

Chapter 1

Section 1.03

Health Quality Ontario

Follow-Up on VFM Section 3.03, 2018 Annual Report

RECOMMENDATION STATUS OVERVIEW						
	# of Actions Recommended	Status of Actions Recommended				
		Fully Implemented	In the Process of Being Implemented	Little or No Progress	Will Not Be Implemented	No Longer Applicable
Recommendation 1	1			1		
Recommendation 2	5		2	3		
Recommendation 3	1		1			
Recommendation 4	4		3	1		
Recommendation 5	3	2		1		
Recommendation 6	2	2				
Recommendation 7	1			1		
Recommendation 8	2			2		
Recommendation 9	3			3		
Recommendation 10	3		1	2		
Recommendation 11	3			3		
Recommendation 12	1			1		
Total	29	4	7	18	0	0
%	100	14	24	62	0	0

Overall Conclusion

According to the information provided to us by Health Quality Ontario and the Ministry of Health, as of July 30, 2020, only 14% of the actions recommended in our 2018 Annual Report had been fully implemented, and an additional 24% of recommended actions were in the process of being

implemented. Little or no progress had been made in implementing 62% of the recommended actions.

Health Quality Ontario (HQP) had fully implemented recommendations such as streamlining the process for assessing which medical devices and health-care services the Ministry should fund where other jurisdictions had already successfully implemented the medical technology or health-care service, and implementing a standardized verification process

for publicly reported data and to centrally track all discrepancies and errors.

HQO was also in the process of implementing recommendations to increase the number of physicians who sign up for individualized practice reports, evaluate the effectiveness of physician practice reports in changing physician behaviour and improving health-care outcomes, and investigate all significant variances in target setting for quality improvement indicators among providers in the same sector.

However, HQO had made little progress on measuring and publicly reporting on the rate of implementation/adoption of its clinical care standards and on the impact its activities are having on the quality of health care in the province. In addition, HQO had done little to establish ideal ranges for performance targets to be set by health-care providers in their quality improvement plans and to assess the potential benefits of enforcing the use of clinical care standards through the Local Health Integration Networks.

With respect to providing HQO with access to patient-level data, the Ministry of Health made proposed changes to the *Personal Health Information Protection Act, 2004* that would enable HQO to collect, use and share patient-level data for better patient care. However, the Ministry made little progress in clarifying the roles and responsibilities of the key parties in the health-care system, adopting recommendations made by HQO and using the quality improvement tools made available by HQO to health-care providers.

The Ministry informed us that the merger of multiple entities with Ontario Health, including the move of HQO and Local Health Integration Networks into Ontario Health, would have an impact on the timing and implementation of some recommendations.

The status of actions taken on each of our recommendations is described in this report.

Background

Health Quality Ontario (HQO) was an agency funded by the Ministry of Health (Ministry) (formerly the Ministry of Health and Long-Term Care) to advise the province on the quality of Ontario's health care. As of March 8, 2019, the board of the newly created Ontario Health agency became the board for certain agencies consolidated into Ontario Health (Cancer Care Ontario, Health Quality Ontario, eHealth Ontario, Health Shared Services Ontario, HealthForceOntario Marketing and Recruitment Agency, Ontario Telemedicine Network and the 14 Local Health Integration Networks). HQO's operations were transferred into Ontario Health effective December 2, 2019. HQO's role is to support quality improvement in the health-care system. In 2019/20, it spent \$32.4 million (\$44.2 million in 2017/18) for its operations and employed the equivalent of 225 full-time staff (291 in 2017/18).

HQO provides tools such as clinical care standards and information such as health-care performance reporting that health-care providers can use to improve their quality of care.

However, HQO had difficulty assessing and demonstrating its impact on the quality of health care in Ontario. This was largely because its recommendations and advice were not required to be implemented by the Ministry or Local Health Integration Networks (LHINs), the two parties that provided funding to and have accountability agreements with health-care providers.

The focus of the LHINs and health-care providers was to meet their own performance goals—and these might not have always corresponded to the areas that HQO identified as needing improvement in the Ontario Health system. Similarly, the Ministry and the LHINs both had the ability to require that HQO's clinical care standards be used by health-care providers, but were not doing so. (Clinical care standards describe the care patients

should be getting for a specific medical condition in line with current evidence of best practices.)

