Strengthening

IN ONTARIO'S
PUBLIC HEALTH UNITS

A LOCALLY DRIVEN COLLABORATIVE PROJECT
2016-2017

QI Maturity Tool - Modified Ontario Version: Results

Ontario Report

MARCH 2017

Acknowledgements

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The CQI LDCP Team would like to thank Public Health Ontario (PHO) for its support of this project. The team gratefully acknowledges funding received from PHO through the Locally Driven Collaborative Projects program. The views expressed in this publication are the views of the project team, and do not necessarily reflect those of Public Health Ontario.

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Suggested Citation:
Law, M. P., Hay, G., Berry, A., Finlay, M., Stefanovici, N. and CQI LDCP Team. (2017).
Quality Improvement Maturity Tool Results: Ontario Report. St. Catharines, Ontario.

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Executive Summary

Introduction

The Locally Driven Collaborative Project (LDCP) Strengthening Continuous Quality Improvement (CQI) in Ontario's Public Health Units was established to examine the current state of continuous quality improvement within Ontario's public health units. For the purposes of this research project, **continuous quality improvement is defined as** an overarching management philosophy or framework within the organization that drives the daily work activities of all employees. **Quality improvement (QI) is defined as** the deliberate and defined processes and methods that are used to continuously develop, design, evaluate and change practices and programs to ensure that they are of high quality. (Sollecito & Johnson, 2012)

The CQI LDCP team is working collaboratively to answer the research question, *"How can systematic continuous quality improvement be strengthened within Ontario's public health units?"*

The primary focus of this research project was to establish a baseline understanding of quality improvement (QI) maturity in Ontario public health units. To facilitate this, the CQI LDCP team used the *QI Maturity Tool - Modified Ontario Version*, a validated survey, to assess the state of QI in 34 public health units who agreed to participate. See Appendix A for *QI Maturity Tool - Modified Ontario Version*. This tool incorporates questions across three dimensions: QI Organizational Culture; QI Capacity and Competency; and QI Perceived Value. Average agency scores allow for the assessment of QI maturity which is described in Table 1.

Table 1. QI Maturity Tool Stage Descriptions

QI Maturity Tool Avg. Score	Stage	Description
< 4.78	Beginning	Have not adopted formal QI projects, applied QI methods in a systematic way, or engaged in efforts to build a culture of QI
4.79-5.12	Emerging	Newly adopted QI approaches, albeit with limited capacity. They have a limited QI culture and few, if any examples of attempts to incorporate QI as a routine part of practice
5.13-5.79	Progressing	Some QI experience and capacity but often lack commitment, have minimal opportunity for QI integration throughout the agency and are less sophisticated in their application and approach
5.80-6.71	Achieving	Fairly high levels of QI practice, a commitment to QI and an eagerness to engage in the type of transformation change described by QI experts
>6.72	Excelling	Achieving high levels of QI sophistication and a pervasive culture of QI

(Adapted from Joly et al., 2013)

The project received research ethics board (REB) approval at Brock University and at four public health units who required an internal REB process. The survey was launched on Oct. 5, 2016 using Fluid Survey and closed on Nov. 15, 2016. An email was sent by the Site Champion in each of the participating public health units to all of their staff inviting them to complete the online survey. The results were collated and reviewed by the Academic Research Lead, Dr. Madelyn Law and Research Assistant Graham Hay.

Summary of Findings

In Ontario there are 36 public health units; of these 34 participated in this survey. From these 34 public health units, 3,503 staff participated in the survey, resulting in a response rate of 46.6%. The average score for all participants from Ontario public health units was 4.94. This places the provincial average in the "Emerging" stage of QI maturity. The survey results suggest that participants place a high value on QI (6.00), but collectively are at less "mature" stages of QI in relation to QI organizational culture (5.09) and the competency and capacity to engage in QI activities (4.58).
In addition, participants were asked to identify their alignment with three core CQI organizational structures. Of the total participants:

- 48.3 % of participants answered "yes" to the statement, "My public health unit has a quality improvement council, committee or team."
- 51.8 % of participants answered "yes" to the statement "My public health unit has designated Quality Improvement Officer/Specialist or equivalent staff person."
- 41.7 % of participants answered "yes" to the statement "My public health unit has a quality improvement plan."

Of the 34 public health units in the study, 12 reported being accredited or certified within the past five years by an organization that reviews business practices, 19 reported not being accredited or certified within the past five years, and three did not report their status.

A review of individual public health unit scores indicates that public health units across Ontario are at varying stages of QI maturity. Of the 34 public health units who participated 32% (N=11) scored in the progressing stage; 30% (N=10) scored in the emerging stage and 38% (N=13) scored in the beginning stage. No public health unit had an average score that would rank them within the achieving or excelling stage of QI Maturity.

