key informants indicated the need for strong clinical representation on the committee. An understanding of the range of issues that affect the uptake of clinical care standards among providers is integral, and membership should include individuals with experience across a variety of professions and practice settings. Consultation with patients also cemented the need for patient, family, and public representation—space for three members will be made available to promote strong participation and prevent tokenism.

Given that the committee will need to consider the diversity of factors that affect the delivery of care across Ontario, the necessity of regional representation was also heard. As part of the next phase of *Patients First*, the Local Health Integration Networks will be implementing new structures for clinical leadership, and opportunities to connect with individuals hired for these regional roles are being investigated.

More broadly, consultation suggested the need for members with other health system expertise including experience in wide-scale implementation and adoption, measurement, improvement science, public health, ethics, and policy.

To ensure transparency in the recruitment approach, an expression of interest process will be launched on the Health Quality Ontario website. Targeted communications will also be sent and nominations solicited to ensure potential gaps in skills are addressed.

Processes

The process by which the committee carries out its work will be refined over the course of its first year of operations and will involve ongoing discussion with system partners. This will include working collaboratively with:

- The Ministry of Health and Long-Term care to refine several processes, including: the Minister’s specification of topic areas (as per the updated language in the *Excellent Care for All Act*); the submission of committee recommendations to the Minister; and the Ministry’s response to recommendations received;

- Organizations that currently produce standards-like products to define opportunities for future collaboration on the development of clinical standards and to establish a robust process for doing so;
- Bodies that support the dissemination and implementation of evidence-based clinical guidance to determine a process for collaborating on communication, adoption planning and implementation support;
- Organizations that may play a role in monitoring adherence to clinical guidance and other data collection bodies to develop collaborative approaches to the measurement of clinical care standards adoption and uptake.

Once committee processes are clarified and formalized, these will be shared publicly to promote transparency. Jurisdictional scanning confirmed the importance of ensuring that system partners and members of the public understand how and why topics are selected and recommendations are made.

Decision-Making

Through environmental and jurisdictional scanning and consultation with patients, clinicians, and other health system experts, a set of principles to guide committee decision-making were identified and further refined. The goal in doing so was to provide the committee with a framework to ensure consistency and transparency in their approach to decisions, particularly during the initiation phase.

Committee decisions should be:

- **Patient-centred and focused on the whole person** – Decisions recognize the importance of partnering with patients, families and caregivers and consider the contributions of medical, psychosocial and behavioural aspects of health to overall quality of life.
- **Transparent** – Committee decisions and the processes that inform them are communicated transparently to enhance clarity and inform the expectations of patients, providers and health services.
- **Integrated** – Decisions emphasize improving care across sectors, settings and providers and enhance coordination and collaboration in the system.
- **Equitable** – Decisions are focused on opportunities to reduce unwarranted variation and improve outcomes for populations, regardless of race, age, gender, ethnicity, income, geographic location, or other demographic factors.
- **Evidence-based** – With standards themselves rooted firmly in evidence and established by experts, committee decisions should also be based on evidence related to impact and adoption.
- **Achievable** – Decisions should take into account issues of feasibility, scalability and capacity in order to maximize impact on the system.
- **Future-oriented** – Decisions should be made in the interest of achieving a long-term vision for clinical care standards and should focus on investing in the future of Ontario's health care system.

Communications

Over the course of the consultation process, the project team heard repeatedly that clarity is needed regarding the nature of clinical care standards and the expectations that could potentially be attached to them. Part of the value proposition of the committee lies in its potential

to help streamline and clarify the evidence associated with clinical practice for both clinicians and patients. It is likely that committee members will need to inform approaches to communicating clinical care standards and champion the process of dissemination through their own networks.

Conclusion

Increased coordination and consistency in the delivery of health care services has been articulated as a key priority of the government's *Patients First* plan. To achieve this, we increasingly ask clinicians and health care organizations to work collaboratively in ways that break down historic silos. We expect integration in our health care system—primary care communicating effectively with specialists; hospitals working closely with community health services; patient health records shared seamlessly between care teams.

But the need for integration goes beyond the point of care. Clinicians and organizations face mounting expectations that they will work collaboratively in the service of patients. Health Quality Ontario and others producing and disseminating clinical guidance also share a responsibility to pursue integration. Only by working together towards the same goals can we ensure we are providing the guidance and supports that the system needs most; that we are using valuable resources effectively; and that we are directing our attention towards the same priorities to observe real gains for patients.

