

IMPROVING BC'S HEALTH SYSTEM PERFORMANCE

Commitment

A Policy Paper by BC's Doctors
January 2017

**doctors
of bc**
Better. Together.



Doctors of BC's Council on Health Economics and Policy reviews and formulates policy through the use of project-oriented groups of practising physicians and professional staff.

Improving BC's Health System Performance Project Group

Dr Alexander (Don) Milliken, Chair – Psychiatry, Victoria
Dr William Cunningham – General Practice, Victoria
Dr Dan Horvat – General Practice, Prince George
Dr Ken Hughes – Orthopedics, Vancouver
Dr Trina Larsen Soles – General Practice, Golden
Dr Lloyd Opper – General Practice, Vancouver

Doctors of BC Council on Health Economics and Policy Membership 2014-2016

Dr Alexander (Don) Milliken, Chair – Psychiatry, Victoria
Dr Andrew Attwell – Oncology, Victoria
Dr David Attwell – General Practice, Victoria
Dr Ernie Chang – General Practice, Vancouver
Dr Tommy Gerschman – Pediatrics, Vancouver
Dr Jaspinder Ghuman – General Practice, Surrey
Dr Brian Gregory – Dermatology, Vancouver
Dr Jeff Harries – General Practice, Penticton
Dr Dan Horvat – General Practice, Prince George
Dr Gordon Hutchinson – General Practice, 100 Mile House
Dr Trina Larsen Soles – General Practice, Golden
Dr Tracy Monk – General Practice, Vancouver
Dr Lloyd Opper – General Practice, Vancouver
Dr Jessica Otte – General Practice, Vancouver
Dr Alan Ruddiman – General Practice, Oliver
Dr Kimberly Shaw – General Practice, Port Coquitlam
Dr David Smith – Pediatrics, Vancouver
Dr Marianne Taylor – Oncology, Vancouver
Dr Elliott Weiss – Rehabilitation Medicine, Vancouver

Doctors of BC Staff Support

Mr Jim Aikman – Executive Director of Economics and Policy Analysis
Ms Deborah Viccars – Director of Policy
Ms Kate Saunders – Senior Policy Analyst
Ms Mary George – Policy Analyst
Ms Helen Thi – Policy Analyst
Mr Jon Wong – Policy Analyst
Ms Tania Webb – Economics and Policy Analysis Assistant



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EXECUTIVE SUMMARY

A key component of the Doctors of BC strategic plan is to engage with partners to achieve a high quality health care system for the citizens of BC.

We are encouraged by the BC Ministry of Health's current approach of collaborating with stakeholders on health system improvement across a wide range of areas, including primary and community care, rural health, and surgical services. In its 2015 policy discussion papers, the Ministry's plans for health system improvement are appropriately guided by the Institute for Healthcare Improvement's Triple Aim framework, which suggests that advancements need to improve health outcomes, patient and provider experience of care, and ensure efficient use of resources.

BC's physicians support these aims and will continue to be actively involved as the collaborative process evolves. However, as participants in and co-creators of our health care system, physicians recognize that if change is to be successful it must be based on a clear, accepted, and evidence-based understanding of how we are performing, what needs to change, and how we will approach such change. There must also be the ability to robustly measure those changes to show whether they have produced the desired end result. This underlies broad international recognition that formal quality improvement processes based on measurement are a necessary part of modern health care.

Physicians continue to be committed to improving the quality of health care delivery. There are countless examples of physicians identifying and acting upon opportunities to improve health care, including, for example, recovery after surgery, hip fracture redesign, improving access to GPs, as well as using measurement for improvement in primary

and specialty care. Physicians are clearly committed to initiating change in our health care system, and are also committed to a Triple Aim approach.

Despite such successes, physicians also recognize the challenges of effecting lasting system change. These include difficulties with coordination of efforts, scaling up and spreading of successes, as well as access to relevant data for measurement and evaluation. Doctors of BC looks forward to working with others to address these challenges.

Physicians are committed to *why* we need to improve our health care delivery system, and largely support the Ministry of Health's identified priorities of *what* we need to improve in the short term. Building on this, we believe there is opportunity to improve *how* we undertake improvement efforts in BC's health care system.

The focus of this policy paper is on quality improvement as distinct from quality assurance as there are already structures and processes in place to address those needs, both through the College of Physicians and Surgeons of BC and the health authorities. In this paper, we identify challenges and opportunities experienced by physicians in their efforts to improve quality of care. Doctors of BC is committed to working with stakeholders to collectively address those challenges and opportunities and to build on current efforts so that we will achieve larger, system-level transformation. Working together we can create a sustainable health care system that is among the best in the world.



DOCTORS OF BC POLICY

Doctors of BC believes there is an opportunity to learn from physician experience with quality improvement efforts in order to build sustained, system-level improvement for health care in British Columbia.

To support this policy position, Doctors of BC has identified the following commitments and recommendations.

Commitments

Doctors of BC commits to:

- a. Engaging physicians and actively collaborating with the BC Ministry of Health, health authorities, and other partners to improve health system performance, including in the areas outlined in the Ministry's 2015 policy discussion papers.
- b. Working with physicians and other key stakeholders to ensure that the best evidence in health system improvement is used to guide improvement efforts.
- c. Continuing to enable physicians to engage in community and provincial training and leadership opportunities in quality and health system improvement.
- d. Working with other stakeholders to develop and use appropriate measures to support improving the quality of health care provided in BC.

Recommendations

Doctors of BC recommends that current quality improvement activities in BC be premised on a commitment among all parties to a common vision for health system and quality improvement, and that these activities be better supported and coordinated through:

- a. Explicit clarification of mutual roles and responsibilities, including leadership responsibility, as agreed by stakeholders involved in health system and quality improvement.
- b. More provincially aligned and transparent health system performance measurement and reporting, including quantifying the need for and effectiveness of changes within our health delivery system.
- c. Investment in the technology and human resources required to obtain and effectively use data for quality improvement, evaluation, research, and system reporting.
- d. Enhancement of structures and processes that support innovation and, where appropriate, enable expansion of successful health system and quality improvement initiatives.



INTRODUCTION

British Columbia is home to the healthiest Canadian population with the lowest rates of disease.¹ We also lead the way in many areas of health care innovation and delivery.