Next Steps

The CQI LDCP Team will engage in a number of knowledge exchange activities related to this provincial data including a series of consultation sessions with key stakeholders and the development of summary documents to highlight the results. Our consultations will be with Site Champions who assisted in the implementation of the *QI Maturity Tool - Modified Ontario Version*, key decision makers in public health units, and public health system decision makers in Ontario. These sessions will integrate the results from all project activities (QI maturity tool results and scoping review) to understand:

- How the results from this LDCP project can be used to support or enhance CQI within and across Ontario's public health units;
- Whether the findings generally reflect key stakeholders' experience of CQI in public health and how the results might be used by stakeholders to inform their work; and
- How these findings, and subsequent discussions, will inform our future research objectives to more fully support and strengthen CQI in Ontario's public health units.

Introduction

Continuous quality improvement (CQI) has been studied and discussed in Ontario public health units for over a decade. Its importance as a part of performance management was recognized in 2006 by the Capacity Review Committee (MOHLTC, 2006) and was included as a required activity for public health units (MOHLTC, 2011). However, understanding of CQI management principles and implementation of quality improvement (QI) practices varies among public health units in Ontario. To date, no comprehensive frameworks or guiding principles have been identified for CQI in Ontario. Individual public health units have developed innovative ways to do this work based on their specific organizational structure, staffing and understanding of CQI. This means that CQI in public health units looks different across the province making it difficult to share information, learn from each other and develop common standards of practice.

The Locally Driven Collaborative Project (LDCP) *Strengthening Continuous Quality Improvement in Ontario's Public Health Units* (project name: CQI LDCP) was established to examine the current state of continuous quality improvement within Ontario's public health units. A team of representatives from 19 public health units has been involved in the development and implementation of the project. The CQI LDCP is led by Principal investigators Alex Berry from Northwestern Health Unit, Meighan Finlay from Wellington-Dufferin-Guelph Public Health, and Academic Research Lead Dr. Madelyn Law from Brock University. The CQI LDCP is funded by Public Health Ontario (PHO) and supported by research assistants at both Northwestern Health Unit and Brock University. Additional funding was also received from the Canadian Institutes of Health Research to support and enhance knowledge exchange activities.

The project research question was:

How can systematic continuous quality improvement be strengthened within Ontario's public health units?

Specific research objectives for this one-year LDCP were identified as follows:

1. Identify the drivers and attributes of CQI that are applicable and transferable to Ontario's public health sector.
2. Describe the current state of CQI in and across Ontario's public health units.

The research project includes two main components: a scoping review of the literature and the implementation of a *QI Maturity Tool - Modified Ontario Version*.

This report summarizes the aggregated provincial results of the *QI Maturity Tool - Modified Ontario Version* implemented in 34 public health units across Ontario. Each of the participating Ontario public health units received an individualized report with their site specific data. The findings from the scoping review will be distributed separately.

Continuous Quality Improvement

For the purposes of this research project, **continuous quality improvement is defined as** an overarching management philosophy or framework within the organization that drives the daily work activities of all employees. **Quality improvement (QI) is defined as** the deliberate and defined processes and methods that are used to continuously develop, design, evaluate and change practices and programs to ensure that they are of high quality. (Sollecito & Johnson, 2012)

Methodology

The CQI LDCP team used the *QI Maturity Tool - Modified Ontario Version*, a validated survey, to assess the state of QI within Ontario's public health units. This tool was developed and used in the US with a specific focus on public health (Joly, et al., 2012a, 2012b, 2013) and was subsequently validated in an Ontario public health unit (Law et al., manuscript submitted). The research team also piloted the survey and felt that the questions would provide a comprehensive

overview of QI in Ontario public health units. The survey was made available to all staff in each participating public health unit. It includes 23 questions to evaluate QI maturity across three dimensions: QI Organizational Culture; QI Capacity and Competency; and QI Perceived Value (See Appendix A for the Survey Tool). Within the context of the survey, these dimensions are defined as:

- QI Organizational Culture – the values and norms about QI that pervade throughout the organization relative to how the public health unit interacts with staff and stakeholders.
- QI Capacity and Competency – the skills, functions, and approaches used to assess and improve quality in an organization.
- QI Perceived Value – the perceptions of employees that QI is a priority in the organization and supported by leaders while also having the potential to impact services and the community.

Each question in the survey was answered on a scale of one to seven, with one being "strongly disagree" and seven being "strongly agree". Participants were also provided the option to select "not sure" for each of the questions. The tool included three additional "yes", "no" or "not sure" questions focused on organizational structures required for QI which are outlined in Figure 5.