Among the specific issues we identified:

- Although HQO was setting priority performance indicators for the different health-care sectors, it did not identify a minimum target or an ideal target range for each indicator. Therefore, health-care organizations (that is, hospitals, long-term-care homes, home-care teams and primary-care teams) were setting their own targets. We found large variations in targets set by health-care organizations in their quality improvement plans, meaning that the quality of care patients received would have varied depending on where they received their care.
- HQO was not monitoring the adoption rate of the clinical care standards it had developed, and the Ministry-accepted medical devices and health-care services HQO was recommending. Nor was it assessing what impact its work, including the annual performance data it published, was having on the overall quality of health care in Ontario.
- HQO was not assessing the training and potential resources required by health-care providers to implement a clinical care standard. Stakeholders we spoke with said they would have welcomed more guidance on implementing standards. Between May 2015 and September 2018, HQO had released 14 clinical care standards with a total of 166 quality statements (meant to guide clinicians and patients on what high-quality care looks like) and 235 recommendations for implementation (meant to help the health-care sector implement a standard).
- One of HQO's four core functions was the assessment of medical devices and health-care services to determine whether the Ministry should fund them. HQO was mostly conducting its own assessments. However, it could have potentially reduced the time taken and money spent to complete these

assessments by collaborating with other jurisdictions or relying on similar work already done in other provinces or by the Canadian Agency for Drugs and Technologies in Health (Agency). In 2017, HQO had started working with the Agency on a limited basis.

- Physicians were not required to receive individualized practice reports prepared by HQO, aimed at changing physician behaviour and improving their practices' performance. As of July 2018, only 32% of primary care physicians and 23% of primary care physicians caring for residents of long-term-care homes had signed up to receive an individualized practice report. Further, these individualized reports did not include performance data on all key provincial improvement priorities.
- With the consolidation of five organizations into HQO in 2011/12, the government had expected cost efficiencies would help lower expenditures from the \$23.4 million spent for the five organizations, combined, in 2010/11. As of March 31, 2018, however, HQO's annual expenditures had increased to \$44.2 million (excluding spending by the Patient Ombudsman's Office) and staffing had increased over the same period from the equivalent of 111 full-time employees to 291. Expenditures had increased partly because HQO's mandate was expanded to include patient relations and because HQO had undertaken more quality improvement initiatives, including the development of clinical care standards.

We made 12 recommendations, consisting of 29 action items, to address our audit findings. At that time, we received commitment from the Ministry that it would take action to address our recommendations.

Status of Actions Taken on Recommendations

We conducted assurance work between April 2020 and July 2020. We obtained written representation from Health Quality Ontario and the Ministry of Health that, effective October 14, 2020, it has provided us with a complete update of the status of the recommendations we made in the original audit two years ago.

Health Quality Ontario's Direct Impact on Health Care Is Difficult to Assess

Recommendation 1

To help bring about continuous quality improvement in health care, we recommend that the Ministry of Health and Long-Term Care clarify the respective roles and responsibilities of key parties in the health-care system—including Health Quality Ontario (HQO), Local Health Integration Networks and hospitals—with respect to requiring the adoption of recommendations made by HQO and the use of quality improvement tools made available by HQO to health-care providers.

Status: Little or no progress.

Details

In our 2018 audit, we reported that HQO shared responsibility for quality improvement in the health-care sector with the then Ministry of Health and Long-Term Care, the Local Health Integration Networks (LHINs), and health-care provider organizations, such as hospitals and long-term-care homes. According to a Ministry-commissioned review in 2012, the respective roles of these entities were unclear. Without clear accountabilities and a co-ordinated approach to quality improvement, results had been difficult to achieve as health-care providers were being asked by various organizations to focus their efforts toward many different quality improvement areas.

At the time of our follow-up, the Ministry of Health had not clarified the roles and responsibilities of HQO, Local Health Integration Networks and health-care providers with respect to quality improvement in the health-care sector. The Ministry acknowledged that the introduction of Ontario Health, and the transition of HQO and LHINs into Ontario Health over time, will have an impact on the implementation of this recommendation as the roles of many parties named in the recommendation will be changing. As part of the accountability agreement discussions, the Ministry plans to focus on how Ontario Health and the Ministry can better implement recommendations stemming from HQO's activities (quality improvement plan priorities, individualized practice reports, recommendations on medical devices and health-care services and clinical care standards) and/or how tools developed by these activities can be used to improve quality of care.

Recommendation 2

To determine whether Health Quality Ontario (HQO) is effectively supporting quality improvement, we recommend that HQO measure and publicly report on:

- *the rate of acceptance of its recommendations to the Ministry on medical devices and health-care services for funding;*

Status: In the process of being implemented by March 2021.

Details

Our 2018 audit found that, even though HQO was tracking the rate of acceptance by the Ministry of its recommendations on medical devices and health-care services, HQO was not reporting on it.

At the time of our follow-up, we found that HQO had publicly reported on its website the cumulative rate of acceptance of its recommendations to the Ministry on medical devices and health-care services since it began making these recommendations to the Ministry. In addition to reporting a cumulative acceptance rate, we would

expect HQO to report the rate of acceptance of recommendations made in a single year. Starting in fiscal year 2020/21, HQO plans to update its website annually with this information and will include the annual rate of acceptance of its recommendations.