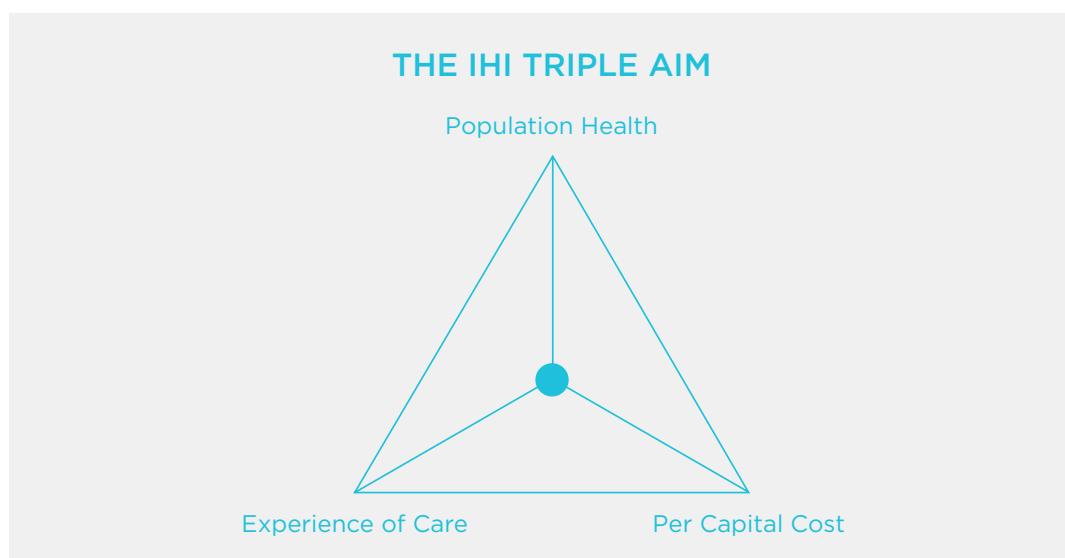
However, it is well understood that there is room for improvement in our health care system, particularly if it is to sustainably meet the needs of future generations.

Doctors of BC, the BC Ministry of Health, and many other stakeholders recognize the need to make significant changes to the way health care is delivered in this province. The Ministry of Health's strategic document, *Setting Priorities for the BC Health Care System*² identifies an approach to system change, while its recent suite of policy papers^{3,4,5} provide further direction on three key areas of focus. These areas are primary and community care, surgical services, and rural health services. As is appropriate, the Ministry frames its efforts to improve health care around the Institute for Healthcare Improvement (IHI) Triple Aim framework.

The dimensions of the Triple Aim are:

- Improving the patient experience of care, including quality and satisfaction (noting that BC has recognized the additional requirement of improving the experience of delivering care for providers and support staff);
- Improving the health of populations; and
- Reducing the per capita cost of health care.⁶

As noted in our 2015 response to the Ministry's policy papers,⁷ a balanced approach that considers all three elements of the triple aim is essential. Overemphasis on reduction of system cost as the primary driver behind improvement initiatives could potentially erode patient and provider support and result in unintended consequences with respect to quality of care.



Source: The IHI Triple Aim framework was developed by the Institute for Healthcare Improvement in Cambridge, Massachusetts (www.ihio.org)



In addition to using the Triple Aim as a quality improvement framework, many organizations also consider quality in terms of a range of different dimensions. The following eight dimensions of quality are regularly used by organizations involved in quality improvement and/or evaluation of health system performance.* While different providers, programs, facilities, and health authorities may add to, or subtract from, these dimensions, they are commonly identified as being the building blocks of a quality health care system.

Dimensions 1 to 7 have been identified by the BC Patient Safety & Quality Council and are included within the BC Health Quality Matrix, a framework designed to provide a common language and understanding about health care quality.⁸ These dimensions are also referred to by the BC Ministry of Health in *Setting Priorities for the BC Health System*.

1 Appropriateness – health care is evidence based and specific to individual needs.

2 Effectiveness – health care is known to achieve intended outcomes.

3 Safety – harm resulting from health care is avoided.

4 Accessibility – health care services are reached with ease.

5 Patient-centredness/Acceptability – health care is respectful to patient and family preferences, needs, and values.

6 Equity – health care delivery, and its outcomes, are distributed fairly according to population need.

7 Efficiency – health care resources are optimized to yield maximum benefits.

8 Timeliness – health care is delivered promptly.

* This includes the Health Council of Canada, the Canadian Institute for Health Information, the Institute for Healthcare Improvement, the Canadian Foundation for Healthcare Improvement, and Accreditation Canada.

Doctors of BC supports the Ministry's overall goals for health system improvement and its commitment to addressing these issues through a collaborative process. Physicians believe that lasting system level change must be undertaken collaboratively, systematically, and through the application of a continuous quality improvement approach. While it is helpful to distinguish quality improvement from quality assurance, this is not a black and white distinction. Generally, quality assurance focuses on identifying and eliminating failures to ensure a particular standard of quality is met.

Quality assurance processes are often retrospective while quality improvement generally looks forward to prevent quality failures in the future by improving current processes and systems. While quality assurance is often considered corrective or judgmental, quality improvement (which more often requires system change) is typically perceived as positive and educational by clinical practitioners.⁹ Additionally, quality assurance is often externally directed, whereas quality improvement tends to be more locally initiated, with physicians and other providers being given the tools and influence to continually evaluate and improve their own practices.

While Doctors of BC considers that health system improvement efforts should largely be focused on continuous quality improvement, there is of course an important role for quality assurance. When undertaken in a collaborative and transparent manner, quality assurance processes can support and identify opportunities for quality improvement. However, the focus of this paper is on quality improvement as there are already structures and processes in place to address quality assurance needs, including through the College of Physicians and Surgeons of BC and the health authorities.

BC's physicians, allied health care providers, administrators, policymakers and patients are already participating in quality improvement activities across the health care system. The Joint Collaborative Committees, established between 2002 and 2006 under the Physician Master Agreement between Doctors of BC and the provincial government, support physician

collaboration with the BC Ministry of Health, the regional health authorities, and other stakeholders on a wide range of initiatives. Some of these quality improvement initiatives are highlighted in this paper. It is clear that the Ministry sees this as important work, noting in the overview to its 2015 suite of policy papers that we need to collectively take action to identify, prioritize, and engage in action at the practice, organizational, and provincial levels to continuously improve outcomes and health services for the citizens of BC.

Through their involvement in leadership and quality improvement initiatives over the last decade or more, physicians have gained an increased understanding of best practices in health system and quality improvement. The knowledge and experience gained is of value at the local, regional, and provincial levels. Doctors of BC sees that there is a unique opportunity to better coordinate and expand on the health system and quality improvement activity occurring across the province and to also build on successes occurring outside of BC.

DOCTORS OF BC COMMITS TO:

- *Engaging physicians and actively collaborating with the BC Ministry of Health, health authorities, and other partners to improve health system performance, including in the areas outlined in the Ministry's 2015 policy discussion papers.*
- *Working with physicians and other key stakeholders to ensure that the best evidence in health system improvement is used to guide improvement efforts.*

The following sections of this paper provide examples of quality improvement initiatives in BC that have either been led or significantly supported by physicians, and then provide both the physician perspective and evidence-based thinking on what more is needed to better support health system improvement in BC.



