

EXECUTIVE SUMMARY

Family practices strive to deliver quality care to their patients. However, there is currently no yardstick for a practice to measure its improvement. As the health care system increases in complexity, a quality framework that supports a continuous quality improvement (CQI) environment is vital.

The *Quality in Family Practice* (QIFP) project (Phase 1) is an exploratory study designed to recommend the best interdisciplinary assessment programme for family practice offices in Ontario. Several Canadian studies are working on quality indicators and some provinces have started to implement quality programmes. The QIFP project has reviewed the national and international literature; completed an environment scan; conducted focus groups with patients, staff and practitioners; held teleconferences with national and international programme leaders, and visited sites in the UK and Ontario that operate quality programmes. These data, together with input from a Steering Committee of clinicians, staff and patients, and an Advisory Committee of key stakeholders, have provided the Project Management Team with information for developing a process for achieving excellence.

The Primary Health Care Transition Fund (PHCTF) funded the two-staged QIFP project for the purpose of recommending a process for achieving excellence in family practices in Ontario. In Stage One, a collaborative consultation was undertaken with patients, family physicians, nurses, other health care professionals, and administrative support staff to develop a model for an Ontario Quality Programme.

Phase 1: Stage One

COMMITTEE STRUCTURE

Three multidisciplinary committees were established in September 2003: the Project Management Team to carry out the work, the Steering Committee to oversee the project, and an Advisory Committee of key stakeholders to direct and guide the process.

THE LAUNCH

A launch of the project was held to introduce the QIFP project to interested practitioners, patients and key stakeholders on November 12, 2003. Prior to the launch, consultation meetings occurred with executive members of some of the professional colleges. There was support for the concept of a quality programme by almost all of the members. Information received from the launch and consultation meetings included contact names of interested practitioners, suggestions for terminology, ownership and housing of the programme, costs, and potential ethical and legal dilemmas during a quality assessment.

STRATEGIC CONSULTATION/PLANNING WORKSHOP

The Advisory Committee was invited to participate in the Strategic Consultation/Planning Workshop for the purpose of developing a strategic plan for all aspects of the project on December 10, 2003.

The purpose of the Strategic Consultation/Planning Workshop was to receive input from the Advisory Committee on the development of a strategic plan for all aspects of the project; specifically, suggestions for searching the quality literature, contact names of quality programmes and/or processes, types of questions to ask the focus group and teleconference participants, Canadian licensing colleges and content experts at the site visits. Research completed included a review of the literature, an environmental scan, focus group sessions with patients and discipline representatives, interviews with provincial, national and international quality project leaders and experts, as well as site visits in the United Kingdom with established programmes and in Ontario with the Ontario Association of Community Health Centres, *Building Healthier Organizations* (BHO).

LITERATURE REVIEW

The literature review was designed to identify quality programmes with relevance to multidisciplinary family practices. The six major objectives were: 1) standards, criteria & indicators, 2) systems of assessment—individual or team, 3) programme administration, 4) training of assessors, 5) nomenclature concepts and definitions, and 6) costs. Search strategies were developed for indexed and grey literature with key words specific to the objectives. Bibliographies and reference lists of relevant articles were also searched. It was noted that the concept of “standard” varies across jurisdictions from minimum to gold standard.

In addition, there is no common use of the terms “criteria” or “indicator”. In standards-based programmes, the degree to which the individual or the team meets pre-defined measures is assessed. There can be a feedback mechanism that functions to prompt quality improvement. In contrast, CQI programmes have an ethos of “achieving” and are often combined with continuing education programmes and/or personal development plans. Some of the standards-based quality assessment programmes and CQI programmes are peer-developed, peer-owned and peer-administered. They tend to focus on structure and process, or clinical practice performance. Although quality assessment programmes and their indicators are not 100% transferable across borders, much can be learned from the structure and process of quality systems in other jurisdictions.

ENVIRONMENTAL SCAN

The main question that guided the environmental scan was “Do you currently have, or are you developing a multidisciplinary, voluntary accreditation programme?” Local, provincial, national, and international programmes were searched.

The objectives of the Environmental Scan were:

- To identify multidisciplinary voluntary accreditation programmes
- To select those programmes with the most relevance to the goals of the QIFP project
- To review the criteria and indicators used in assessment tools
- To recommend programmes for the teleconference information gathering process

Possible programme inclusions were identified by three main sources:

- The mandate of the Quality Assessment/Voluntary Accreditation Project
- Suggestions from the Strategic Consultation/Planning Workshop
- A scan of the grey literature

A critical review of the environmental scan material was conducted to identify programmes most relevant to the purposes of the project.