- *the rate of implementation/adoption of its clinical care standards;*
Status: Little or no progress.

Details

During our 2018 audit, we found that HQO was not tracking whether the clinical care standards, in particular the quality statements it developed with the intent to improve patient outcomes, were being implemented by health-care organizations.

At the time of our follow-up, we noted that HQO was still not tracking and reporting on whether clinical care standards, in particular the quality statements, are being adopted by health-care providers. Since our audit, HQO had developed clinical care standards in 16 additional health-care areas, for a total of 30. We found that HQO was contemplating an approach for measuring the rate of implementation and adoption. For example, for 13 of the 30 clinical care standards, HQO was surveying health-care providers to assess how likely they were to use the standards and measuring how often the standards were downloaded from its website. While the latter provides interesting information, it is not effective in measuring the rate of implementation.

- *the rate of implementation/adoption of its recommendations to the Ministry on medical devices and health-care services for funding;*
Status: Little or no progress.

Details

Our 2018 audit found that HQO was not measuring the rate of adoption of its recommended medical devices and health-care services after the Ministry approved them for public funding.

During our follow-up, we found that HQO had started to review how it could measure implementation and adoption in the context of the transition to Ontario Health, but had not yet finalized an approach.

- *the number and percentage of physicians who sign up for individualized practice reports;*
Status: In the process of being implemented by March 2021.

Details

Our 2018 audit found that HQO was not publicly reporting on the percentage of physicians or hospitals that had signed up to receive and use the individualized practice reports it had developed for them.

At the time of our follow-up, we noted that HQO had reported the number and percentage of individuals that had signed up for the individualized practice reports in its 2018/19 annual report. The annual report stated that “3,178 (35% of) family physicians, 230 (93% of) executive directors in community health centres and family health teams, and 440 (55% of) long-term care physicians registered for” individualized practice reports. However, HQO’s annual report for 2018/19 has not been made public. We noted that this information is not published by either the Ministry of Health or Ontario Health. According to HQO, the 2018/19 annual report was submitted to the Minister of Health on July 31, 2019, but had not yet been tabled in the legislature at the time of our follow-up.

In September 2020, HQO publicly reported on its website the total number and percent of physicians who have signed up for individualized practice reports to date. Unlike the annual report it prepared but was not yet made public, it did not report the information by the type of individualized practice report it issues. This is important as each type of report contains performance information on priority areas needing improvement for those types of practices. Starting in fiscal year 2020/21, HQO

plans to annually update information on its website to include the number and percentage of physicians who have signed up for individualized practice reports by type of report.

- *the impact its activities (such as clinical care standards and priority indicators for quality improvement plans) are having on the quality of health care in the province.*

Status: Little or no progress.

Details

At the time of our audit in 2018, HQO was not measuring whether its standards or recommendations were having an impact on the quality of care and leading to better health outcomes for patients.

During our follow-up, we noted that HQO had not finalized an approach to measuring the impact of priority indicators for quality improvement plans or for clinical care standards. According to HQO, work was under way to determine an approach to measuring impact and to integrate greater information on impact into its annual report.

As part of HQO's internal scorecard, it had set baseline statistics for clinical care standards but had not measured the annual impact or the trend in the measure since the baseline year. Although HQO had also explored the potential for tracking the impact of recommended medical devices and services, it had not started to track their impact.

HQO'S Reporting on Health System Performance Not Clearly Effecting Quality Improvement

Recommendation 3

We recommend that the Ministry of Health and Long-Term Care assess whether it is necessary to provide Health Quality Ontario with access to patient-level data in order for it to better meet its mandate of supporting continuous quality improvement.

Status: In the process of being implemented by March 2021.

Details

During our 2018 audit, one of the main reasons provided for why some physicians were reluctant to sign up for individualized practice reports was that the reports' usefulness was limited because the data provided did not identify for the physician the specific patients who may not have been treated correctly. Neither the *Personal Health Information Protection Act, 2004* nor the *Excellent Care for All Act, 2010* allows HQO to access individuals' personal health records for the purpose of producing reports for physicians.

At the time of our follow-up, we noted that the Ministry, as part of its Digital First for Health strategy, had proposed changes to the *Personal Health Information Protection Act, 2004*. The proposed changes will ensure that Ontario Health (including HQO) can collect, use and share personal health information. According to the Ministry, additional regulations are required to define how information can be accessed and used by HQO within Ontario Health. The Ministry expects to have the regulations in place by March 2021.