The average score for each question of the tool was calculated for each of the 34 participating public health units. The average of those scores were then used to determine the QI maturity score for each public health unit. The average of all 34 public health unit QI maturity scores was then calculated to determine the provincial average for QI Maturity. This method was used so that each question and each public health unit was weighted equally in the calculation of the provincial average score. Responses of "not sure" were excluded from the calculations. Table 1 was then referenced to determine the stage of QI maturity.

Table 1. QI Maturity Tool Stage Descriptions

QI Maturity Tool Avg. Score	Stage	Description
< 4.78	Beginning	Have not adopted formal QI projects, applied QI methods in a systematic way, or engaged in efforts to build a culture of QI
4.79-5.12	Emerging	Newly adopted QI approaches, albeit with limited capacity. They have a limited QI culture and few, if any examples of attempts to incorporate QI as a routine part of practice
5.13-5.79	Progressing	Some QI experience and capacity but often lack commitment, have minimal opportunity for QI integration throughout the agency and are less sophisticated in their application and approach
5.80-6.71	Achieving	Fairly high levels of QI practice, a commitment to QI and an eagerness to engage in the type of transformation change described by QI experts
>6.72	Excelling	Achieving high levels of QI sophistication and a pervasive culture of QI

(Adapted from Joly et al., 2013)

The survey was launched on Oct. 5, 2016 and ran until Nov. 15, 2016. Local Site Champions involved with the CQI LDCP distributed and promoted the survey within their public health unit. Access to the *QI Maturity Tool - Modified Ontario Version* was sent via web-link to all the employees of the 34 participating Ontario public health units.

Individual public health unit reports were prepared and distributed by Dr. Madelyn Law and Graham Hay in mid-January 2017. This provincial report was created collectively by the CQI LDCP team. However, to protect anonymity and confidentiality of the participants and sites, only Dr. Law and Graham Hay had access to the raw data; no other members of the CQI LDCP team had access to the raw data or the individual public health unit reports.

Results

The following section provides detailed tables of the questions in the *QI Maturity Tool - Modified Ontario Version* as aggregated to the three dimensions of the survey: QI Organizational Culture; QI Capacity and Competency; and QI Perceived Value. These are highlighted by division and professional group (See Appendix A for professional group examples). Aggregate scores are provided by dimension to facilitate an in depth understanding of the results.

Overall Results

There were a total of 3,503 participants from 34 Ontario public health units who completed the survey, which resulted in a response rate of 46.6%. The average score for all public health units across the province was 4.94. This places the provincial QI maturity in the "Emerging" stage of maturity (See Table 2 below).

Table 2. Response Rate and Average Public Health Unit Score

	All public health units
Total number of responses	3,503
Total number of Employees (as of September 2016)	7,515
Response rate	46.6%
Average public health unit score	4.94 – Emerging

Participants were asked to select a "division" that most closely aligned to the division, department, program or area in which they work. The divisions included in the tool were based on the current Ontario Public Health Standards (OPHS). Table 3 outlines the average score for each area for all participants. Administrative and Corporate divisions appeared to score in the higher QI Maturity stage (N=5.2) with the Foundational Standard division scoring at the lower end (N=4.3) as compared to the other divisions.

Table 3. Average Score by OPHS Standard (Division)

OPHS Standard (Division)	**All public health units**		
	Total Participants (n)	**QI Maturity Tool Avg. Score**	**Stage**
Administrative/Corporate	379	5.20	Progressing
Chronic Disease and Injuries	570	4.86	Emerging
Emergency Medical Services	129	4.78	Beginning
Emergency Preparedness	20	4.95	Emerging
Environmental Health	380	4.88	Emerging
Family Health	946	5.06	Emerging
Foundational Standard	212	4.30	Beginning
Infectious Diseases	739	4.79	Emerging

