

Governance for Quality and Patient Safety: The Impact of the Ontario Excellent Care for All Act, 2010

G. Ross Baker and Anu MacIntosh-Murray

Abstract

The passage of the Excellent Care for All Act, 2010 (ECFA Act) in Ontario has confirmed the responsibilities of hospital boards for quality of care and reinforced expectations that they will monitor performance and establish strategic aims in this area. Quality of care and patient safety have created a new agenda for many healthcare boards that had only a limited focus on these issues. Here, we report on interviews with five Ontario healthcare organizations identified by experts as having high-performing boards. Our question was, how has the ECFA Act influenced Ontario healthcare organizations' governance practices relating to quality and safety?

While the act has raised the profile of these issues, in the short-term it may have blunted the effectiveness of some boards that had already developed a clear strategic focus on quality and patient safety. Executive compensation was the most contentious issue; the introduction of pay for performance was considered poor timing, given the Ontario government's pay freeze. Overall, the act is an important step in increasing responsible governance and has helped align governance activities with the core work of hospitals – delivering high-quality care. However, effective policy must create an environment where all organizations focus on improvement, but where regulation does not limit the capabilities of leading organizations to achieve even higher performance.

The growing awareness of quality and patient safety problems in healthcare has helped to elevate these issues from internal operational matters to strategic concerns (Flemons et al. 2005; Leape and Berwick 2005). Governments and regulators (both in Canada and elsewhere) see boards as key mechanisms for accountability not only on financial performance but also, increasingly, on the quality of patient care (Joshi 2006; Health Quality Ontario 2011). As a result of both these trends, there is greater attention to the role of governing boards in reviewing quality and patient safety performance and in stimulating better outcomes in these areas. Recent research in the United States indicates that board attention to quality of care is associated with better performance (Jha and Epstein 2010; Jiang et al. 2008, 2009). This evidence, coupled with growing demands to improve performance, has created new pressures on healthcare trustees to focus on quality of care and patient safety.

Quality of care and patient safety create a new agenda for many healthcare boards that had only a limited focus on these issues. Enhancing knowledge and attending to specific governance practices can heighten board effectiveness in these efforts. Baker et al. identified five critical levers for creating more effective governance for quality and safety (Baker et al. 2010). They include:

- Better information for the board on quality and patient safety
- Improved trustee education and skills

- Changes to governance roles and processes
- Improved efforts to create and monitor a quality and safety plan, and
- More effective relationships between the board, medical staff and senior leadership

The passage of the Excellent Care for All Act, 2010 (ECFA Act) in Ontario has confirmed the responsibilities of hospital boards for quality of care and reinforced expectations that they will monitor performance and establish strategic aims in this area (Legislative Assembly of Ontario 2010). Although the intent of the legislation was to create minimum standards (Ontario Hospital Association 2010), there have been concerns that using a legislative approach could be overly prescriptive and not sufficiently responsive to local conditions and needs. So how has the ECFA Act influenced Ontario healthcare organizations' governance practices relating to quality and safety?

To explore this question we conducted interviews with five Ontario healthcare organizations nominated by several key informants knowledgeable about the status of healthcare governance in the province. The organizations were recommended because they were seen as leaders in their focus on and approaches to quality and safety at the board level. They ranged in size and focus from small rural to large urban teaching hospitals. The interviews with the five CEOs and one board chair were conducted by telephone (using semi-structured interview guides) in November–December 2011. All interviews were recorded (with permission) and were analyzed, compared and mapped to explore key themes. These interviews were part of a larger project to explore the current status of healthcare governance in Canada.

The Impact of the ECFA Act on Five Ontario Organizations

The ECFA Act was passed into law in June 2010. Among other requirements, the act requires hospitals in Ontario to develop and post annual quality improvement plans; create quality committees to report to each hospital board on quality-related issues, including annual quality improvement plans; and link executive compensation to the achievement of quality plan performance improvement targets.

Interview participants from the five Ontario organizations were divided in their views of the legislation and the impact that it has had on their organization's quality work with their boards. At one end of the spectrum, the CEO of a large teaching hospital stated:

“I think it is one of the most important pieces of legislation introduced in this province to really help to improve quality of care, not just the review and the governance but overall quality. I think it really is very important.”