Recommendation 4

To maximize the likelihood that organizations and physicians receive individualized performance reports focused on targeted quality improvement and can readily act on the information provided, we recommend that Health Quality Ontario in collaboration with the Ministry of Health and Long-Term Care:

- *explore opportunities to increase the participation rate of primary care physicians and long-term-care home physicians receiving individualized practice reports, and consider making receipt and use of these reports mandatory;*

Status: In the process of being implemented by December 2020.

Details

During our 2018 audit, we noted that physicians were not required to receive individualized practice reports and HQO could not provide them unless the

physician signed up voluntarily. As of July 2018, only 23% of long-term-care home physicians and 32% of primary care physicians who were not part of a community health centre had signed up to receive the reports.

Based on the information reported in the 2018/19 annual report, the latest information available at the time of our follow-up, the participation rate by long-term-care home physicians more than doubled from 23% to 55%, but the participation rate for family physicians who were not part of a community health centre increased only slightly from 32% to 35%.

At the time of our follow-up, HQO had taken some action to increase the participation rate of primary care physicians. For example:

- HQO partnered with Ontario Health's Cancer Care Ontario to streamline access to reports issued for primary care physicians. This involved combining notification to physicians on the availability of HQO's individualized practice report and Cancer Care Ontario's Screening Activity Report.
- HQO's individualized practice report for primary care physicians is also featured as part of the College of Physicians and Surgeons of Ontario new Quality Improvement program.
- HQO was working with the Ontario College of Family Physicians to have the review of individualized practice reports and attending related webinars by physicians count toward the accumulation of Continuing Medical Education Credits.

The Ministry stated that it will work with HQO and Ontario Health to determine best practices to increase the participation rate of primary care physicians and further increase the participation rate of long-term-care home physicians. With the integration of HQO into Ontario Health, the agency informed us that it is considering new levers to make participation mandatory, and plans to submit these considerations to the Ministry of Health by December 31, 2020.

- *work toward having physicians receive patient-level data for their own patients, to better target their quality improvement efforts;*

Status: In the process of being implemented by March 2021.

Details

During our 2018 audit, we noted that without patient-level data, physicians were required to search through their medical records to identify the relevant patients. This would be a time-consuming process that takes away from the physician's time that could be spent seeing patients.

At the time of our follow-up, the Ministry had proposed changes to the *Personal Health Information Protection Act, 2004* that would permit Ontario Health (including HQO) to collect, use and share personal health information to allow for better patient care and outcomes. The Ministry expects these changes to be implemented by March 2021. HQO anticipates that the proposed changes will allow HQO to provide personal health information to physicians through the individualized practice reports.

- *provide improvement ideas on all applicable provincial priority improvement areas in reports to physicians and hospital CEOs;*

Status: Little or no progress.

Details

At the time of our 2018 audit, HQO had identified priority improvement areas specific to different health-care sectors—eight priority improvement areas for primary care, eight for long-term-care homes and 12 for hospitals. However, the individualized reports prepared for physicians and hospital CEOs provided information on only four priority areas for primary care physicians, one priority area for physicians providing medical care to residents of long-term-care homes, and one priority area for hospital CEOs.

At the time of our follow-up we noted that there was no plan to include information on all priority improvement areas identified by HQO in

the practice reports. The Ministry indicated that as individualized practice reports are developed and refined, the Ministry will work with Ontario Health (including HQO) to ensure that practice reports reflect provincial priorities.

- *evaluate the effectiveness of physician practice reports in changing physician behaviour and improving health-care outcomes.*

Status: In the process of being implemented by June 2022.

Details

In our 2018 audit report, we reported that HQO had not fully evaluated how effective individualized practice reports had been in changing physician behaviour and improving health-care outcomes. Only one review had been conducted by HQO in 2017 to evaluate the effectiveness of its individualized practice reports on long-term-care home physicians who signed up for individualized practice reports.

During our follow-up, we found that HQO had started two new research studies to evaluate the effectiveness of physician practice reports. One study was to assess the impact of practice reports on antibiotic prescriptions in long-term-care homes, and the other study was looking into the impact of practice reports on opioid prescriptions by primary care physicians. HQO stated that it expected these studies to be completed by June 2022.

Recommendation 5

To improve the accuracy and reliability of publicly reported data on the health-care system, we recommend that Health Quality Ontario:

- *enter into a data-sharing agreement with each data provider that clearly defines the provider's responsibility for data reliability and the verification procedures to be undertaken by the provider;*

Status: Little or no progress.

Details

In 2018 we reported that, for the purposes of producing its 2017 Measuring Up report, HQO obtained data from 11 data providers but had contractual agreements with only five of them. Further, with the exception of one data provider, HQO had not established or did not have written documentation with its providers that clearly defined the provider's responsibility for data reliability and the quality-assurance measures the data provider should undertake to ensure the reliability of the data provided.