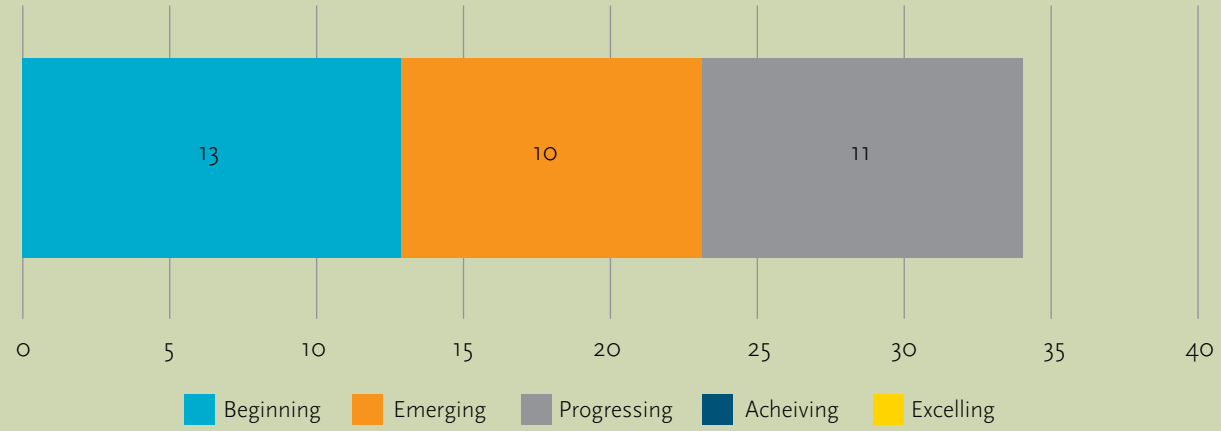
Participants were asked to select one of six professional groupings to which their job at their public health unit most closely aligned. The results based on professional groupings are found below in Table 4. Those individuals in the support staff role scored at the higher end of QI Maturity stage (N=5.3) with specialist staff scoring at the lower end (N=4.38) as compared to the other professional groups.

Table 4. Average Score by Professional Grouping

Professional Grouping	All public health units		
	Total Participants (n)	QI Maturity Tool Avg. Score	Stage
Frontline Staff	2,229	4.91	Emerging
Administrative Staff	189	5.01	Emerging
Support Staff	417	5.30	Progressing
Specialist	238	4.38	Beginning
Management	346	4.95	Emerging
Senior Management	168	5.10	Emerging

A review of individual public health unit scores indicates that public health units are at varying states of QI maturity (see Figure 1). Of the 34 public health units who participated 32% (N=11) scored in the progressing stage; 30% (N=10) scored in the emerging stage and 38% (N=13) scored in the beginning stage. No public health unit had an average score that would rank them within the achieving or excelling stage of QI Maturity.

Figure 1. Ontario PHUs QI Maturity Stage



Results by Dimension

The following section describes the results for each of the three unique dimensions of the *QI Maturity Tool - Modified Ontario Version* by division and professional grouping. This is followed by a section outlining the distribution of the public health units rating in each of the QI maturity stages.

These dimensions include:

1. QI Organizational Culture;
2. QI Capacity and Competency; and
3. QI Perceived Value.

1. QI Organizational Culture

QI Organizational Culture is defined as the values and norms about QI that pervade throughout the organization relative to how the public health unit interacts with staff and stakeholders. Results for QI Organizational Culture are assessed by examining questions one to four of the survey. **The provincial average for this dimension was 5.09 which is in the emerging stage of QI maturity.**

The average scores for questions one to four are reported by division and professional groupings in tables 5 and 6.

Table 5. QI Organizational Culture by OPHS Standard Division

OPHS Standard (Division)	All public health units		
	Total Participants (n)	QI Maturity Tool Avg. Score	Stage
Administrative/Corporate	379	5.30	Progressing
Chronic Disease and Injuries	570	5.04	Emerging
Emergency Medical Services	129	4.76	Beginning
Emergency Preparedness	20	5.10	Emerging
Environmental Health	380	5.07	Emerging
Family Health	946	5.13	Progressing
Foundational Standard	212	4.91	Emerging
Infectious Diseases	739	4.94	Emerging

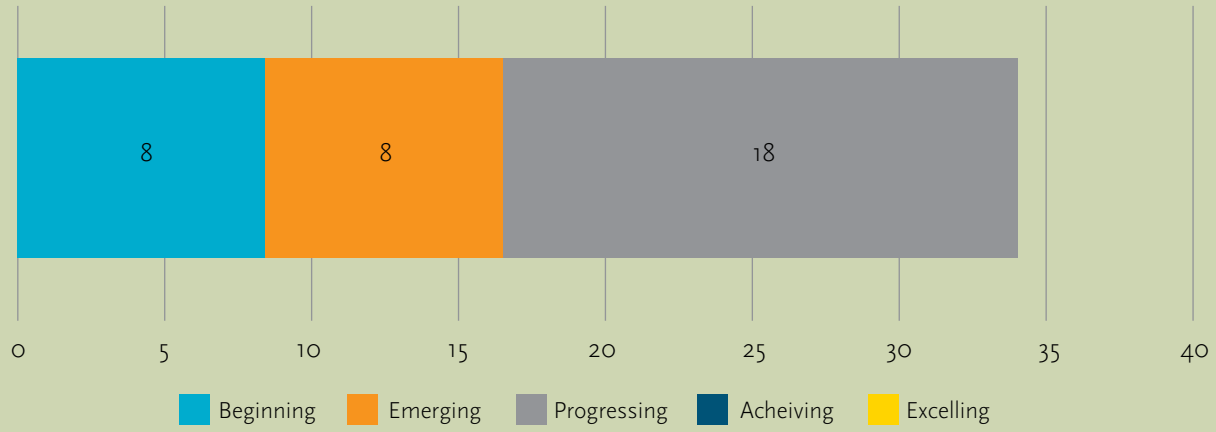
Table 6. QI Organizational Culture by Professional Grouping