PHYSICIAN INVOLVEMENT IN QUALITY IMPROVEMENT INITIATIVES

Quality improvement is being undertaken at all levels of BC's health care system and by a range of different stakeholders including Doctors of BC, the Ministry of Health, health authorities, the BC Patient Safety and Quality Council, and the BC Medical Quality Initiative.

BC physicians, both individually and in groups, are active participants in the creation of a wide range of initiatives designed to achieve the dimensions of the Triple Aim. Many quality improvement projects have engaged a variety of stakeholders, including through the Divisions of Family Practice and through partnerships with Doctors of BC, the Ministry of Health, and the health authorities on the Joint Collaborative Committees. Recognizing the importance of the patient voice in quality improvement efforts, some of these initiatives have ensured that patients and families have been involved throughout the process. The Joint Collaborative Committees in particular have benefitted from the invaluable contributions that patients have made to the dialogue and decision making on health system improvement.

It is not the purpose of this paper to provide a comprehensive report on quality improvement initiatives undertaken to date in BC or elsewhere. However, we highlight examples of quality improvement initiatives below to demonstrate how physicians are leading positive change in our health care system. This experience, along with learning from the experience of other health care systems, has enabled physicians to identify the principles that will assist with improvement at the broader system level.

Most of the initiatives described below are sponsored, for example, through the Joint Collaborative Committees, and some are relatively large scale. However, there are many other examples of quality improvement initiatives happening across BC at a more grassroots level, including in individual practice settings.



Joint Collaborative Committee Initiatives

The Joint Collaborative Committees are partnerships between Doctors of BC and the Ministry of Health, with significant input from the health authorities and patients. The term “Joint Collaborative Committees” refers to the three Joint Clinical Committees and the Joint Standing Committee on Rural Issues. As defined in the Physician Master Agreement the Joint Clinical Committees are the General Practice Services Committee, the Specialist Services Committee, and the Shared Care Committee. Each Joint Clinical Committee has a different mandate, but all are responsible for supporting and incentivizing changes in physician service delivery to improve patient care and more effectively utilize physician and other health care resources.

All committees are expected to strengthen the application of Triple Aim principles and to identify gaps in care and address population health needs. The mandate of the Joint Standing Committee on Rural Issues is to enhance the delivery of rural health care and administer various rural programs relating to recruitment, retention, and education of rural physicians. Examples of Joint Collaborative Committee quality improvement initiatives that involve significant physician input are set out here.



Enhanced Recovery After Surgery Collaborative

Sponsored by the Specialist Services Committee, the BC Enhanced Recovery After Surgery (ERAS) Collaborative brings together 11 diverse, multidisciplinary hospital teams from across the province to learn from and support each other, while implementing evidence-based ERAS protocols for elective colorectal surgery at their sites. ERAS protocols are multimodal perioperative care pathways designed to achieve early recovery after surgical procedures by maintaining preoperative organ function and reducing the profound stress response following surgery.

Together, the Collaborative teams aimed to reach 80% compliance with all pathway elements, cut complication rates by 50%, and decrease hospital length of stay, all without adversely affecting readmission rates. The Collaborative’s activities include learning sessions, data collection support, clinical guidance, a website of resources, and a new, online patient education video. Importantly, Collaborative teams have made significant investments to develop a measurement infrastructure that tracks a common set of process and outcome measures; comparison of the processes of care that contributed to outcomes can provide insight into causal relationships and inform further quality improvement. The work of the Collaborative culminated in an Outcomes Congress in January 2016 and a Final Report in April 2016.

READ MORE:
enhancedrecoverybc.ca





BC Hip Fracture System Redesign Project

The BC Hip Fracture System Redesign Project was initiated by two BC orthopedic surgeons and is funded by the Specialist Services Committee. The project aims to increase the positive outcomes for patients who suffer a hip fracture, particularly elderly patients. The project's goals are to:

- (i) Review hip fracture care across the care continuum.
- (ii) Implement simple, proven best-practice measures in a pilot setting.
- (iii) Measure the system's performance at baseline and following implementation of best practices.
- (iv) Assess the feasibility of expansion of these best practices on a provincial scale.

The project team has surveyed hip fracture care at 28 BC hospitals, developed a provincial dataset, and established quality improvement pilot projects at eight sites across five health authorities. Major project achievements to date include improved time to surgery, demonstrated improvements in service delivery, BC Ministry of Health recognition of the project, and committed funding to scale up the initiative. Because of the success, a provincial change management strategy is under development with the project currently being extended to all acute care centers that provide hip fracture care.

FOR INFORMATION:
sscbc@doctorsofbc.ca



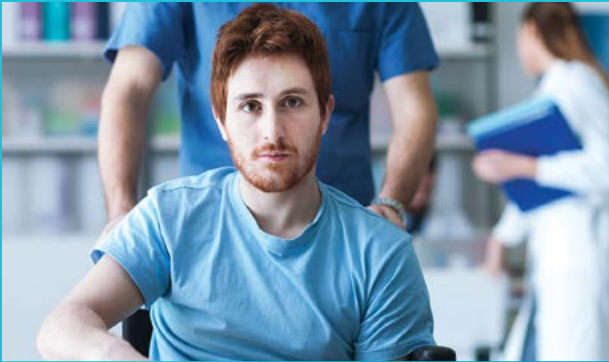
Polypharmacy Risk Reduction Initiative

Taking multiple medications, known as polypharmacy, is a risk factor for serious adverse events for seniors, especially for the frail elderly, and adds unnecessary cost to health services. The Shared Care Committee's Polypharmacy Risk Reduction initiative aims to reduce risks of polypharmacy in the elderly by providing physicians with tools and strategies to reduce medications for improved safety and quality of life. Initiative goals are to improve health outcomes, improve provider and resident care experience, and demonstrate sustainable per capita costs.

The Polypharmacy Initiative is being implemented in phases, focusing on prescribing in three care settings: residential care, acute care and transitions, and community care. So far, this has included physician engagement and clinical learning sessions, development of a train-the-mentor program, evidence-based summaries to inform medication review processes and decision making, and tools and guidelines to support a team approach to meaningful medication reviews in residential care.

READ MORE:
sharedcarebc.ca/initiatives/polypharmacy





Transitions in Care Initiatives

The Shared Care Committee's Transitions in Care initiative aims to address the various challenges of patient transition into, through, and out of acute care. The Youth Transitions initiative aims to improve the transition from pediatric to adult care for youth and young adults (age 10 to 24) with chronic health conditions and/or disabilities.