At the time of our follow-up, HQO had not amended or entered into any other data-sharing agreements that clearly define the provider's responsibility for data reliability and verification procedures to be undertaken. At the time of the follow-up, HQO was planning to leverage the data available within Ontario Health and enter into new data-sharing agreements with data provider organizations outside of Ontario Health.

- *implement a standardized verification process for data used for each indicator, with consistent management oversight;*

Status: Fully implemented.

Details

Our 2018 audit found that HQO did not specify the procedures that the staff conducting data reliability reviews should use. Since each of the nine HQO staff who conducted reviews used their own technique to assess data quality, there was no consistency of method.

During our follow-up we found that, as of August 2019, HQO has implemented a data quality assessment framework and a data quality checklist that outlines the verification procedures. HQO had assigned an individual to each publicly reported indicator. The individual assigned to the indicator completes the checklist, which is subsequently reviewed and signed off by the manager.

- *develop a process to centrally track all discrepancies and errors, and the corrective measures taken to address them.*

Status: Fully implemented.

Details

Our 2018 audit found that HQO had not developed a standardized process for documenting and addressing errors to reduce the risk of similar errors going undetected.

During our follow-up, we noted that HQO had created an error log to track discrepancies and data errors that had been identified, along with the corrective action taken to address the error. The error log was created in August 2019.

HQO Missing Opportunity to Save Time and Money through Collaboration on Assessments of Health Technology and Services

Recommendation 6

To complete health technology and services assessments in a more efficient and timely manner, we recommend that Health Quality Ontario:

- *streamline the process for health technology and service assessment where other jurisdictions have already successfully implemented the medical technology or health-care service under consideration;*

Status: Fully implemented.

Details

At the time of our 2018 audit, we reported that most other jurisdictions in Canada were relying on the assessments for medical devices and health-care services that were prepared by the Canadian Agency for Drugs and Technologies in Health. The Agency was created in 1989 by Canada's federal, provincial and territorial governments to focus on a co-ordinated approach to conducting assessments.

During our follow-up, we noted that HQO was still conducting a significant portion of its own provincial assessments. However, HQO had

developed an expedited review process that allows it to rely on work already completed by other jurisdictions. According to the process map which HQO developed in 2019, if high-quality assessment information is available, then HQO will rely on that work.

For example, in 2019/20, HQO completed 14 assessments, of which nine were completed by HQO without collaborating with or relying on another jurisdiction. For the other five assessments that year, four were done in collaboration with the Canadian Agency for Drugs and Technologies in Health (one with reliance on another jurisdictional assessment) and one assessment was completed by HQO with reliance on work already completed by the National Institute for Health and Care Excellence in the United Kingdom.

For the five assessments performed between April 1, 2019, and June 30, 2020, where HQO relied on evidence from previously completed assessments, HQO estimated that it saved between two weeks and 29 weeks of assessment time.

- *evaluate whether it would be more timely and cost-effective to adopt, where appropriate, the results of assessments performed by the Canadian Agency for Drugs and Technologies in Health or to jointly work on health technology and services assessments for Ontario.*

Status: Fully implemented.

Details

In our 2018 audit we reported that most other jurisdictions in Canada were relying on the assessments for medical devices and health-care services that were prepared by the Canadian Agency for Drugs and Technologies in Health. The Agency was created in 1989 by Canada's federal, provincial and territorial governments to focus on a co-ordinated approach to conducting assessments.

At the time of our follow-up, HQO was working on eight assessments in collaboration with other jurisdictions. As mentioned earlier, HQO has developed an expedited review process that allows

HQO to rely on work already completed by other jurisdictions. According to HQO, for two assessments it is planning to use another jurisdictional assessment as the evaluation criteria without conducting any further evaluations of its own.

Recommendation 7

To increase implementation of recommendations regarding medical devices and health-care services made by Health Quality Ontario (HQO) and accepted by the Ministry of Health and Long-Term Care, we recommend that HQO provide the guidance and supports required to assist health-care providers to implement the recommended devices and services in cases where the adoption rate is found to be low.

Status: Little or no progress.

Details

In our 2018 audit, we found that HQO did not prepare adoption strategies or supports to help health-care providers implement the approved medical devices or health-care services it recommended. In contrast, HQO prepared adoption strategies for the clinical care standards it develops.

At the time of our follow-up, HQO had not prepared adoption strategies for its recommended medical devices and health-care services. In addition, HQO was not measuring the adoption rate of recommended medical devices and services by health-care providers. The adoption rate would allow HQO to focus and target its supporting resources toward health-care providers and recommended devices and services that have not been implemented.