In undertaking the process of establishing this committee, the project team heard that there would be significant value in a more coordinated approach to developing, communicating, and adopting evidence-based care in the province. Over time, we hope that, in partnership with others, this new committee at Health Quality Ontario could support this vision.

Appendix 1 – Project Team Membership

Executive Sponsors

- Bill MacLeod, CEO, Local Health Integration Network (MH)
- Fredrika Scarth, Director, HQO Liaison and Program Development Branch, Ministry of Health and Long-Term Care
- Dr. Joshua Tepper, CEO, Health Quality Ontario
- Jill Tettmann, CEO, Local Health Integration Network (NSM)

Members

- Blair Audet, Senior Program Consultant, HQO Liaison and Program Development Branch, Ministry of Health and Long-Term Care
- Alison Blair, Director, LHIN Renewal, Ministry of Health and Long-Term Care
- Dr. Irfan Dhalla, VP Evidence Development and Standards, Health Quality Ontario
- Dr. Jennifer Everson, Primary Care Lead, Local Health Integration Network (HNHB)
- Lee Fairclough, VP Quality Improvement, Health Quality Ontario
- David Fry, VP Patient Care, Community Care Access Centre (MH)
- Kelly Gillis, Senior Director, System Design and Integration, Local Health Integration Network (SW)
- Terri Irwin, Director Evidence Development and Standards, Health Quality Ontario
- Anna Greenberg, VP Health System Performance, Health Quality Ontario
- Kathryn McCulloch, VP Care Innovations & Planning, Ontario Association of Community Care Access Centres
- George Mihalakakos, Peer Support Worker, Centre for Addiction and Mental Health
- Olivia Nero, Senior Policy Advisor, Minister's Office (Health and Long-Term Care)
- Vanessa Perry, Manager, Quality Programs and HQO Liaison, Ministry of Health and Long-Term Care
- Jennie Pickard, Director Strategic Partnerships, Health Quality Ontario
- Michelle Rossi, Director Policy & Strategy, Health Quality Ontario
- Dr. Jeff Turnbull, Chief Clinical Quality, Health Quality Ontario

Health Quality Ontario Staff Support Team

- Arielle Baltman-Cord, Team Lead, Quality Improvement
- Lauren Bell, Partnership Lead, Strategic Partnerships
- Mary Boushel, Manager, Strategic Partnerships
- Erik Hellsten, Manager, Evidence Development and Standards
- Samantha Irving, Executive Assistant, Policy and Strategy
- Danyal Martin, Manager, Quality Improvement
- Lacey Phillips, Manager, Evidence Development and Standards
- Adele Small, Senior Communications Advisor
- Claude Soulodre, Project Manager, Evidence Development and Standards
- Patricia Sullivan-Taylor, Strategic Advisor, Health System Performance
- Kate Wilkinson, Policy Analyst, Policy and Strategy

Appendix 2 – Definitions

Term	Definition	Audience	Key Attributes	Example
Practice guidelines/ clinical practice guidelines	"Statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options" ⁴	Clinicians and patients	<ul style="list-style-type: none"> Often highly detailed (many pages in length) Specific to particular professionals, settings Meant to guide clinician and patient decision-making, but not designed to be definitive 	Canadian Medical Association's guidelines database
Clinical pathways	Tools that "guide care management for a well-defined group of patients for a well-defined period of time" ⁵	Clinicians	<ul style="list-style-type: none"> Based on evidence and also local context⁶ Detail the steps in a course of treatment/ care plan Relate to a specific clinical problem, procedure or episode of care in a specific population 	The Ontario Association of Community Care Assess Centre's pathways
Professional/ practice standards	Established by regulatory colleges; "standards of practice to assure the quality of the practice of the profession" ⁷	Clinicians	<ul style="list-style-type: none"> Broad statements describing what a professional is accountable/responsible for in practice High-level; often referring to expectations for education, ethics, communication, etc. Not often changed or updated based on evidence 	College of Nurses of Ontario Professional Standards
Accreditation or facility standards	Used by accrediting or inspecting bodies to assess services of a particular facility	Health care organizations/ facilities	<ul style="list-style-type: none"> May address a range of issues (e.g. infection prevention and control, service excellence or specific types of services/populations) 	Accreditation Canada's standards for hospitals
Service standards	Consumer-oriented standards that define what patients, clients, or residents can expect from customer service associated with health care delivery ⁸	Clinicians, patients	<ul style="list-style-type: none"> Often focused on issues of access, timeliness, communication In some cases could have indirect implications for clinical outcomes (e.g. long wait times lead to worsening condition) 	Cancer Care Ontario setting wait time targets for Regional Cancer Centres
Public health standards	"The minimum requirements for fundamental public health programs and services to be delivered by Ontario's 36 boards of health" ⁹	Boards of health	<ul style="list-style-type: none"> Published by the Minister of Health and Long-Term Care in Section 7 of the Health Protection and Promotion Act, R.S.O. 1990 Programs can be tailored to local needs, but must be offered 	Infectious Diseases Prevention and Control
Quality Standards	Term used by Health Quality Ontario to define its standards. "Concise sets of easy-to-understand statements based on the best evidence"	Patients, clinicians and health care organizations, policymakers	<ul style="list-style-type: none"> Five to 15 statements (vs. hundreds in practice guidelines) Describe quality care regardless of setting, professional, or other factors Accompanied by quality measures and improvement tools to support adoption 	Health Quality Ontario's Quality Standard for Major Depression