The Transitions in Care initiative is focused on finding local solutions to local problems, with family and specialist physicians working together, and with others, to improve the patient journey and streamline care. Initiative leads work with local physicians and other groups in acute care and community settings in order to understand the characteristics of the patient journey(s) in each site, create or support sustainable processes to alleviate tension or congestion, and create solutions that can be replicated in other programs and locations within BC. The Youth in Transitions initiative was initially based at BC Children's Hospital, with processes and tools now available to be implemented in other communities. These include expedited referral processes, medical transfer documentation, and an algorithm for tracking and evaluation to identify transitioning patients.

Transitions in Care projects include improving data quality in the acute care system, improving information sharing about an acute care episode (including diagnosis, prognosis, follow-up care, medication management and re-referral triggers), developing local strategies to address unattached patients admitted to hospital, and collaborating with community resources and residential facilities to adopt standards to facilitate a coordinated transfer out of hospital.

READ MORE: sharedcarebc.ca/initiatives/transitions-in-care and sharedcarebc.ca/initiatives/youth-transitions



GPSC Visioning

The General Practice Services Committee (GPSC) launched an extensive engagement process between July and September of 2015 to help create a vision for the future of primary care in BC. The visioning process was initiated in partnership between Doctors of BC and the Ministry of Health to ensure that the views of family physicians would be well represented in provincial discussions on the transformation of primary and community care.

Hundreds of GPs participated in the process, which involved 26 in-person meetings co-hosted by local Divisions of Family Practice as well as an online forum. Feedback has been captured in a Visioning Engagement Report, with topics including the scope of primary care services, practice and payment models, the role of the GP in team-based care, and physician health and wellness.

While the visioning process itself does not necessarily meet the criteria for a quality improvement project, the initiative is a very important component of the Ministry of Health and partners' plans for overall health system improvement in the area of primary and community care. It highlights that physicians are invested in the future of health care in this province and that they are willing to collaborate with key partners on its transformation.

READ MORE: gpscbc.ca/what-we-do/collective-voice/visioning





Residential Care Initiative

The General Practice Services Committee (GPSC) has recognized that there is a downward trend in the number of family physicians providing care in residential facilities. It is also anticipated that there will be significant growth in the residential care population as our senior population increases. The GPSC's Residential Care Initiative is designed to address this challenge by enabling physicians to implement local solutions to improve care of patients in residential care facilities across BC. These local solutions must meet best practice expectations (such as 24/7 availability, proactive visits, and meaningful medication reviews) and system level outcomes (such as reduced unnecessary or inappropriate hospital transfers, and improved patient/provider experience). This initiative is aligned with the Shared Care Committee Polypharmacy Risk Reduction Initiative to ensure that physicians receive optimal support as they work to improve care for all frail seniors in residential facilities.

Evaluation will be a major component of the Initiative, with the GPSC currently planning processes that will measure local and provincial expectations and outcomes. For example, the evaluation framework includes a series of quarterly reports customized with data pertaining to each participating physician group. This will provide baseline historical and ongoing information to support Residential Care Initiative planning and ongoing improvement. There will also be a process to share lessons learned with all stakeholders.

READ MORE: gpscbc.ca/family-practice-incentive/residential-care



Practice Support Program

The Practice Support Program's (PSP) main objectives are to improve care for patients throughout the province and to increase physician job satisfaction. The PSP was initially launched as a program of the General Practice Services Committee but is now also supported by the Shared Care Committee and Specialist Services Committee. The main components of the PSP are:

- Accredited clinical and office efficiency learning modules and materials to support physician practices.
- Mentors to provide group or one-to-one practice support and focus on a variety of quality improvements, including providing physicians with EMR support.
- Compensation for physicians and medical office assistants to assist them in taking time away from their practice to study and implement quality improvement changes.
- Accredited small-group learning sessions focusing on regional and local quality improvement priorities. These sessions require less time than modules and allow GPs and specialists to work together on shared-care quality improvements.

READ MORE: pspbc.ca



Divisions of Family Practice Initiatives

Divisions of Family Practice are community-based affiliations of family physicians working together to achieve common health care goals. There are currently 35 divisions across BC providing physicians with a stronger collective voice in their community and supporting them to improve their clinical practices, offer comprehensive patient services, and engage with their local health authority to enhance the delivery of care. The Divisions of Family Practice initiative is funded by the General Practice Services Committee.

Given the grassroots nature of this initiative, the divisions are at varying stages of development and have embarked on different projects as appropriate to their community. Two examples of quality improvement initiatives undertaken by divisions are set out here.



Enhanced Multidisciplinary Care Services

To help increase capacity, efficiency, and the scope of health care support at family doctors' offices, the White Rock – South Surrey Division of Family Practice created a pilot project that provides grants to assist local practices in adding nurses to their care teams. It is one of the programs implemented under the Division's Attachment Initiative. The nurses contribute to patient care by helping patients with chronic diseases manage their health, supporting patients with complex needs, and providing patient education and vaccinations.

A 2014 evaluation of the project found that the initiative was able to increase support for vulnerable patients by enabling them to spend more time with a care provider and increasing their access to a range of interventions. The grants enabled the practices to attach more patients and also contributed to increasing the capacity of the primary health care system through:

- Increased efficiencies in practices.
- Improved administration, charting, and record keeping.
- Increased physician satisfaction with their practices.
- Increased inter-professional practice.

READ MORE:
divisionsbc.ca/white-rock-south-surrey/multidisciplinicare





e-Notification Initiative

In August 2014, the Victoria and South Island Divisions of Family Practice, in partnership with Island Health, and with funding from the Shared Care Committee, launched a pilot study of an automated electronic notification system for patient admission to, discharge from, or death in hospital. The complex e-notification system is designed to coordinate data from hospital information systems, the Excelleris platform, and physician EMRs to deliver timely patient care transition messages to community GPs. This was very much a physician driven initiative, with Division members highlighting patient scenarios illustrating the consequences of GPs not being informed about their patient's care. Physicians were also closely involved with the development of notification forms and provided essential feedback on how well the system worked and how it added value to their practice.

An independent evaluation of the e-notification pilot found that 96% of participating GPs felt it would be an asset to their practice and 83% agreed that it helped them provide better care for their patients. As a result of the pilot project's success, Island Health decided to introduce the e-notification system to all 13 hospitals within the health authority.

The North Shore Division of Family Practice is working on a similar project, with a GP/hospitalist working group currently in the process of developing e-notifications of admission and death from acute care to community physicians.

READ MORE:
divisionsbc.ca/victoria/enotificationsystem

Health Authority Based Initiatives

In addition to physician engagement through the Joint Collaborative Committees and the Divisions of Family Practice, an increasing number of facility-based physicians are leading and/or participating in quality improvement initiatives. Some examples are provided on the next page. Physicians and other health providers are becoming increasingly engaged in the work of health authority medical advisory committees. These committees provide advice to health authority boards on a range of matters including the provision of medical care within health authority facilities, the monitoring of quality and effectiveness of care, and continuing medical education.