HQO hired a liaison officer to build and maintain relationships between HQO, the Canadian Agency for Drugs and Technologies in Health and key health-care system partners in order to create and promote awareness of health technology assessments. In November 2019, the liaison officer conducted an online training session for Ontario hospitals on the benefits of cognitive behaviour therapy to increase awareness of HQO's assessment in this area. As of July 2020, this was the only

online training session that had been held by the liaison officer.

Clinical Care Standards Recommended and Improvement Areas Identified by HQO Not Followed

Recommendation 8

To have health-care providers implement clinical care standards on a timely basis and to reduce the variation of care across Ontario, we recommend that Health Quality Ontario, in conjunction with the Ministry of Health and Long-Term Care:

- *prepare training and support material for each clinical care standard, where appropriate;*

Status: Little or no progress.

Details

In our 2018 audit, we reported that HQO was not assessing the training and potential resources required by health-care providers to implement a clinical care standard. We also noted that stakeholders we spoke with told us they would welcome more guidance on implementing clinical care standards.

During our follow-up, we noted that in May 2019 HQO started providing additional training and tools to support the adoption of certain clinical care standards. For example, for the standard dealing with the transition between hospital and home, HQO developed a detailed plan and webinars to raise awareness of the standard and to provide guidance on how to implement it. A similar emphasis was put on the palliative care standard, through webinars and other educational activities. However, HQO had not prepared similar training materials or held training sessions for all clinical care standards. According to HQO, it chose to focus its efforts on a subset of priority quality standards (for example, opioids, transitions in care, palliative) because preparing supporting materials for each standard requires substantial resources.

The Ministry stated that it will work with HQO and support both HQO and Ontario Health as they determine an approach to support adoption of clinical care standards.

- *assess the potential benefits of enforcing the use of clinical care standards through the Local Health Integration Networks.*

Status: Little or no progress.

Details

In our 2018 audit we noted that most health-care sectors (for example, hospitals, community health centres and long-term-care homes) have service accountability agreements with the Local Health Integration Networks (LHINs). However, performance indicators used by LHINs to oversee the operations of these entities are set by the entities themselves and are not required to include clinical care standards.

During our follow-up we noted that neither the Ministry nor HQO had undertaken an assessment of the potential benefits of enforcing the use of clinical care standards through the LHINs. HQO stated that analysis and assessment of enforcing quality standards will be dependent upon the timing of the transfer of the LHINs into Ontario Health and subsequent discussions with the Ontario Health board. The Ministry informed us that it will support HQO and Ontario Health as they determine an approach to supporting the clinical adoption of care standards.

Recommendation 9

To improve the effectiveness of the quality improvement plan initiative, we recommend that:

- *the Ministry of Health and Long-Term Care (Ministry) require that all health-care organizations that are performing below the provincial average on a priority indicator identified by Health Quality Ontario (HQO) include the indicator in their quality improvement plans*

and tie those indicators to their executives' compensation;

Status: Little or no progress.

Details

At the time of our 2018 audit, health-care organizations were allowed to select the performance indicators for their quality improvement plans that would be tied to executive compensation. Of the four health sectors we reviewed, hospitals were the least likely to select priority indicators developed by HQO for inclusion in their quality improvement plans, even in cases where they were performing below the provincial average. Specifically, we found that for the five priority areas for 2017/18 that we reviewed, 15% to 24% of hospitals, depending on the priority indicator, had both performed below the provincial average and had not selected the indicator as an area of focus in their 2017/18 quality improvement plan.

During our follow-up, we noted that HQO has not altered its approach on quality improvement plan indicators and requires hospitals to select only two indicators from a list of priority indicators (i.e., the time taken to find a bed for a person admitted to hospital and the number of workplace violent incidents). The selection of these indicators for hospitals is mandatory without a consideration of the hospital's level of performance in each indicator. For 2020/21 quality improvement plans, HQO informed us that it had discussed the possibility of making indicators mandatory for poor performers; however, it had not finalized a consistent approach for defining poor performers. HQO also stated that as the system was going through significant change with the creation of Ontario Health, it had decided to maintain continuity with the previous year's indicators. The Ministry stated that it expects to further explore this area for the 2021/22 quality improvement plans.

HQO completed an analysis of which indicators in the 2019/20 quality improvement plans were linked to executive compensation. The analysis noted that five hospitals did not link their

quality improvement performance to executive compensation as required under legislation, and one-third of the hospitals did not indicate the quality indicator that was tied to executive compensation. The Ministry informed us that together with Ontario Health it has begun a review of best practices for executive compensation, with a goal of making recommendations related to executive compensation as part of a refreshed quality improvement plan strategy for 2021/22.

- *the Ministry assess whether other health-care sectors (such as mental health providers and land ambulance operators) should be required to submit quality improvement plans to HQO;*
Status: Little or no progress.