International Quality Programmes

Nine programmes were identified for the teleconferences. Multidisciplinary primary care quality programmes with the most relevance for Ontario family practices include those in New Zealand, the United Kingdom, and Australia. *Aiming for Excellence*, developed by the Royal New Zealand College of General Practitioners (RNZCGP), has relevance for our *Quality in Family Practice* project because it includes a practice accreditation and a self-assessment by the individual practice team members. In the UK, there is a multiplicity of quality assessment programmes under the umbrella of the Royal College of General Practice (RCGP), including individual standards-based peer assessed professional performance programmes, the *Quality Team Development* (QTD) and the *Quality Practice Award* (QPA). In Australia, the Royal Australian College of General Practitioners (RACGP) has developed the third edition of the *Australian Standards for General Practices*.

Provincial Quality Programmes

In Ontario, *Building Healthier Organizations* (BHO) has been established for multidisciplinary teams in Community Health Centres (CHC).

A questionnaire was sent to each of the medical licensing authorities in Canada to inquire about their participation in family practice and re-validation programmes. Manitoba, Alberta, Saskatchewan, PEI and Ontario reported that they are currently in the process of developing or have developed a system using the *Monitoring and Enhancing Physician Performance* (MEPP) guidelines from the Federation of Medical Licensing Authorities of Canada (FLMAC). Physicians in Alberta participate in the *Physician Achievement Review* (PAR) programme every five years. The programme that emerged from the MEPP process in Saskatchewan is the *Practice Enhancement Program*, a fairly traditional office audit programme.

FOCUS GROUPS

Qualitative community consultations using focus groups and key informant interviews were conducted with patients, practitioners and staff working in family practices. The purpose was to provide direction and guidance in the development of the quality assessment tools.

Two generic questions were asked:

- “If you or someone you care about asked you to recommend a family physician, who would you recommend and why does this person come to mind?”
- “If you had the chance to design the ideal family practice, what would it look like?”

One discipline-specific question was asked:

- “What would the ideal (dietitian/nursing/pharmacy/physician/reception/social work) practice look like in family practice setting?”

Findings from the generic questions indicate that the ideal professional organization of care is a multidisciplinary family practice using a shared care model with diagnostic services, on-site pharmacy and other services, with timely communication between providers of all services.

Following the discipline-specific question, each stakeholder group spoke to their own special interests about quality in terms of their role and multidisciplinary team functions.

TELECONFERENCES

Teleconferences were held with national and international leaders in various programmes in Canada, Australia, Scotland, New Zealand, Sweden, and the United States to gather more information about quality programmes.

In Australia, the RACGP has developed the third edition of the *Australian Standards for General Practices*. Through the voluntary self-assessment programme, general practitioners assess themselves against established criteria. Then, two peer surveyors from two third-party accreditation agencies visit the practice and assess the general practitioner against the criteria. In the UK, the QPA was initially owned by the Scottish College and quickly became UK-wide. The Scottish College also developed the QTD programme, which is also used in England. In New Zealand, the *General Practice Accreditation Program* is based on peer-developed standards and validated by the New Zealand College. In Sweden, the *Swedish Audit Project* is a voluntary programme that has become a very popular way for physicians in Sweden to review their own practices. The health system in the United States (US) is complex in terms of delivery, organization structure and financing. There are many tensions in the US quality systems: public versus private, the individual versus the collective, safety versus the pure quality for quality sake issue, the tension between counting numbers versus the kind of qualitative care that is provided at the doctor's office. These important issues form the tapestry of what quality is about.

SITE VISITS

Site visits were planned to experience the “hands-on” process of quality assessment programmes in other jurisdictions. Two team programmes, QTD and QPA, were chosen for site visits in England and Scotland. The QTD, as its name implied, is a development process and is viewed as a stepping-stone to QPA, the gold standard award. The programmes includes education and training, clinical audits, risk management, communication, methods of determining clinical effectiveness, and systematic documentation with written evidence. All practices visited said it was essential to have a computerized office system for producing the audits and monitoring services and procedures. Both QTD and QPA promote “reflective practice” and a “culture of audit” with a healthy curiosity about feedback to achieve higher levels of excellence.