Professional Grouping	All public health units		
	Total Participants (n)	QI Maturity Tool Avg. Score	Stage
Frontline Staff	2,229	5.00	Emerging
Administrative Staff	189	4.83	Emerging
Support Staff	417	5.19	Progressing
Specialist	238	4.84	Emerging
Management	346	5.57	Progressing
Senior Management	168	5.69	Progressing

In the dimension of QI culture, corporate services and family health scored highest in the progressing stage. For professional grouping, those in support staff, management or senior management reported QI to be in the progressing stage.

Looking across all health units, more than half (N=18) of participating public health units scored in the progressing stage of QI Maturity for the QI Organizational culture dimension. The remaining 16 public health units were evenly divided between beginning and emerging stages. See Figure 2.

Figure 2. Ontario PHUs by Dimension: QI Organizational Culture



2. QI Capacity and Competency

QI Capacity and Competency is defined as the skills, functions, and approaches used to assess and improve quality in an organization. Results for QI Capacity and Competency are assessed by examining questions five to 19 of the survey. **The provincial average for this dimension was 4.58 which places it in the beginning stage of QI maturity.**

The average scores for questions five to 19 are reported by division and professional groupings within each division in the tables below.

Table 7. QI Capacity and Competency by OPHS Standard (Division)

OPHS Standard (Division)	All public health units		
	Total Participants (n)	QI Maturity Tool Avg. Score	Stage
Administrative/Corporate	379	4.88	Emerging
Chronic Disease and Injuries	570	4.46	Beginning
Emergency Medical Services	129	4.63	Beginning
Emergency Preparedness	20	4.67	Beginning
Environmental Health	380	4.59	Beginning
Family Health	946	4.76	Beginning
Foundational Standard	212	3.61	Beginning
Infectious Diseases	739	4.41	Beginning

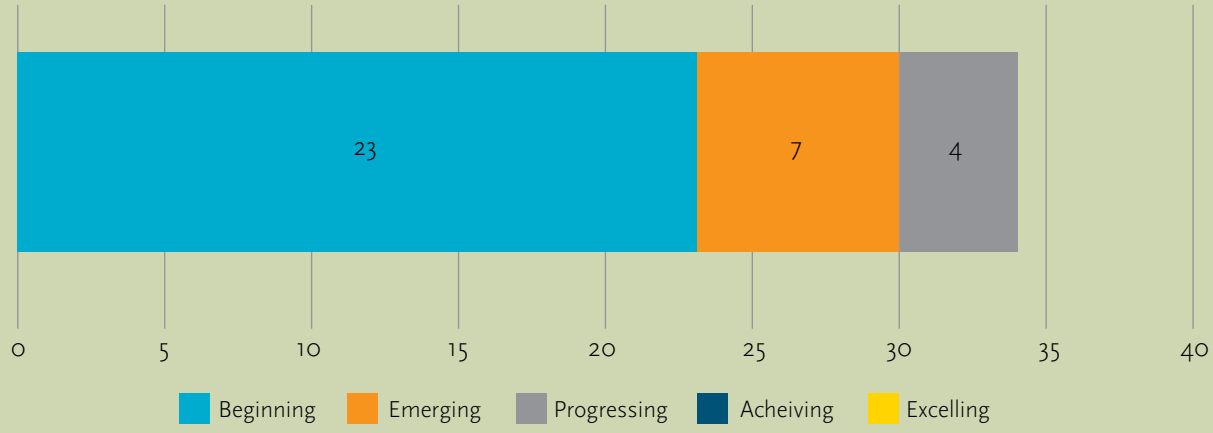
Table 8. Capacity and Competency by Professional Grouping

Professional Grouping	All public health units		
	Total Participants (n)	QI Maturity Tool Avg. Score	Stage
Frontline Staff	2,229	4.57	Beginning
Administrative Staff	189	4.76	Beginning
Support Staff	417	5.11	Emerging
Specialist	238	3.79	Beginning
Management	346	4.41	Beginning
Senior Management	168	4.54	Beginning

In QI capacity and competency, all but one (Administrative/Corporate) rated this dimension in the beginning stage of maturity. As well, all professional groups except for support staff rated this dimension in the beginning stage.