Details

In our 2018 audit report we noted that certain health-care sectors (such as mental health and addictions, land ambulance and assisted living) were not required to complete an annual quality improvement plan that identifies areas of focus for improvement along with performance targets that hold the entity accountable for its improvement goals.

At the time of our follow-up, the Ministry had not assessed whether other health-care sectors should be required to submit quality improvement plans. The Ministry stated that quality improvement plans for other sectors will be prioritized as part of the new quality improvement plan strategy expected to be completed by March 2021. In addition, the Ministry noted that work is under way to explore the development of integrated quality improvement plans for Ontario Health Teams. As part of Ontario Health Teams, health-care providers (including hospitals, doctors and home and community care providers) are to work as one co-ordinated team no matter where they provide care. The Ministry identified the first set of Ontario Health Teams in November 2019.

- *HQO remove improvement areas from the list of provincial priorities only when there is evidence of sustained improvement over several years.*

Status: Little or no progress.

Details

During our 2018 audit, we found instances where HQO removed improvement areas from its list of priorities for health-care sectors due to stakeholder feedback or because few organizations were selecting them for their quality improvement plans. In these cases, HQO did not consider whether the area of focus had shown sufficient improvement and was eligible for removal based on performance improvement.

At the time of our follow-up, HQO was not clearly documenting its rationale for removing indicators from the priority list. According to HQO, the rationale for any changes are communicated in the annual guidance materials. However, for the three indicators that were retired for 2020/21 quality improvement plans (namely, 30-day hospital readmission rate for mental health or addiction, the number of long-term-care complaints acknowledged within 10 business days and overall satisfaction of long-term-care resident experience), there was no rationale provided. The retirement of these indicators was not explained in the annual technical guidance document or the technical specifications. There was no evidence provided that any of these priority indicators had shown sustained improvement.

HQO informed us that Ontario Health is looking at new processes for aligning and streamlining indicators in the system, including how indicators are added or removed from the quality improvement plans. The new process is expected to be completed by April 2021 as part of the new quality improvement plan strategy.

Recommendation 10

In order to support continuous quality improvement and reduce variation in care across the province, we recommend that Health Quality Ontario:

- *establish ideal ranges for performance targets;*
Status: Little or no progress.

Details

In our 2018 audit, we reported that HQO set priority areas for quality improvement but was not identifying specific targets or target ranges that health-care organizations should meet according to best practices, nor was it setting minimum targets. Consequently, there were instances of variation in targets set for the same indicator and variations in care. For example, in September 2016, one long-term-care home gave 26% of its residents without a psychosis diagnosis an antipsychotic medication, while another long-term-care home gave the same medication to 5% of its residents.

During our follow-up, we found that HQO did not have any plans in place to introduce ideal ranges for performance targets or to set performance benchmarks for all priority indicators. HQO noted that it supports organizations in understanding ideal performance targets for improvement; however, sometimes there is no single ideal range that would apply across all health-care provider organizations.

HQO further told us that due to COVID-19, it has delayed the submission of quality improvement plans by health-care organizations for 2020/21 and 2021/22, and would not be setting an ideal range for performance targets at this time.

- *investigate all significant variances in target-setting for priority indicators among providers in the same sector;*
Status: In the process of being implemented by March 2021.

Details

Our 2018 audit found that HQO was not investigating significant variances in targets set by various providers in the same health-care sector.

Our follow-up found that HQO had analyzed the targets set for 2019/20 quality improvement plans and found that health-care organizations generally set targets close to their actual performance for the

prior year. These were targets set for the following indicators: wait time for an inpatient bed in a hospital, medical reconciliation at discharge and timely access to a primary care provider. HQO plans to conduct further analysis on the 2020/21 target setting and include the results into the new quality improvement strategy in 2021/22.

- *in consultation with the Ministry of Health and Long-Term Care and the Local Health Integration Networks, ensure all organizations are setting targets toward improvement in health quality and that the targets are for better than current performance (not retrograde targets).*
Status: Little or no progress.

Details

In our 2018 audit, we reported that there were health-care organizations that set improvement targets in their quality improvement plans that were worse than the latest available performance result for that indicator—these are called retrograde targets. The number of health-care organizations setting a retrograde target for at least one priority indicator increased from 12% of health-care organizations in 2016/17 to 16% in 2017/18.

During our follow-up, we found that HQO had no plans to restrict health-care providers from setting targets that were worse than their current performance. The Quality Improvement Plans advisory group, comprised of health-care executives and a few HQO staff, meet regularly to discuss quality improvement plan related strategies and improvement priorities. Based on the Quality Improvement Plans advisory group discussions, the group agreed to allow targets worse than current performance when there might be valid reasons to set a worsening target. For example, the group noted that a worsening target could be a sustainability strategy to acknowledge that an initial rush led to better performance but that this may settle over time. However, the group did not review individual cases where an organization had set worsening targets to determine whether setting worsening performance targets was justified.