He observed that the act had made little impact for his organization and board because they met most of the requirements already. However, he emphasized that it was needed to move many other organizations in the same direction:

“I have spoken to many other colleagues, I have been to other organizations, and I am aware that not all organizations had a quality committee or quality of care committee, and not all had directors as engaged in quality as they are now, post introduction of the ECFA Act. So in other organizations, I believe it has changed the approach to quality. Not only do I believe, I know: I know it from speaking to my colleagues and to directors and other organizations.”

A CEO in a community hospital expressed surprise that the Act was needed, that other organizations would not have had the required structures and activities in place:

In many respects when we looked at the minimum requirements for the ECFA Act, to see where we were relative to compliance with the new legislation, lots of these things were already in place for us. We'd been doing patient satisfaction surveys for many years, and we'd had a quality committee in place for many years. Of course we hadn't done a QIP (quality improvement plan) in the way that we were required to now under the Act, so that was new for us.... I was a bit surprised when the legislation came out that there would be hospitals out there without a quality committee, who weren't participating in patient satisfaction surveys, and that kind of thing. I think most hospitals were a little surprised that those things weren't universally in place across the sector.

While one board chair observed, “I don't think we've really changed our way of thinking or our strategies very much. We've always been focused on patient safety,” for others the act became a distraction for both their boards and staff as they dealt with the quality improvement plan and the executive pay-for-performance requirements.

The Quality Improvement Plan and Indicators Template

CEO and board chair reactions to the legislated requirement to complete the quality improvement plan (QIP) template and submit it to Health Quality Ontario were mixed. For some, it caused no changes for their board reports; one CEO noted that the ECFA Act just heightened awareness at the board level:

“I would say that the ECFA Act ... certainly has brought more attention on the part of directors to the legislation, and they may have a heightened awareness, but it hasn't actually changed the way that we deal with quality measurements and reporting in the organization.”

Several other participants voiced their frustration with the template and submission requirements. The CEO of a smaller organization observed that the measures emphasized with the legislation reflected provincial priorities that were not issues for rural hospitals, and had resulted in some “non-value-added activities.” In smaller rural hospitals, Emergency Department waits are not as pressing an issue as in larger urban facilities. In another case, a CEO noted that his hospital’s ventilator-associated pneumonia and central line infection rates were already “down around zero, [but] there was huge pressure to develop an improvement plan for that.”

Another participant concurred with that view, noting that the board was distracted from the organization’s quality strategy because members became preoccupied with compliance with the ECFA Act and completion of the indicator template, which were not all relevant to the hospital’s own goals and scorecard. She noted:

... measures emphasized with the legislation reflected provincial priorities that were not issues for rural hospitals, and had resulted in some “non-value-added activities.”

“The Excellent Care for All Act was a huge barrier for us because it distracted a lot of attention from the work at hand.... It really got us caught up in what we have to do to be compliant with the legislation, and that was very, very distracting.”

The requirement that the board has to sign the QIP elevated the anxiety of this board’s members about the templates and further focused their attention on the indicators spreadsheet template. This CEO noted that the requirement to sign off the QIP “reinforced the attitude, ‘we’ll pay attention to the things that are mandatory because somehow they must be more important than other things.’”

Other experienced boards also faced some confusion when trying to understand how to reconcile the fit of the new QIP documents with their organization’s existing quality strategic plans. The ECFA Act’s influence varied depending on the nature of the extant planning processes, foci/goals and the format of the quality plans. Organizations with less experience may opt to use the QIP template as their sole document. Others may have a format that is amenable to merging with the QIP format. “The quality plan under the ECFA Act is the main quality plan.



We have departmental quality initiatives that are going on, not that the board really is too aware of those,” commented one CEO. However, the act’s requirements may result in several quality plans in an organization: one for regulatory reporting and another (one or several) tailored to local strategic and improvement needs. Several CEOs indicated that their organizations had decided to maintain their plans and include the QIP as a subset.