Physician Quality and Regional Safety Team

The Physician Quality and Regional Safety Team (PQRST) is a joint project of Fraser Health, the physicians who work in Fraser Health, and the Specialist Services Committee. The PQRST aims to provide a venue for physicians to learn leadership and quality improvement skills, discuss quality issues, and act on opportunities for quality improvement activities that enhance patient care. The intent of the PQRST is to be guided by the IHI Triple Aim to build a culture within the physician community that enables widespread engagement and collaboration to improve the quality of patient care.

The PQRST began its work in April 2015 and members dedicate one day a week to PQRST work. Members attend learning sessions devoted to learning about quality improvement and identifying individual quality improvement projects.

These learning sessions also provide an opportunity for members to learn from their colleagues and collectively discuss quality improvement ideas. Members are now working on individual projects, promoting quality improvement within their departments, and mentoring others. The PQRST meets monthly to share learnings and further define projects.

FOR INFORMATION:
sscbc@doctorsofbc.ca



Physician Leadership Projects

There are a number of opportunities through the Joint Collaborative Committees for physicians to undertake leadership and quality training (this is described in more detail later). One example is the Physician Leadership Program offered by the Sauder School of Business. A number of physicians have taken advantage of scholarships offered by the Specialist Services Committee and Shared Care Committee for this particular program. An important component of the program is that physicians identify and undertake a real-time change initiative within their facility.

One example of such a change initiative relates to urine culture test ordering at Vancouver General Hospital's Emergency Department. A multidisciplinary team collaborated to develop a daily Emergency Department Microbiology Report for noncritical culture results of discharged patients. This highlighted that a large number of cultures were being ordered without indication, particularly in cases of asymptomatic bacteruria. These cultures were being performed with little value to patient care and were wasting health care dollars.

The project aimed to reduce by 30% the average number of monthly urine cultures within 12 months of the introduction of the Microbiology Report. A 29% reduction was achieved between 2014 and 2015, with cost savings estimated at \$100,000 for decreased urine testing alone.

READ MORE: qualityforum.ca/qf2016/wp-content/uploads/2016/03/7_To-pee-or-not-to-pee.pdf



HOW TO BEST SUPPORT HEALTH SYSTEM IMPROVEMENT IN BC

Over the last decade there has been an increased focus on quality improvement in the province and increasing provider engagement, including through the Joint Collaborative Committees and the Divisions of Family Practice.

Doctors of BC would like to see expansion and better coordination of these efforts to achieve a culture of, and the capability to perform, continuous system-wide quality improvement.

We have identified a number of system elements and activities that are necessary to support health system improvement in BC. We have based this paper on the experience of physicians in undertaking improvement projects such as those identified in Section 2. The work of the Joint Collaborative Committees in particular has identified unique elements of the quality improvement and engagement process that are critical to success. We have also reviewed leading studies on the characteristics of high performing health care systems and health care organizations that have undergone successful transformation.^{10,11}

There are systems and organizations, both health care related and otherwise, that have been recognized internationally for having achieved sustainable improvement across a wide range of areas simultaneously, namely, Intermountain Healthcare (Utah), Southcentral Foundation (Alaska) and Jonkoping County Council (Sweden). While Doctors of BC is not advocating for replication of these systems in BC, lessons can be learned from high-performing systems and applied as appropriate to the BC system.

Development of this paper was informed by the views of international and provincial health system leaders who participated in a structured dialogue on what enables a health care organization to

support sustainable improvement (D. Horvat, e-mail communication, June 17, 2015). Doctors of BC also consulted with stakeholders on a draft version of this policy paper. We received a lot of useful feedback and updated the paper to reflect many of our stakeholders' comments.

Applying learnings from within and outside BC, Doctors of BC identifies the following elements and activities as necessary to best support health system improvement in BC.

1. Commitment to a Shared Purpose

The development and articulation of a shared purpose is the most crucial element of creating a highly effective and efficient health care system. In health care, this means using resources wisely to address the health and wellness needs of the population being served. Health care providers and other key stakeholders must then commit to that shared purpose, with all activities being connected to and working toward achieving that purpose. There should be an examination of, and agreement on, the functions required to deliver on that purpose, as well as clarity on how these functions will be delivered and coordinated. Where possible, there should be application of a systematic approach that uses the same or similar processes and infrastructure across the province. However, there will need to be sufficient flexibility to take into account the specific needs of certain communities (e.g., rural and remote). It is important to find an appropriate balance between central structure and local flexibility.



Significant work has already been undertaken by the BC Ministry of Health to develop a vision for our health care system. The Ministry's work is appropriately guided by the Institute for Healthcare Improvement's Triple Aim Framework, but this is of course only a framework. More detailed plans have been laid out in *Setting Priorities for the BC Health System*² and the suite of policy discussion papers released in 2015.^{3,4,5} While these provide an excellent foundation for improvement to take place, Doctors of BC believes that implementation, as well as application beyond the specific areas identified, will be more successful if the quality improvement practices modeled by the most effective health care systems are applied. We look forward to working on this agenda with the Ministry of Health, health authorities, and key stakeholders such as nurses, other allied health providers, and patients. In particular, Doctors of BC will be looking for increased clarity on the processes and structures that will be needed to ensure that improvement initiatives at all levels are able to align with and contribute to both the shared purpose and a sustainable and effective health care system.

The consultation on the draft version of this paper highlighted that there are differing views among stakeholders on who is responsible for determining the vision for health system and quality improvement in the province. The Ministry of Health, health authorities, and the BC Patient Safety and Quality Council were all mentioned. Some stakeholders, on the other hand, feel that there should be no one body responsible for developing a vision and overseeing its execution. Rather, there must be collaboration and co-creation of the vision and commitment and ownership by all organizations within the umbrella of that vision. Doctors of BC has carefully considered this feedback and adapted its recommendations accordingly. Quality improvement activities in BC must be premised on a commitment among all parties to a common vision, and these activities should be better supported and coordinated through clarification of mutual roles and responsibilities of relevant stakeholders.

DOCTORS OF BC RECOMMENDS THAT:

- *Current quality improvement activities in BC be premised on a commitment among all parties to a common vision for health system and quality improvement.*
- *There is explicit clarification of mutual roles and responsibilities, including leadership responsibility, as agreed by stakeholders involved in health system and quality improvement.*

2. Transformational Leadership

A key feature of high performing systems is the presence of transformational leadership capable of aligning activity with a shared purpose. Significant transformation in health care delivery requires leaders at all levels of the system who are dedicated to improvement, can think strategically, and are able to inspire interdisciplinary teams to work towards a common purpose. Most health care providers choose a career in health care because they want to help others. Most providers also go to work not just wanting to carry out their duties, but also wanting to improve the work they do. However, they do not necessarily have the skills and strategic vision required to effect sustainable, large-scale change. It is necessary for there to be early identification and empowerment of those who have the ability to lead interdisciplinary teams and to provide the necessary supports to make this happen. To support this goal, such approaches should become required foundational training in medical school and residency and for others who will work in the field of health.