⁴ Committee on Standards for Developing Trustworthy Clinical Practice Guidelines. (2008). *Clinical Practice Guidelines We Can Trust*. The Institute of Medicine. Retrieved from: <https://www.nap.edu/read/13058/chapter/1>

⁵ De Bleser LDR, De Waele K, Vanhaecht K, Vlayen J, Sermeus W. (2006). Defining pathways. *J Nurs Manag.* 14:553–563.

⁶ Kinsman L, Rotter T, James E, Snow P, Willis J. (2010). What is a clinical pathway? Development of a definition to inform the debate. *BMC Medicine*, 8, 31.

⁷ Regulated Health Professions Act, 1991, S.O. 1991, c. 18. Retrieved from: <https://www.ontario.ca/laws/statute/91r18>

⁸ Agency for Healthcare Research and Quality. Standards for Customer Service. Retrieved from: <https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/customer-service/strategy6q-custservice-standards.html>

⁹ Ontario Ministry of Health and Long-Term Care. Ontario Public Health Standards. Retrieved from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/

Appendix 3 – Jurisdictional Scan

Body	Scope/Role	Levers	Governance/Logistics
Health Quality Ontario's Ontario Health Technology Advisory Committee	Makes recommendations about the public funding of health care services and medical devices ¹⁰	<ul style="list-style-type: none"> Recommendations made to the Minister—public posting to enhance transparency Ministry is working with HQO to support an enhanced evidence adoption pathway 	<ul style="list-style-type: none"> Appointed by HQO Board Committee of the Board that makes recommendations to them, requiring approval Between 15 and 20 committee members serve three-year term; 6-12 meetings per year Supported by HQO secretariat
Quality Standards Advisory Committees (National Institute for Health and Care Excellence)	QSACs prioritise areas for QI, advise on content of quality standards in development and review current quality standards ¹¹	<ul style="list-style-type: none"> Standards are integrated into performance measures (i.e. as part of the Quality and Outcomes Framework payment for performance scheme) They are not mandatory but it is expected that they will be used by patients/members of the public, health care professionals, provider organizations, and commissioning groups to ensure high-quality care is commissioned 	<ul style="list-style-type: none"> Four committees that operate as standing Advisory Committees of the NICE Board Roughly 21 standing members of each QSAC; five specialist committee members invited to join temporarily to develop each standard QSACs submit quality standards to NICE's Guidance Executive, which acts under delegated powers of the Board to approve for publication
Cancer Quality Council of Ontario (Cancer Care Ontario)	Advises CCO and MOHLTC in efforts to improve the quality of cancer care. Monitors/publicly reports on the performance of the cancer system. Identifies targeted QI opportunities. Provides international comparisons and benchmarking ¹²	<ul style="list-style-type: none"> The Cancer System Quality Index (CSQI) measures cancer system performance The Quality and Innovation Awards recognize frontline QI and innovation The Signature Event identifies areas for QI action, with policy recommendations made following Programmatic Reviews of progress, analyzing effectiveness and making recommendations 	<ul style="list-style-type: none"> Reports to CCO's Board and MOHLTC; is independent of CCO management Supported by a Secretariat at CCO (six members); uses CCO infrastructure, including clinical and scientific expertise and data holdings; maintains an independent oversight role Currently 18 members
Clinical Council (Cancer Care Ontario)	Sets clinical policies for the cancer system, including best practice guidelines, standards for quality and access, and data reporting requirements for monitoring clinical performance ¹³	<ul style="list-style-type: none"> Reviews and recommends to the CEO of CCO all policies, standards, guidelines, and clinical care initiatives related to cancer control and care Advises on information system for quality measurement With Regional VPs, establishes targets for quality measures, strategies for improving and a monitoring system for quality Liases with CQCO 	<ul style="list-style-type: none"> Members include Provincial Heads and Provincial VPs The Program in Evidence-Based Care is accountable to the Council Supported by a Clinical Secretariat, accountable to Chair