A physician/nurse team undertook another site visit to witness an accreditation of a CHC in Toronto which underwent the BHO assessment, and two members of the Steering Committee incorporated a visit to quality programs while they were in Australia and New Zealand.

THE SECOND STRATEGIC PLANNING/CONSULTATION MEETING

The Second Strategic Planning/Consultative Meeting was held to provide feedback to the Advisory Committee on the work that had been completed, draft recommendations for the Ministry of Health and Long Term Care, and incorporate the advice from the Advisory Committee into the draft report. On June 2, 2004 the Project Management Team presented the findings from the literature review, and the community consultations, which were composed of personal interviews and focus groups. The pre-site visit to England, and the site visits in the UK were described in detail, and an overview of the environmental scan and proposed

teleconferences were discussed. A Glossary of Terminology was presented and helped the participants further understand the magnitude of some of the issues associated with the project. Through small and large group processes, participants had the opportunity to brainstorm the suggested recommendations, add comments and clarify outstanding issues.

Phase 1: Stage Two

Stage Two included the following:

- Developing the assessment tools
- Undertaking the Master Assessors Training Workshop to train multidisciplinary professionals in the tools and assessment process of the QIFP programme
- Preparing and submitting a Summative Evaluation and Final Report in preparation for a rollout of the demonstration project (Phase 2) for submission to the Ministry of Health and Long Term Care

IT SYSTEM AND WEBSITE DEVELOPMENT

The Project Management Team met with Dr. David Chan, an IT expert, on November 8, 2004 to identify and discuss the IT needs of the project. These included enabling users to review document drafts on our website, setting up a discussion board on our website, facilitating tool development and feedback on our website, and developing web-based resources and assessment grids for practices and assessors. Following the discussion, it became clear that the pilot sites would need to have an IT system in place in order to participate in the project.

ASSESSMENT TOOL DEVELOPMENT

Aiming for Excellence was chosen for our initial framework. After considerable work on the tool, the Steering Committee were updated on the development process and had the opportunity to practice with the tool at a workshop on December 15, 2004. Following the meeting, layering of the QIFP assessment tool was successfully completed at a two-day workshop on December 21 and 22, 2004. The QPA, QTD, RACGP *Standards for General Practices*, and the Hamilton Tool were reviewed and incorporated. In addition special features identified through the focus groups were added to the tool.

Three tools were developed for different users:

- QIFP Overview of Sections, Indicators & Criteria in Assessing Family Practice
- QIFP Assessment Tool for Practices
- QIFP Assessment Tool for Assessors

The first draft of the QIFP Overview was sent to the Ministry and the Steering Committee on December 23, 2004 for review and feedback. The first draft of the QIFP Assessment Tool for Practices was sent to the Steering Committee on the December 29, 2004. The first draft of the QIFP Assessment Tool for Assessors was circulated to the Steering Committee at the workshop on January 26, 2005.

Other quality indicators have also been layered into the tool and include: European indicators; indicators from other PHCTF projects; and indicators from Manitoba. The process of refining the assessment tool will continue until the completion of Phase 2.

MASTER ASSESSORS TRAINING WORKSHOP

A Master Assessors Training Workshop was held on January 26 and 27, 2005. Dr. Ronald MacVicar from Scotland was the international expert facilitator and eighteen participants were trained as master assessors. This multidisciplinary team included: 2 physicians, 3 nurses, one social worker, one dietitian, one pharmacist, 2 receptionists, 3 executive directors/managers, 3 patients and 2 researchers.

COST ANALYSIS

To forecast the potential cost of developing an Ontario QIFP programme, data was extracted on the costs of existing international quality programmes. The following countries have been contacted to elucidate the cost of their quality programmes – England, Scotland, Australia and New Zealand, and a spreadsheet will delineate the cost comparisons for each of the above programmes. The costs of the BHO for CHCs in Ontario is also being assessed. This is intended to provide the rationale from which to draw the baseline costs for an Ontario programme.

SUMMATIVE EVALUATION

Evaluations were conducted at every event through questionnaires and the results collated and reviewed. In addition, qualitative feedback was encouraged at all events and the comments captured in the reports. Throughout the review process, reviewers were asked to provide feedback on the process of development and content of the draft documents. These comments were captured and reported in the feedback sheets. In general, participants have demonstrated confidence with the process through their surveyed comments. A summative evaluation of all these reports is included in the final report.