Physician leadership is required for effective quality improvement. Physicians bring a broad perspective of patient care needs, are integral to most health care processes, and are well informed in multiple areas of health delivery given their unique position in working with patients, administrators, and other health care providers—usually across many sectors within health care simultaneously.



However, support for physicians and other health care providers to become leaders at the local or regional level has historically been insufficient. Although there are programs available through the Joint Collaborative Committees (see pullout box highlighting such programs), further engagement and training of physicians is needed. Ideally, this should be provided in conjunction with real opportunities to carry out quality improvement and change activities. Leaders then need an environment that supports, rewards, and recognizes their contributions and is consistent with their professional values. This includes compensation that is competitive with clinical remuneration.

DOCTORS OF BC COMMITS TO:

- *Continuing to enable physicians to engage in community and provincial training and leadership opportunities in quality and health system improvement.*

Joint Collaborative Committee Support for Leadership and Quality Training

Significant progress has been made in developing physician leaders who are working within their communities and health authorities to improve health care delivery. There are now hundreds of physicians involved in leadership through various Joint Collaborative Committee activities, including the Divisions of Family Practice. Also, each of the divisions has physician leaders involved in joint planning with their health authority through Collaborative Services Committees. These are transformational changes that put BC's health system in a strong position to build upon leadership capacity for broader system improvement.

The following Joint Collaborative Committee supported programs have helped to build this leadership capacity:

- **GPSC Leadership and Management Development Program:** The General Practice Services Committee (GPSC) partnered with Simon Fraser University's Beedie School of Business to develop the Leadership and Management Development Program. The program is available to physicians who are already in a leadership role within their division of family practice or are planning to be in a leadership role in the near future. Participants are given the tools to build common skills and language in initiatives related to primary care redesign. The program provides opportunities for stakeholders from around the province to build relationships, learn together, support each other, solve problems and, ultimately, through face-to-face learning activities, set the foundation for innovative ideas to enhance primary care.
- **SSC and SCC Physician Leadership Training Scholarships:** The Specialist Services Committee (SSC) and Shared Care Committee (SCC), in partnership with the health authorities, contribute up to \$250,000 annually toward leadership training scholarships for interested physicians. The purpose of the scholarships is to support physicians who will be undertaking leadership activities approved by a health authority, such as taking on a leadership position within the authority. Applications must be endorsed by a health authority. Physicians who receive a scholarship may choose which leadership training course to undertake. Popular courses include those offered by the Canadian Medical Association's Physician Management Institute and the UBC Sauder School of Business Physician Leadership Program.



- **The Clinician Quality Academy** is a professional development program for quality improvement administered by the BC Patient Safety and Quality Council (BCPSQC), with the first cohort beginning in April 2016. The Academy is founded on the learning and experience of international organizations such as Intermountain Healthcare’s Advanced Training Program, as well as the BCPSQC’s own Quality Academy. The BCPSQC has partnered with the Joint Collaborative Committees in order to incorporate their perspective on the development and delivery of a program geared specifically to practicing clinicians. Representatives from these committees will continue to provide expertise and insight as members of the Academy’s Advisory Committee. The Joint Collaborative Committees also act as funding partners by providing support to potential physician participants through scholarship opportunities.

3. Education and Support of the Workforce

Health system and quality improvement is dependent on those involved with providing, administering, governing, or making policy in health care having the necessary knowledge, skills, and support to drive positive change in the health care system. The most effective health care organizations not only enable the development of these skills, but also work to develop the culture, infrastructure, and processes necessary to support and encourage their use at all levels. Doctors of BC sees a strong need for such training and support for all members of the health care team. This requires identification and development of, and support for, accredited, accessible learning opportunities as a component of workplace support for team-based quality improvement. As appropriate, quality improvement competencies can be formally embedded in professional development pathways. Participants should have the opportunity to bring an improvement project to their training to get real experience as they learn. This results in changes in

approach in thinking as well as enabling tangible improvement work to take place. There should also be resources embedded in the workplace to support quality improvement initiatives.

Jonkoping County Council in Sweden is an example of a high-performing health care organization. Jonkoping County was the highest performing of 13 organizations that worked together in a multi-year, international effort aimed at effecting system-wide improvement. This effort, “Pursuing Perfection,” was co-sponsored by the Robert Wood Johnston Foundation and IHI. One of the key enablers of their success was the development of Qulturum, a dedicated center for learning and innovation in health care. Jonkoping County aims to have 100% of people in their organization go through training that involves imparting a greater understanding of the organization’s approach to quality improvement, as well as training in project management, facilitation, leadership, and other skills. Participants in the program have applied, and continue to apply, these skills to system and quality improvement work that improves patient outcomes and experience and generates savings. Similar programs have been developed in other highly effective health care organizations, including Intermountain Healthcare and Southcentral Foundation. These high performing organizations also have quality improvement support embedded in the workplace.

There is also scope for individual physicians and other health care providers to learn quality improvement skills as part of regular continuing professional development (CPD). Doctors of BC is aware that the Royal College of Physicians and Surgeons of Canada, the Canadian College of Family Physicians, and the UBC Faculty of Medicine in particular are promoting a quality improvement based approach to CPD that includes a focus on supportive feedback facilitation and coaching. Evidence suggests that feedback on performance alone is not usually sufficient to generate change. Instead, there is a need for physicians to be able to reflect on and discuss feedback as part of a broader group, and then access appropriate support or education as needed. This of course aligns with the medical profession’s tradition of peer review, an important component of self-regulation.



There is no perfect approach to educating health care providers, administrators, and others on quality improvement. Rather, there is a trend toward convergence of quality improvement models (such as LEAN, Plan-Do-Study-Act cycles, etc.), education models (such as practice coaching, reflection), and risk management processes. As an example, the Salus MORE^{OB} obstetrical performance improvement program has been successfully implemented in Northern Health. The program aims to align the elements of quality improvement, risk management, and professional development (for both clinicians and non-clinicians). Evaluation of the program found a growth in leadership capacity with safe patient care at the core. It also found that participants had an improved sense of work culture, including open communication with respect to patients and general knowledge, valuing each other's knowledge-base and skills sets, and an improved sense of teamwork.*

4. Responsiveness to Ideas for Change

Health care providers, including but not limited to physicians, are well-positioned to identify opportunities for quality improvement in their practice or facility. This has been highlighted through the numerous projects undertaken through the Joint Collaborative Committees and by individual physicians, as described in Section 2. An environment that encourages continuous quality improvement must be responsive to these innovative ideas. Structures, including clear lines of communication, need to be in place to ensure health care providers have the ability to influence quality improvement at all levels of the system. Existing examples of such structures include the Divisions of Family Practice, Medical Staff Associations, and the Facility Engagement Program that has recently been created as per the 2014 Memorandum of Understanding on Regional and Local Engagement.**