¹⁰ Ontario Health Technology Advisory Committee. Health Quality Ontario. Retrieved from: <http://www.hqontario.ca/Evidence-to-Improve-Care/Health-Technology-Assessment/Ontario-Health-Technology-Advisory-Committee>

¹¹ Quality Standards Advisory Committee. National Institute for Health and Care Excellence. Retrieved from: <https://www.nice.org.uk/get-involved/meetings-in-public/quality-standards-advisory-committee>

¹² Cancer Quality Council of Ontario. Retrieved from: <http://www.cqco.ca/>

¹³ Clinical Council. Cancer Care Ontario. Retrieved from: https://www.cancercare.on.ca/about/who/executive/clinical_council/

Agency for Healthcare Research and Quality	Publishes guidelines submitted to the National Guideline Clearinghouse. Moved away from developing guidelines; now carries out research or funds research elsewhere to produce guideline syntheses, evidence reviews, etc. National Quality Measurement Clearinghouse provides quality measures and benchmarks ¹⁴	<ul style="list-style-type: none"> Organizations (including states, health care providers, insurers) can choose to adopt both the guidelines and performance measures provided through the clearinghouse 	<ul style="list-style-type: none"> One of 12 agencies within the Department of Health and Human Services NGC/NQMC Expert Panel composed of expertise in evidence-based health, clinical practice guidelines, quality measurement and reporting, policy The Expert Panel provides feedback and guidance on broad project areas
Australian Safety and Quality Commission	Clinical Care Standards “identify and define the care people should expect to be offered or receive, regardless of where they are treated.” Work plan is set federally and by state and federal ministers, but commission provides impartial advice about feasibility of implementation ¹⁵	<ul style="list-style-type: none"> Organization has a role in supporting implementation Develops indicators for standards that can be used at a local level; also shares a case for improvement for a given topic to articulate the issue addressed by each the quality statement 	<ul style="list-style-type: none"> Standards developed by topic working groups, supported by a Clinical Care Standards Advisory Committee that provides advice on the development process/the program Agency itself has a board with a number of advisory committees beneath it—clinical care committee reports into these
Ontario Health Informatics Standards Council	Provincial body of health informatics standards experts. Review standards submitted to the council and provide recommendations to the Ministry. A growing role in monitoring and managing the use of standards. Focus is driven by the Ministry ¹⁶ interoperability strategy	<ul style="list-style-type: none"> Primary levers are recommendations to the Minister; role in a partnership of all informatics/ehealth agencies Council members are representatives from a number of health informatics organizations; champion the use of standards in their home roles 	<ul style="list-style-type: none"> Chair is appointed by the Ministry of Health and Long-Term Care Terms of four years, can be renewed indefinitely Supported by Ministry secretariat team Council has maximum of 20 members

¹⁴ Clinical Guidelines and Recommendations. Agency for Healthcare Research and Quality. Retrieved from: <https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/index.html>

¹⁵ Clinical Care Standards. Australian Safety and Quality Commission. Retrieved from: <https://www.safetyandquality.gov.au/our-work/clinical-care-standards/>

¹⁶ Ontario Health Informatics Standards Council. Ministry of Health and Long-Term Care. Retrieved from: <http://www.health.gov.on.ca/en/public/programs/ohisc/default.aspx>

Appendix 4 – Consultation Summary

Organizations and Groups Consulted

- Accreditation Canada
- Association of Family Health Teams of Ontario
- Association of Ontario Health Centres
- Cancer Care Ontario
- Cardiac Care Network
- Centre for Effective Practice
- Choosing Wisely Canada
- College of Nurses of Ontario
- College of Physicians and Surgeons of Ontario
- Council of Academic Hospitals of Ontario
- Health Quality Ontario Patient, Caregiver and Public Advisors Council
- Health Quality Ontario Regional Clinical Quality Leads
- Home Care Ontario
- Local Health Integration Networks (LHIN Renewal Steering Committee; LHIN Senior Directors)
- Ministry of Health and Long-Term Care
- Nurse Practitioners' Association of Ontario
- Ontario Association of Community Care Access Centres
- Ontario College of Family Physicians
- Ontario Hospital Association
- Ontario Medical Association Primary Care Advisory Group
- Ontario Public Health Association
- Ontario Renal Network
- Primary Care Quality Advisory Committee (HQO)
- Registered Nurses Association of Ontario