According to HQO, it followed up with organizations that had targets that appeared to be in error and worked to educate those organizations on appropriate target setting. HQO plans to do further analysis for the 2020/21 quality improvement submissions, but for now its focus will remain on educating rather than enforcing improving targets.

Recommendation 11

To maximize the impact of quality improvement plans on health-care quality, we recommend that Health Quality Ontario, in collaboration with the Ministry of Health and Long-Term Care and the Local Health Integration Networks (LHINs):

- *track whether health-care organizations are implementing the change ideas included in their improvement plans and whether the ideas have resulted in positive improvement;*

Status: Little or no progress.

Details

Our 2018 audit found that HQO did not request health-care organizations to self-report in the following year whether the change ideas that the organizations thought would help them to achieve their improvement goals had been implemented. HQO was not able to summarize the data or analyze the relationship between the implementation of the change idea and its impact on quality improvement, due to the limitations of its information system. As a result, HQO was also not able to determine the percentage of change ideas implemented and whether the implementation improved performance.

At the time of our follow-up, HQO was still attempting to implement a tool that would allow it to capture whether change ideas are being implemented. In 2019, HQO analyzed the change ideas that long-term-care homes selected and their impact on the homes, and noted that poor performers were not selecting good change ideas or were not implementing them.

As part of its transition to Ontario Health, HQO informed us that it intends to start capturing information on performance and change ideas that will allow HQO to assess the types of change ideas that lead to improvement.

- *follow up with and encourage organizations that are not showing improvement in their performance to implement the change ideas;*

Status: Little or no progress.

Details

In our follow-up, we noted that since our audit HQO had followed up once, in October 2019, with primary care physicians who were not providing their patients with timely access to health care and/or were measuring current performance without setting improvement targets, to encourage them to attend an upcoming webinar on how to meet these performance indicators. HQO also invited these physicians to meet with a quality improvement specialist.

At the time of our follow-up, HQO did not have plans to regularly follow up with low-performing organizations. Instead, HQO planned to focus on highlighting successful change ideas.

- *share effective change ideas put forth by health-care organizations as part of their quality improvement plans that may benefit other health-care organizations.*

Status: Little or no progress.

Details

Our follow-up found that HQO provides training and support focused on quality improvement but does not highlight successful change ideas to the health-care sectors. HQO informed us that it plans to work toward sharing effective change ideas in 2020. Although HQO is not evaluating change ideas and sharing the most effective change ideas with all health organizations, it does provide a platform for the health-care providers to discuss ideas amongst themselves.

Cost Savings Expected from Consolidation of Five Organizations into HQO in 2011 Did Not Materialize

Recommendation 12

To support Health Quality Ontario in using its resources efficiently, we recommend that the Ministry of Health and Long-Term Care assess whether the agency's growth in expenditures and staff size is reasonable in relation to its current mandate.

Status: Little or no progress.

Details

In our 2018 audit, we reported that the government of Ontario created HQO on April 1, 2011, by consolidating five different entities, to reduce operational costs. However, at the time of our audit, both expenditures and the number of staff had increased. From 2010/11 to 2017/18, HQO's annual expenditures had increased from \$23.4 million to \$44.2 million (89%) and the number of full-time employees (FTEs) had increased from 111 to 291 (162%). Although HQO's mandate was expanded from what was originally envisioned for the consolidated entity, the Ministry did not know if the increase in costs and FTEs was reasonable.

At the time of our follow-up, we noted that the Ministry had reduced HQO's 2019/20 budget

to \$35.2 million (\$13.9 million reduction from scheduled payments of \$49.1 million) as part of its transfer into the new Ontario Health agency. In May 2019, HQO was notified by the Ministry that the reduction in funding reflected the outcomes of two central processes that occurred in 2018. These were a comprehensive multi-year planning process built on the findings of a line-by-line review of government spending conducted by a government-appointed external consultant and the Planning for Prosperity consultation through which Ontarians had the opportunity to rank the importance and effectiveness of a range of government services. The budget reduction letter noted that all ministries were required to identify administrative savings by identifying opportunities to modernize services to reduce administrative costs and burden while improving services. When the Ministry informed HQO of its new budget allocation of \$35.2 million, it directed HQO to identify operational and administrative efficiencies associated with non-direct programs and services while ensuring the ongoing provision of front-line services.

The reduction in expenditure was a general direction to HQO to reduce its costs, but the Ministry did not specifically assess whether HQO was using its resources efficiently and if the growth in expenditures and staff size was reasonable.