At the facility or organization level, quality improvement models, such as LEAN, can enable all individuals to influence change. These models allow for a bottom-up approach that can be supported by senior administrators, as opposed to top-down mandating of change that is unlikely to be as well received. The Virginia Mason Medical Centre in Seattle, recognized as a leader in system-wide quality improvement, has developed the Virginia Mason Production System, an adapted version of LEAN. A key component of this system is that all staff members are encouraged to speak up if they have ideas for how their job could be done more effectively or if a process can be improved. There is a clear understanding that those who do the work know what the problems are and are best positioned to identify solutions.¹²

The key to responsiveness to ideas for improvement is the need to eliminate fear of reprisal for identifying opportunity for change or for appropriately varying from existing practice. Self-review, as well as peer and team-based review, should be encouraged and supported as it is necessary to promote quality care. For example, while clinical practice guidelines are an important element of improving the quality and safety of patient care, not all variation in care is necessarily detrimental.¹³ An effective system of quality improvement will recognize this and not seek to eliminate all variation in practice. Rather, it will encourage and be responsive to appropriate variation from guideline based care and enable discovery of whether the practice variation is helpful or harmful. Under this model, clinical practice guidelines should be considered as work in progress that should be continually refined based on emerging evidence and context. In recognition of this important issue, the General Practice Services Committee has adopted the use of the term “guideline *informed* care” as opposed to “guideline *based* care.” Data provided through quality improvement work should be used to contextualize and refine guidelines.

* For more information, see <https://bcpsqc.ca/quality-awards/2009-bc-quality-awards/northern-health-managing-obstetrical-risk-efficiently>

** Memorandum of Understanding: Regional and Local Engagement between the BC Ministry of Health, Fraser Health Authority, Interior Health Authority, Island Health, Vancouver Coastal Health, Northern Health, and Provincial Health Services Authority, and Doctors of BC. April 1, 2014.



5. Data-Supported Change

Health system improvement is not possible without robust and timely data collection and measurement. Due to the complexity of this topic, we have divided this section into measurement for quality improvement at the local level and measurement for overall health system improvement. However, there are clear overlaps between the two processes, particularly when measurement activities are considered in the context of data lifecycles. A full data lifecycle involves the linking of data collection with meaningful use at the point of collection, aggregation of that data to support quality improvement at the practice/team level, and further data aggregation to support system planning and improvement.

Not all aspects of health care, or all dimensions of quality health care, easily lend themselves to measurement. For example, it can be particularly challenging to obtain robust data on patient-centredness and acceptability of care. There is therefore a risk that those areas that are less difficult to measure may be inappropriately prioritized.

Measurement for Quality Improvement

Those who are most closely involved in quality improvement initiatives must have the opportunity to ensure that measures used are relevant to the improvement work being performed and that they are obtainable in a way that is timely and ensures accuracy. Ideally, collection of the relevant data should not be overly time-consuming and should not detract from patient care. Often, technology can be used to build measurement into standard workflow processes. It is also ideal if the data is useful at many levels within the system to help analyze whether individuals, teams, and organizations are achieving the goals they have set out to achieve.

In BC, health care measurement data is generally fed upward to facilitate decision making at a facility, health authority, or ministry level. By way of contrast, for quality improvement, it is more important for providers and others directly involved with making change to have access to the data. Physicians recognize that the ability to carry out successful quality improvement requires greatly

enhanced access to data in as real time as possible. Real-time production and analysis of data provides opportunities for health care providers and those with whom they work to immediately improve patient care. There should also be the ability to compare efforts, in a secure way, across providers, facilities, communities, and regions.

Physicians are actively involved in improving the quality and availability of data for quality improvement. One example in BC is the Health Data Coalition, a joint undertaking by the Physicians Data Collaborative and Aggregated Metrics for Clinical Analysis, Research and Evaluation (see pullout box on the facing page highlighting this work). Another example is the BC Primary Care Research Network, part of the Canadian Primary Care Sentinel Surveillance Network. Family physicians collaborate with the BC Primary Care Research Network to contribute to the development of primary care population health surveillance in Canada. By actively engaging family physicians and residents in primary care research and knowledge translation, the network aims to increase opportunities for primary health care quality improvement.

Significant work is also underway through the Joint Collaborative Committees to create an inventory of indicators for quality improvement. It is hoped that over time, information will be captured on indicators and measures that have been used successfully and that ultimately these will be used more consistently across the province. These initiatives are a step in the right direction, but Doctors of BC sees a need for significant further investment in improving the collection and availability of data for quality improvement. This includes investment in both technology and human resources to better support production, analysis, and use of data. Ensuring that the technology meets clinical needs, and that there is support to use the data to guide and improve clinical care, will be vital to realizing a return on any such investment.



The Health Data Coalition

The Physicians Data Collaborative of BC and Aggregated Metrics for Clinical Analysis, Research and Evaluation have partnered to form the Health Data Coalition.

The Physicians Data Collaborative is a not-for-profit organization working to enable the collaborative use of privacy-protected, aggregated electronic medical record (EMR)-derived clinical data to improve patient care. Membership is open to all divisions of family practice in BC.

Aggregated Metrics for Clinical Analysis, Research and Evaluation is a joint effort between (mostly northern) physicians, UBC, UNBC, and Northern Health that has been doing such work for a growing number of physicians since 2010. Aggregated Metrics for Clinical Analysis, Research and Evaluation has established a palette of over 100 measures relating to disease prevention, screening, and chronic disease management.

The aim of the Health Data Coalition is to build on the efforts of Aggregated Metrics for Clinical Analysis, Research and Evaluation and the Physicians Data Collaborative to extend capabilities across the province and to increase the sophistication of the data queries that can be achieved. This new data source, along with the required enhanced use of EMRs, is helping family physicians to measurably improve their practice, to identify local health related trends, and to see the impact of interventions (e.g., continuing professional development). This is an example of making data collection and analysis efficient and creating a tight feedback loop to support quality improvement using Plan, Do, Study, Act cycles. It is also very sensitive to the many privacy concerns that exist when it comes to using health-related data.