Participants from smaller organizations commented that completion of the template and submission of the reports put additional pressure on their staff and managers as they did not have the same resources that were available in the larger hospitals. One interview participant commented that:

“With all the new legislation and the new standards come a whole lot of bureaucracy and reporting and accountability and contracts and monitoring. In small organizations that’s particularly challenging because the same people do all of those things; we don’t have special departments to work on things. So it’s getting very, very challenging in terms of measuring and monitoring, and making sure, and a lot of these processes that are being imposed on us don’t necessarily add value to the patient experience.”

Another point of disagreement was the appropriateness of the inclusion of a financial measure, total margin, as one of the effectiveness indicators on the improvement targets and initiatives template. One CEO noted the importance of balancing attention to both financial health and quality. Another participant expressed strongly that this was not the place to include finance indicators that were covered by other agreements; this was political tinkering that detracted from the quality focus, “Because you have other kinds of agreements that are signed off, this ought to be about quality, the things that we have not paid attention to as much as finance.”

The interviews occurred as organizations were preparing for the second round of QIP submissions for 2012, and participants commented on how the planning cycle would be different this time and what would help the process. The timeline was very short for hospitals to complete and submit their first round of QIPs in 2011, and some participants indicated that this adversely affected the planning process. The longer time available to prepare QIPs for 2012 may permit fuller planning and engage more staff in the planning of improvement priorities.

Another CEO remarked that although the QIP template had made it easier in some ways to create the plan, and that Health Quality Ontario had published a document with feedback (based on their review of the 2011 QIPs that the 152 Ontario organizations had submitted),¹ more explicit guidance was still needed:

“I believe that there’s still a better job that that group [Health Quality Ontario] could do in helping organizations really understand what they wanted.... I think that they need to be more helpful [to] hospitals on exactly what it is they expect, and I’m hoping that comes this year.... I think if they showed exactly what they were looking for ... and what they would consider some best practice examples, that would be helpful. I think hospitals received some inconsistent information from them as we were going through the process leading up to the due date for the first QIP.”

Creating Quality Committees

Creating quality committees was not an issue for these organizations because most had already had a functioning quality committee for some time. In one smaller organization, the board’s governance committee had carried out the quality oversight responsibilities. The CEO explained that in response to the ECFA Act, the board now has a separate quality committee, “So now we have a quality committee of the board, we have a governance committee, and we have our resource management committee; those are the three main committees.”

The main structural change for most of the organizations was to their quality committee membership. ECFA Act regulations require the addition of the senior nursing executive, a representative from

the Medical Advisory Committee (MAC), and another representative who was not a member of either the College of Physicians and Surgeons or the College of Nurses of Ontario. One CEO noted that the chief of the medical staff was already part of the organization’s committee,

“So the decision that we made related to changes in the Public Hospitals Act, and the ECFA Act was to put a non-nursing, non-physician professional practice leader on the quality committee of the board, so that’s been in place for about 10 months now.”

Changes to board membership in regulations under Ontario’s Public Hospitals Act appeared around the same time as the ECFA Act quality committee membership regulations. PH Act regulations stipulated that the senior nursing executive, the president of the medical staff, and the chief of staff (or chair of the MAC) would become non-voting members of hospital boards. One CEO noted that this caused some additional distraction as the board and senior leaders sorted out the implication for roles.

... pay for performance appears to be a new practice for many smaller organizations

Pay for Performance

Although pay for performance appears to be a new practice for many smaller organizations, this practice has been in place for some time in larger Ontario teaching hospitals as well as in healthcare organizations in other parts of Canada. The requirement that a portion of senior executives’ compensation be tied to achievement of improvement targets appears to be the most contentious component of the ECFA Act, according to a number of interview participants. Their concerns are linked to the perceived inequities caused by introducing pay for performance tied to the QIP measures and improvement goals in the context of the provincial pay freeze. One CEO stated, “I think the most troubling thing for most hospitals was the intersection of the wage restraint legislation and the introduction of pay for performance at that time.... I think that is no way to introduce pay for performance.” Another CEO agreed, noting that the pay-at-risk provision amounted to a compensation rollback for most executives.