Key Informant Input

- Ross Baker, Professor, Institute of Health Policy, Management and Evaluation
- James Downie, CEO, Australian Independent Hospital Payment Authority
- Alan Grill, College of Family Physicians of Canada; Ontario Renal Network
- Caroline Heick, Executive Director Ontario and Quebec, Canadian Institute for Health Information
- David Kaplan, Primary Care Lead, Health Quality Ontario
- Philip Klassen, Vice-President Medical Services, Ontario Shores Centre for Mental Health Sciences
- Niek Klazinga, Head of the Health Care Quality Indicators (HCQI) Project, OECD Health Division
- Christina Krause, Executive Director, BC Patient Safety & Quality Council
- Darren Larson, Chief Medical Information Officer, OntarioMD
- Hugh Macleod, Founder of Global Healthcare Knowledge Exchange
- Charlene McBrien-Morrison, Executive Director, Health Quality Council of Alberta
- Abel McDonald, Program Director, Clinical Standards, Australian Safety and Quality Commission for Healthcare
- Kathleen Morris, Vice-President Research and Analysis, Canadian Institute for Health Information
- David Price, McMaster University, Chair-Department Family Medicine
- Neil Stuart, Board Member, Patients Canada; Board Chair, Victorian Order of Nurses; Ministerial Advisor
- Terry Sullivan, Chair of the Board, Canadian Agency for Drugs and Technologies in Health
- Jeremy Veillard, Program Manager, Primary Health Care Performance Initiative, World Bank

Summary of Feedback

Theme	Scope/Role
Opportunities	<ul style="list-style-type: none"> • Make it easier for providers to know and deliver evidence-based care; reduce duplication in the system; minimize standards “chaos” • Partnerships and enhanced coordination allow strengths of multiple organizations to be leveraged (e.g. evidence development, guidance tools, implementation, education, etc.) • Potential to streamline and focus investment in priority areas to enhance gains; working toward shared priorities with clear accountabilities/expectations • Improved engagement of providers and patients in setting clinical standards • New mandate to make recommendations to the Minister enhances supports to the system; a clear path on what to do, how and why • Drive the quality agenda by aligning standards, measurement and improvement • Enhance quality and value-based care by aligning funding models that leverage standards
Risks	<ul style="list-style-type: none"> • Lack clear definition of the term “standard”; could create confusion or resistance • High expectations for the committee to solve complex system issues; need feasible scope and clear communication to help manage expectations • Complex change effort required to improve variation is not always recognized • Significant system changes underway could impact ability of organizations to devote resources or time to adopting new standards • Providers must feel sufficiently engaged so standards are not seen as “top down” • Accountability for standards implementation and uptake requires appropriate levers and authority • Ministry-HQO processes could prevent timely standards uptake/response • Speed of standard development may outpace system capacity to adopt
Governance	<ul style="list-style-type: none"> • Requires independence from political drivers or specific agendas to ensure decision-making is based on evidence • Use priority areas of focus to influence a provincial quality agenda
Membership	<ul style="list-style-type: none"> • Skills-based recruitment; avoid selecting representatives of particular agendas • At least three patient advisors • Sub-regional clinical representation • Expertise and experience in QI, implementation, change management, population health, measurement, health and social policy, ethics, research and evaluation • Collaborative leadership skills
Decision-making	<ul style="list-style-type: none"> • Transparent decisions, taking into account input from multiple stakeholders (including patients) • Establish decision-making framework to ensure consistency • Address issues that matter to patients; focus on standards that support overall health • Ensure feasibility; consider how/ where things can be adapted to suit local contexts
Activities	<ul style="list-style-type: none"> • No single model of implementation; may vary based on standard, regional context, capacity, etc. • Improvement requires more than just publication of a standard Identify and communicate to Ministry and others what resources/levers are required to implement and improve • Pace development and implementation based on readiness and capacity of system
Monitoring/evaluation	<ul style="list-style-type: none"> • Determine if monitoring adoption is for QI or accountability and develop appropriate tools • Data for QI needs to be timely and useful for improvement • Evaluation framework for adoption and impact must consider multiple perspectives (region, effectiveness of interventions, income, access, etc.)
Communication	<ul style="list-style-type: none"> • Clear about expectations of providers • Clarity necessary related to roles and responsibilities of respective organizations (e.g. Ministry, LHINs, sub-regions, clinicians, HQO, etc.)