Across all health units, 23 PHUs in the province reported being in the beginning stages of QI maturity in the dimension of Capacity and Competency. Seven others scored in the emerging stage and four in the progressing stage. See Figure 3.

Figure 3. Ontario PHUs by Dimension: QI Capacity and Competency



3. QI Perceived Value

QI Perceived Value is defined as the perceptions of employees that QI is a priority in the organization and supported by leaders while also having the potential to impact services and the community. Results for QI Perceived Value are assessed by examining questions 20-23. **The provincial average for this dimension was 6.00 which places it in the achieving stage of QI maturity.**

The average scores for questions 20-23 are reported by division and professional groupings within each division in the tables below.

Table 9. QI Perceived Value by OPHS Standard (Division)

OPHS Standard (Division)	All public health units		
	Total Participants (n)	QI Maturity Tool Avg. Score	Stage
Administrative/Corporate	379	6.15	Acheiving
Chronic Disease and Injuries	570	6.07	Acheiving
Emergency Medical Services	129	5.43	Progressing
Emergency Preparedness	20	6.20	Acheiving
Environmental Health	380	5.71	Progressing
Family Health	946	6.02	Acheiving
Foundational Standard	212	6.07	Acheiving
Infectious Diseases	739	5.93	Acheiving

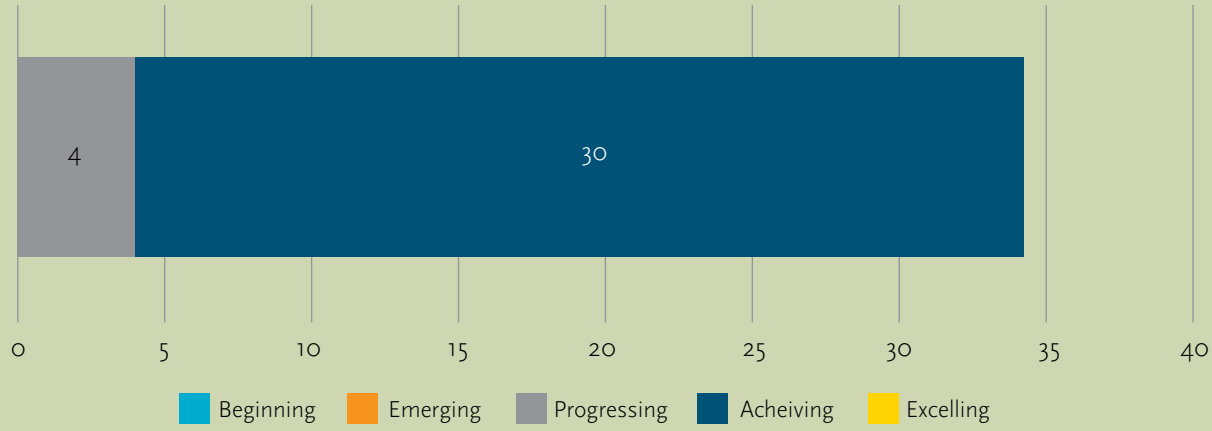
Table 10. Perceived Value by Professional Grouping

Professional Grouping	All public health units		
	Total Participants (n)	QI Maturity Tool Avg. Score	Stage
Frontline Staff	2,229	5.95	Acheiving
Administrative Staff	189	5.86	Acheiving
Support Staff	417	5.99	Acheiving
Specialist	238	5.90	Acheiving
Management	346	6.23	Acheiving
Senior Management	168	6.41	Acheiving

It is evident that there is a high value placed on QI Perceived value with most divisions (N=6) reporting this dimension in the achieving stage. As well, the average score for the professional groupings was in the achieving stage.

At the agency level, 30 public health units scored in the achieving stage of QI maturity in the dimension of Perceived Value, with the remaining units scoring in the progressing stage. See Figure 4.

Figure 4. Ontario PHUs by Dimension: Perceived Value



Additional QI Related Questions

Three additional questions were asked related to organizational structures in place to support CQI efforts in each public health unit as illustrated in Figure 5. Please note that these questions were aimed at examining what staff know about their organizational supports and may not reflect what is actually in place in Ontario public health units. This provides an understanding of staff awareness and knowledge of organizational structures and/or work being conducted in Ontario public health units related to CQI.

Figure 5. Additional QI-related Questions

Accreditation / Certification

All participating public health units were asked if they had been accredited or certified within the last five years. The focus of this question was to determine if organizations were accredited or certified through an organization that focuses on quality improvement at the corporate, program and individual level. Such processes normally include an external audit of agency business practices against standards based on evidence-informed best practices shown to contribute to organizational effectiveness, along with ongoing contact with support, education and networking to achieve improvements. Results are shown in Table 11.