DOCTORS OF BC COMMITS TO:

- *Working with other stakeholders to develop and use appropriate measures to support improving the quality of health care provided in BC.*

DOCTORS OF BC RECOMMENDS:

- *Investment in the technology and human resources required to obtain and effectively use data for quality improvement, evaluation, research, and system reporting.*

We are encouraged by the BC Ministry of Health's identification of enhanced use of data for decision support as a strategic priority in its recent policy discussion paper on information management and information technology (IM/IT).¹⁴ The Ministry is recommending various actions to better enable access to the data needed to inform the selection of areas to focus on for improvement and to inform improvement efforts. This should also serve to influence and inform decisions and to improve the quality and robustness of health-related data. As part of this strategic priority, the Ministry is also proposing to review the current legislation governing the use of health data in order to improve its utilization, while still respecting patient privacy. Doctors of BC hopes that this will better enable physicians working on quality improvement initiatives, including through the Joint Collaborative Committees and Divisions of Family Practice, to access information crucial to the success of those initiatives.



Doctors of BC is particularly supportive of the Ministry's emphasis on the use of data to enhance the performance of the health system as this more closely aligns with our vision of a culture of continuous quality improvement over a focus on use of data for quality assurance processes. There is a potential risk that too much focus on quality assurance could lead to an increased push for individual performance reporting. There is evidence that performance reporting can have unintended consequences, such as discouraging physicians from taking on complex patients.^{15,16} While we are very supportive of the Ministry's objectives for IM/IT, it is also recognized that the time frame for technological improvement can be long. Doctors of BC stresses the importance of identifying immediate opportunities for improved data use within current IM/IT capabilities.

System Level Measurement

It is necessary to have a full understanding of current system performance in order to identify areas for improvement, and then monitor and measure the impact of system changes that have been applied. Given the complexity of the health care system, and the range of different stakeholders involved, it is difficult to achieve consensus on what system performance indicators to use and how they should be measured.

A measurement and reporting framework needs to clearly set out the interrelationship between measurement for quality improvement at a clinical/process level and measurement of overall health system performance. As much as possible, measures for improvement should assist with measurement at other levels within the health care system. Doctors of BC recognizes that efforts have been made to create such frameworks, such as the Canadian Institute for Healthcare Improvement *Performance Measurement Framework for the Canadian Health System*.¹⁷ While this is described as a pan-Canadian framework, it is also intended to support individual provinces and territories in their efforts to improve health system performance.

While there is significant overlap between quality improvement and health system improvement, the indicators and measures used in quality improvement will be greater in number and pertain to a level of detail that can be used for overall system performance. For example, health system indicators might involve broad measurement of population health (e.g., smoking and obesity rates, life expectancy, infant mortality, etc.) and consideration of the impact of public health prevention initiatives on health status (e.g., incidence rates of vaccine preventable diseases).

System performance measurement may also involve consideration of how well organized the system is (e.g., is there a continuum of care with integrated services and coordination of transitions in care). However, just as the system is built from the various parts, the need for such high-level data collection must not take precedence over the need to ensure availability of data to measure how well the individual parts are functioning.

Currently in BC there is a range of frameworks and reporting mechanisms applied at different levels, including performance goals set in the BC Ministry of Health's Service Plan and individual health authority performance reports that do not all report on exactly the same indicators. This makes comparison between regions difficult. Even if all health authorities used consistent reporting methods, the information does not provide the public and providers with an overview of provincial health system performance. More transparency would help guide both system level improvement and quality improvement work at the local level.

DOCTORS OF BC RECOMMENDS:

- *More provincially aligned and transparent health system performance measurement and reporting, including quantifying the need for and effectiveness of changes within our health delivery system.*



6. Shared Learning

A successful system of continuous quality improvement requires sharing of both innovative ideas and lessons learned by those involved in quality initiatives. The outcomes of quality improvement projects should be well communicated so that there are opportunities for similar improvements to be made in other clinics and facilities, or potentially applied to all areas of the province. Additionally, quality improvement project teams often face similar challenges but are not always aware of opportunities to learn how other teams overcame these issues.

The recent report from the Canadian Advisory Panel on Healthcare Innovation, *Unleashing Innovation: Excellent Healthcare for Canada*,¹⁸ highlights the difference between spread and scaling up of innovative ideas. The report notes that innovation spread is primarily a diffusion exercise, involving sharing and learning among relatively homogenous groups of practitioners or settings. On the other hand, scaling up implies taking a system-wide perspective on adoption and expanding successful initiatives to have a wider impact. Doctors of BC considers there is a place for both spread and scaling up of ideas and initiatives, but agrees with the Advisory Panel on Healthcare Innovation that the latter is likely to have a more profound impact.

Joint Collaborative Committee forums, Practice Support Program meetings, the UBC Continuing Professional Development Roundtable and Practice Improvement Hub activities, and the BC Patient Safety and Quality Council's Health Quality Network are some examples of existing efforts to support innovation spread. Much has been learned about how to enable innovation, but more needs to be done province-wide to enable better communication about quality improvement.

Some work is being done to create a common provincial database of quality improvement initiatives that provides access to detailed information, searchable by clinical and geographic area. This should help to ensure groups undertaking quality improvement projects have up-to-date

information on whether similar projects have already been tried and what has been learned. Work is also underway to develop an Academic Health Science Network in BC to drive effective teaching, placements, and applied health research to promote and encourage improved quality and innovation linked to identified health care and service needs. Development of this network is one of the key actions in the Ministry of Health's strategic document, *Setting Priorities for the BC Health System*.² Given that some of the most important population health improvements in BC wouldn't have been possible without scientific research and the translation of this into clinical practice, Doctors of BC is very supportive of such a network. It has great potential to expand and strengthen the ability to support shared learning in health quality improvement.

In-person activities and events can be very effective in terms of building and committing to a shared purpose, sharing multidisciplinary perspectives that can't be conveyed electronically or via a database, facilitating communication, and improving relationships and trust. Doctors of BC feels strongly that support for events that bring together a range of health care providers, patients, administrators, and policy makers should continue.

Enabling and scaling up initiatives requires significantly more attention. Doctors of BC is willing to work with the Ministry of Health to play a leadership role in enhancing structures and processes that enable increased and more effective innovation and the spread and scaling up of successful quality initiatives.

DOCTORS OF BC RECOMMENDS:

- *Enhancement of structures and processes that support innovation and, where appropriate, enable expansion of successful quality improvement initiatives.*



CONCLUSION

Physicians are an essential part of the health care system and have a clear leadership role in terms of system improvement and delivery of quality health care in BC.

However, success is dependent on collaboration between all health care providers, patients, administrators, and policymakers. Doctors of BC is committed to working with the BC Ministry of Health, health authorities, and other stakeholders on initiatives designed to improve population health, improve the patient and provider experience of care, and reduce the per capita cost of health care.

Physicians have gained valuable knowledge and experience from their involvement in, and leadership of, a significant number of quality improvement initiatives across the province and have learned from what has worked in other jurisdictions. We are confident that the physicians in BC will continue to play a leadership role to help to ensure that British Columbians have a health care system that is among the best internationally. We look forward to working with others towards this common aim.



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