The organizations did not all have comparable executive pay arrangements. Some executives, mostly in the larger teaching hospitals, already had bonus clauses, so they just had to realign some portion to attach to the ECFA Act measures. One CEO indicated that this was a minor change. Another was supportive

of the provision but noted that the board had some difficulty in deciding how to re-apportion the percentage at risk in total and the proportion of that aligned with the quality plan. A third CEO described the board's consternation when the executive leaders proposed that their at-risk compensation should depend on achieving 100% of an ambitious stretch goal. She noted:

Two of the members of the compensation committee of the board, which is the committee that makes the decisions about the allocations of the performance incentives, said in the corporate world this would be unacceptable ... if we only got 50% of the way to where we want to go, that would be a failure.

Several interview participants described the challenges (and perceived inequity) of being responsible for improving outcomes of processes that are not under the executives' scope of control. One noted that the board does not always appreciate the complexity of improvement:

"In terms of the board, I think it takes a while to get them to understand the complexities of quality improvement, the complexities of having really challenging targets and the real complexity around changing clinical practice. And that it takes a long time to change the clinical practice, and then from the sustainability perspective it becomes a real challenge."

One interview participant observed that many of the ECFA Act measures relate to processes that require physician behaviour change, and this is difficult when there is little leverage with medical staff, who are not employees and are difficult to replace in the context of a physician shortage:

"The biggest problem is that when you're looking at setting targets, you have to make sure that those targets are within the scope of control of the managers involved. I think some of them are little bit outside of that; some of them really were dependent on a lot on medical staff and physician practice, which we don't always have a lot of influence on.... So we did have a couple of issues this year with physician practice that were very difficult to influence, and I think that has impeded our performance in terms of reaching some of those goals."

Challenges Facing the Organizations and their Boards Relating to Quality

Participants observed that the political environment and regulatory context relevant to the quality agenda was becoming increasingly more complicated and confusing for their boards. Government and accreditation agencies each have their own agendas, goals, language and requirements; it can be difficult to show how these relate to the organization's own strategy, as one CEO pointed out:

"We have so many people and agencies looking over our shoulders. We have government inspectors from various ministries, we've got Accreditation Canada, we've got lab accreditation, and they all overlap. And they all have their own language too, so it makes it very confusing. I think it makes it even more confusing for the board, because we have a quality agenda for the ECFA Act, and we have a quality agenda for accreditation, and we have a quality agenda for some other piece of legislation, accessibility or whatever it might be, and I think the board has some difficulty in keeping all that straight and how it all relates to the organization's strategy, et cetera."

... goals emphasized by the government and Health Quality Ontario have created tensions for some boards in balancing local needs and provincial targets.

The CEO was not optimistic that the situation would change:

"I think there's a lot of awareness; some of these things are out there. I don't know if there is a lot of political will to change much of it, because it's very political – the environment. Sometimes you wonder; sometimes you think it's more the politicians driving the bus than the practitioners."

Another CEO commented that this increase in regulatory requirements – including the "extraneous noise around the ECFA Act" – has prompted the board and quality committee to become much more focused on compliance rather than improvement:

"This year it has been tougher because of all the extraneous noise around the ECFA Act. A lot of it, particularly at the quality committee, and even at the main board, was, 'Here are the compliance issues.' And there've been a lot of other compliance requirements over the past year that have affected boards: there are the broader public sector guidelines, all those kinds of things; it's a real struggle to try and keep all the balls in the air when boards are accountable now for so much more. They feel their accountability and sometimes they just default to getting very narrow in their focus. 'There's this compliance issue; are you compliant? Let's move on to the next compliance issue.' And they're losing the forest for the trees around getting down to focus on quality in a broader perspective."

One participant summarized on a positive note:

“We don’t have very many like hospitals immediately around us, so while I’m talking to my colleagues on a regular basis, you don’t always get a chance to say, “What are you doing with this and how is that going for you?” So we don’t know where we are sometimes on the continuum, but we’re hoping that some of these things will bear fruit, and if they don’t work out we’ll try something else to make sure that we keep quality as a prime focus.”

Discussion

Based on the responses of those we interviewed, it is clear that the new Ontario legislation, The Excellent Care for All Act, has had an important impact in raising the profile of quality of care and patient safety issues for the boards of Ontario hospitals. At the same time, the implementation of the ECFA Act has required adjustments for boards in some organizations that were already focused on quality performance. For these boards, the act inserted additional priorities and measures that were not viewed as critical issues for their organizations. Although these boards could have maintained their focus on the priorities established before the act, the goals emphasized by the government and Health Quality Ontario have created tensions for some boards in balancing local needs and provincial targets.