Table 11 - Accreditation/Certification

	Yes
My public health unit has participated in an accreditation process BUT NOT an external quality assurance/certification program within the past 5 years	9
My public health unit has participated in BOTH accreditation and an external quality assurance/certification program within the past 5 years	3
My public health unit has been through an external quality assurance program or certification program process in the past five years but NOT accreditation	1

Of the 34 participating public health units, 31 answered the related questions. An initial review of the results did not demonstrate differences between sites that were accredited/certified (5.08) versus those not accredited/certified (4.82) in their stage of QI maturity average score. Both groups on average were in the emerging stage of QI maturity. Eighteen public health units outlined that they were not accredited or certified.

Conclusions

The average score of 4.94 places Ontario public health units in the Emerging stage of QI Maturity. However, there was an almost equitable distribution across the Beginning, Emerging and Progressing stages when examining individual public health unit reports. By QI dimensions, Ontario public health units as a group scored in the:

- Emerging stage for the dimension of "QI Organizational Culture";
- Beginning stage for the dimension of "QI Competency and Capacity"; and
- Achieving stage for the dimension of "QI Perceived Value".

The *QI Maturity Tool - Modified Ontario Version* demonstrates that Ontario public health units value QI and its potential positive impact on programs and services, as well as the potential for QI to help improve the health of the community. Ontario public health units rate their competency and capacity to implement and support QI as low or needing improvement. It is worth noting that of the 34 public health units who participated, not one scored overall in the Achieving or Excelling stages, despite many having indicated that they have staff who are trained or participate in QI methods or tools.

Additionally, Site Champions in the public health units were asked to report on their participation in activities related to accreditation or certification in the past five years. An initial review of results did not demonstrate differences between sites that were accredited/certified versus those not accredited/certified in their stage of QI maturity average score. This may be an area for further investigation given the current public heath context where accreditation is not mandatory.

The results of this survey will enhance public health professionals understanding of the current state of the implementation of QI in Ontario. Results will also be used by the CQI LDCP team to develop the next research proposal to identify and/or enhance specific tools, systems and structures that support CQI across and within Ontario public health units.

In general, more research is required to understand what types of structures, practices and overall supports are required to help public health units progress to the higher stages of QI maturity. The scoping review, currently underway, will highlight key factors that are important in the development, implementation and sustainability of QI that can be used in all public health units. However, further research in an Ontario context is warranted to further engage and foster CQI in Ontario public health units.

Limitations

The use of self-reported surveys has inherent flaws that are difficult to control. These include the potential for participant bias (i.e., those with more knowledge and experience in CQI may have filled out the survey), potential lack of understanding of the survey questions, and social desirability bias (i.e., choosing a higher rating to appear better than the reality).

Strategies were employed to reduce these issues. Notification was provided to health professionals related to the fact that the survey results would be anonymous to encourage participants to be open and honest in their responses. The survey was sent to all staff in each public health unit in order to maximize our reach to employees across the organization and not just those with a knowledge or interest in CQI.

Regarding the choice of division and profession, it is not possible to state with absolute certainty that individuals chose the most appropriate category. Public health units have different organizational structures, varying job titles and different professional roles and responsibilities, which presented challenges related to defining categories that would unequivocally apply to all public health units. Therefore, the research team used the OPHS standards and core professional groupings to set the categories, in order to facilitate a more consistent approach.

The response rates by public health unit for this project ranged from 22.8% to 86.7%. This range of participant responses by public health unit was controlled for by weighting the individual public health unit results equally to create the provincial averages.

Next Steps

This is the second of three planned reports from the CQI LDCP team. Individual site reports were distributed to all public health units that participated in the survey, and this aggregate report will be distributed to all Ontario public health units' leaders, participants who requested a copy of the results and key stakeholders (e.g., ministry staff) as identified by the CQI LDCP team. In early 2017, the LDCP team will be releasing a report on the results of a scoping review of the literature conducted in 2016 that will also be shared with key stakeholders, including individuals in public health units.

Looking ahead the LDCP team plans to undertake a series of consultation sessions with key stakeholders, including the Site Champions, key decision makers in Ontario public health units, and public health system decision makers in Ontario. These sessions will integrate the results from the scoping review and QI maturity tool survey and seek to understand:

- How the results from this one year LDCP project can be used to support enhanced CQI within Ontario's public health units.
- Do the findings generally reflect the experience of CQI in public health for the stakeholders and how are they relevant (or not) to the needs of those stakeholders?
- What do these findings, and subsequent discussions, tell us about future research directions to support and strengthen continuous quality improvement in Ontario's public health units?

The CQI LDCP team will then submit a renewal application to extend this research project for an additional two years. The development of this proposal will be based on the feedback and engagement from key stakeholders in this consultation process.