These unintended tensions are being addressed in several ways. Some boards are broadening their quality plans to include new priorities, others are creating parallel scorecards: one linked to the QIP process, the second for internal use. Health Quality Ontario did not establish a minimum number of goals for hospital quality improvement plans, but they acknowledge that “too many priorities may lead to diluted efforts” (Health Quality Ontario 2011: 5). In practice, most hospitals selected only a few Priority 1 (“high priority”) goals and could decide to include both local issues and provincial priorities in their goals, so this issue may be only a transitional problem.

Still, in the short run, the new Ontario legislation may have blunted the effectiveness of some boards that had already developed a clear strategic focus on quality and patient safety issues. Effective policy requires a continued system focus on accountability for quality and patient safety performance. But greater autonomy for those hospitals that have already demonstrated strong performance might enable them to maintain their previous efforts and limit the consequences of the current prescriptive approach. A strategy of “earned autonomy” (Mannion et al. 2007), where high-performing organizations are given greater freedom to set goals and allocate resources, might enable government to maintain oversight, while not limiting the effectiveness of local leadership. The evidence of the impact of earned autonomy policies in the United Kingdom is limited, although a recent study found that managers in two Foundation

Trusts (FT) (hospitals that were granted greater freedom from regulatory regimes) saw their hospitals as more autonomous and more capable of service delivery improvements than hospitals that did not have FT status (Anand et al. 2012).

The linkage of executive compensation to the QIP goals was complicated by the concurrent government restraint on executive compensation, producing the potential for penalties but no possible compensation benefits for hospital senior leaders. Perhaps not surprisingly, some hospitals opted to create limited targets for the goals that were linked to performance; some, in fact, set targets below current performance, an approach that violates the intent of these reforms. Pay for performance is an intuitively appealing idea, but often difficult to implement in a way that fosters broad system improvement rather than paying for small gains or leading to explicit gaming (Doran et al. 2006; Lindenauer et al. 2007; Petersen et al. 2006).

The most critical issue is whether the government’s efforts through the ECFA Act to engage boards and heighten their attention to and accountability for quality and patient safety translate into organizational and system-wide improvements. Many of the focal issues (and accompanying core indicators) identified by the government and Health Quality Ontario have been difficult to improve. These include healthcare-associated infections such as *C. difficile*, pressure ulcers and falls. While increased emphasis on these issues will enable organizations to prioritize activities, the number and nature of these problems will be difficult to remedy, given the limited improvement capability and capacity of many hospitals and other organizations. These organizations may lack sufficient expertise and support needed to maintain high levels of infection prevention and control, and ongoing quality improvement efforts.

Hospitals were the first set of delivery organizations asked to create quality improvement plans. The Ontario government has signalled its intention to engage other healthcare organizations in setting quality improvement goals. Thus most of the attention to date has been focused on quality and patient safety performance within delivery organizations. However, there is growing awareness of the important challenges of ensuring safety across the continuum of care (Jencks et al. 2009; MOHLTC 2011). This is already evident in the addition of “integration” as a core quality area in the hospital quality improvement plans developed for 2012–2013. Hospitals are now being asked to set targets on readmission rates and ALC (alternate level of care) days. Influencing these measures requires system changes, not just departmental or organizational improvements. Thus the emerging challenge is to create quality improvement plans and system accountability that ensure effective and safe care across referral networks and levels of care.

Conclusion

The Excellent Care for All Act in Ontario is an important step

in creating responsive governance. The implementation of the act has helped to raise the bar on quality of care and patient safety in Ontario hospitals, and has helped to align governance activities with the core work of hospitals – delivering high-quality care. Our research focused on a small number of hospitals identified by experts as having high-performing boards. Several of these hospitals reported difficulties in reconciling these new external demands with their ongoing strategic agendas for improving services. Effective policy must create an environment where all organizations focus on improvement, but where regulation does not limit the capabilities of leading organizations to achieve even higher performance. **HQ**

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