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Appendix A

QI Maturity Tool - Modified Ontario Version

Professional Grouping
Please select one of the professional groupings from the list provided that you identify most with.

- Administrative Staff (i.e. IT, Finance, Communications, Human Resources)
- Support Staff (i.e. Executive Assistant, Program Assistant, Clerk, Receptionist, Maintenance)
- Frontline (i.e. PH Nurse, PH Inspector, PH Dietitian, PH Dental Hygienst, Health Promoters, Paramedic, Speech Pathologists)
- Specialist (i.e. Epidemiologists, Researchers, Program and Planning)
- Management (i.e. Supervisors, Program Managers)
- Senior Management (i.e. MOH, AMOH, CEO, Director)

Division
Please select the OPHS category that your role within the Health Unit aligns with most. If your role aligns with multiple OPHS categories, pick the one you feel is most relevant or where you spend the most time.

- Environmental Health
- Emergency Preparedness
- Family Health
- Foundational Standard
- Infectious Diseases
- Chronic Disease and Injuries
- Administrative/Corporate
- Emergency Medical Services (EMS)
- None of the Above

If you have selected "none of these" to the previous question, please identify what non-OPHS division/category you operate within your health unit below:

(if you do not wish to identify yourself you may skip this question)

Quality Improvement Maturity Tool

Survey Questions rated on a Scale of 1 to 7	**Strongly Disagree**						**Strongly Agree**
1. Leaders (e.g. senior management team, middle managers) of my public health unit are receptive to new ideas for improving unit programs, services, and outcomes.	1	2	3	4	5	6	7
2. The board and/or the management team of my public health unit work together for common goals.	1	2	3	4	5	6	7
3. Staff consult with, and help, one another to solve problems.	1	2	3	4	5	6	7
4. Staff members are routinely asked to contribute to decisions at my public health unit.	1	2	3	4	5	6	7
5. The middle managers of my public health unit are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.	1	2	3	4	5	6	7

	Strongly Disagree						Strongly Agree
6. Staff at my public health unit who provide public health services are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.	1	2	3	4	5	6	7
7. Many individuals responsible for programs and services in my public health unit have the skills needed to assess the quality of their program and services.	1	2	3	4	5	6	7
8. My public health unit has objective measures for determining the quality of many programs and services.	1	2	3	4	5	6	7
9. Many individuals responsible for programs and services at my public health unit routinely use systematic methods (e.g., root cause analysis) to understand the root causes of problems.	1	2	3	4	5	6	7
10. Many individuals responsible for programs and services at my public health unit routinely use best or promising practices when selecting interventions for improving quality.	1	2	3	4	5	6	7
11. Programs and services are continuously evaluated to see if they are working as intended and are effective.	1	2	3	4	5	6	7
12. The quality of many programs and services in my public health unit is routinely monitored.	1	2	3	4	5	6	7
13. Job descriptions for many individuals responsible for programs and services at my public health unit include specific responsibilities related to measuring and improving quality.	1	2	3	4	5	6	7
14. Good ideas for measuring and improving quality in one program or service USUALLY are adopted by other programs or services in my public health unit.	1	2	3	4	5	6	7
15. Staff members at all levels participate in quality improvement efforts.	1	2	3	4	5	6	7
16. Accurate and timely data are available for program managers to evaluate the quality of their services on an ongoing basis.	1	2	3	4	5	6	7
17. When trying to facilitate change, staff has the authority to work within and across program boundaries.	1	2	3	4	5	6	7
18. Improving quality is well integrated into the way many individuals responsible for programs and services work in my public health unit.	1	2	3	4	5	6	7
19. Public Health unit staff is aware of external quality improvement expertise to help measure and improve quality.	1	2	3	4	5	6	7
20. Spending time and resources on quality improvement is worth the effort.	1	2	3	4	5	6	7
21. The key decision makers in my public health unit believe quality improvement is very important.	1	2	3	4	5	6	7
22. Using QI approaches will impact the health of my community.	1	2	3	4	5	6	7
23. Public health unit staff and stakeholders will notice changes in programs and services as a result of our QI efforts.	1	2	3	4	5	6	7

Additional questions answered with Yes, No, Not sure, Decline to Answer

24. My public health unit has a quality improvement council, committee or team.	**Yes**	**No**	**Not Sure**	**Decline**
25. My public health unit has designated a Quality Improvement Officer/specialist or equivalent staff person.	**Yes**	**No**	**Not Sure**	**Decline**
26. My public health unit has a quality improvement plan.	**Yes**	**No**	**Not Sure**	**Decline**

Strengthening

IN ONTARIO'S PUBLIC HEALTH UNITS

A LOCALLY DRIVEN COLLABORATIVE PROJECT
2016-2017