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Brock University

Assessing Quality Improvement Maturity Across Ontario Public Health Units

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Public Health Ontario (PHO) Rounds – April 23, 2026

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Disclosures

- Madelyn Law, Kelly Pilato, and Krista Galic have no conflicts to disclose.

Overview

- Learning Objectives
- QI Maturity Survey Results
- QI Spotlight: Public Health Sudbury & Districts
- Q&A
- Wrap-up

Learning Objectives

By the end of this event, participants will be able to:

1. Describe the **variation in Quality Improvement (QI) understanding and implementation** across Ontario public health units (PHUs)
2. Interpret **provincial averages** of QI maturity scores and identify what the results indicate for system readiness
3. Reflect on your own **organization's QI practices**

PHO QI Implementation: Adapted Definition & Aims

Quality Improvement (QI) in public health is a proven, effective way to improve community services, care for clients, and to improve practice for staff. In the health system, there are always opportunities to **optimize**, streamline, develop and test processes, and QI should be a systematic, data driven, **continuous** process and an integral part of **everyone's work**, regardless of role or position within the organization.[1]

National Focus

Core Competencies for Public Health in Canada – Release in October 2025[2]

"Core competencies are the essential knowledge, skills and attitudes necessary for the practice of public health."

Program Planning, Implementation and Evaluation Section

4.1 Use quality improvement approaches to plan, implement, evaluate, modify and improve programs, services and actions.

Provincial Focus

- Quality Improvement (QI) has been a topic of discourse in Ontario Public Health Units (PHUs) since 2006
  - Recognized by the Capacity Review Committee as important for performance management (2006)[3]
  - Required activity for PHUs based on a Ministry of Health and Long-Term Care (MOHLTC) report (2011)[4]
  - Foundational to Ontario Public Health Standards (2018)[5]
- Other health sectors are required to develop plans and report on QI through annual Quality Improvement Plans (QIPs)

QI in Public Health Practice

- Understanding of QI management principles and implementation of QI in practice varies among PHUs in Ontario.
- Individual PHUs have developed innovative ways to apply QI approaches based on their specific organizational structure, staffing and understanding of QI.
- This means that QI in PHUs looks different across the province making it difficult to share information, learn from each other, and develop common standards of practice.

QI Maturity Tool: Dimensions, Scores & Stages

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 with limited capacity, limited QI culture, and few examples QI in routine practice
5.13-5.79 Progressing	Some QI experience and capacity but lack commitment, opportunity for QI integration and sophisticated in application and approach
5.80-6.71 Achieving	High levels of QI practice, commitment to QI and eagerness to engage in QI
> 6.72 Excelling	High levels of QI sophistication and pervasive culture of QI

Twenty-three questions measuring three dimensions of QI:

1. **Perceived Value:** staff beliefs about leadership support and impact of QI
2. **Capacity & Competency:** skills, methods, and structures for QI
3. **Organizational Culture:** norms, values, staff relationships

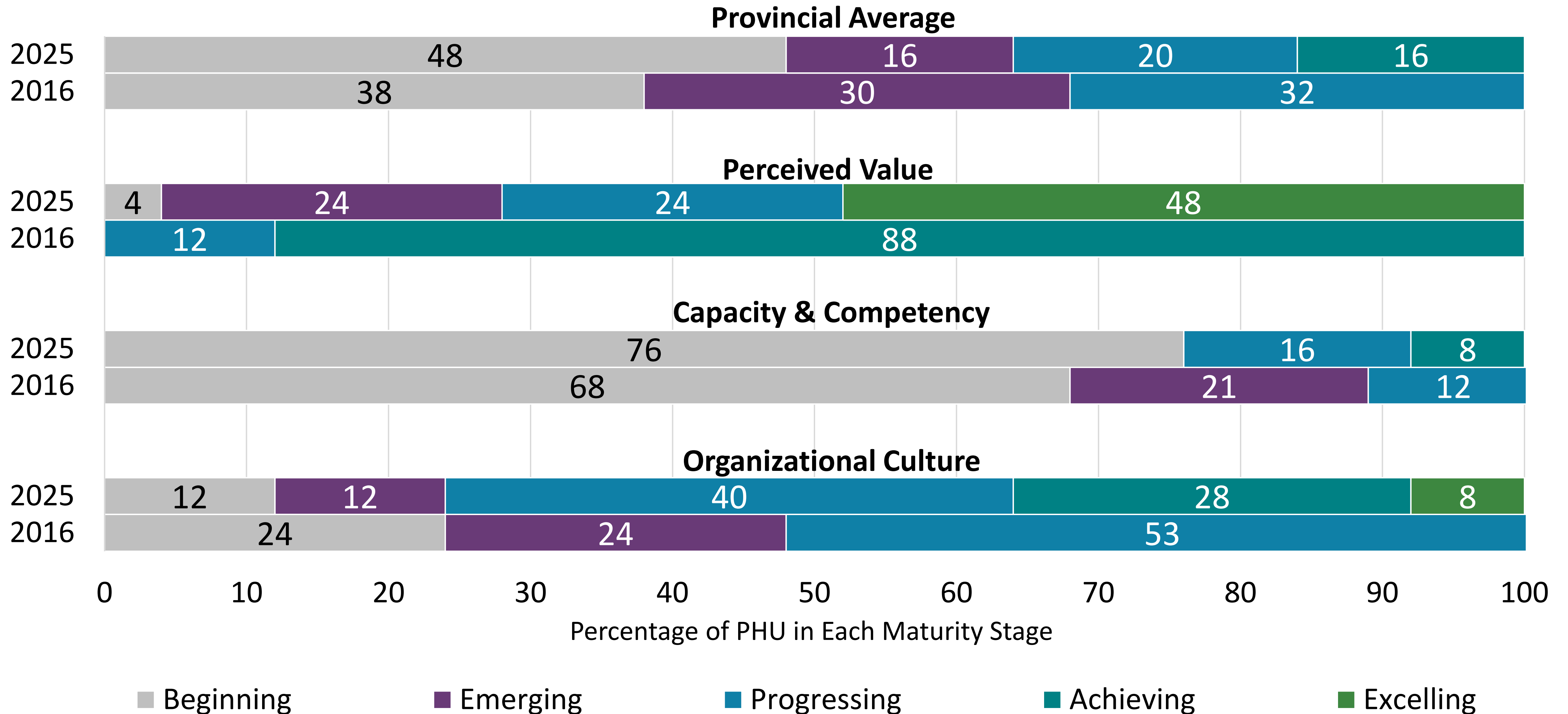
Provincial QI Maturity: 2016 and 2025 Results

2016	2025
• **Emerging stage (4.94)** • 3503 staff across 34/36 PHUs completed the survey (94% of PHUs represented) • Participants represented 8 public health divisions	• **Emerging stage (4.88)** • 25/29 PHUs completed the survey (86%) • Participants represented 16 public health divisions (based on 2018 OPHS)

Distribution of PHUs Across QI Maturity Stages (% of PHUs)

Stage	2016 (34/36 PHUs)	2025 (25/29 PHUs)	% Difference
Beginning	38%	48%	+10%
Emerging	30%	16%	-14%
Progressing	32%	20%	-12%
Achieving	0%	16%	+16%
Excelling	0%	0%	-

Provincial QI Maturity: 2016 and 2025 Results



Provincial Scores by QI Dimension and % Change

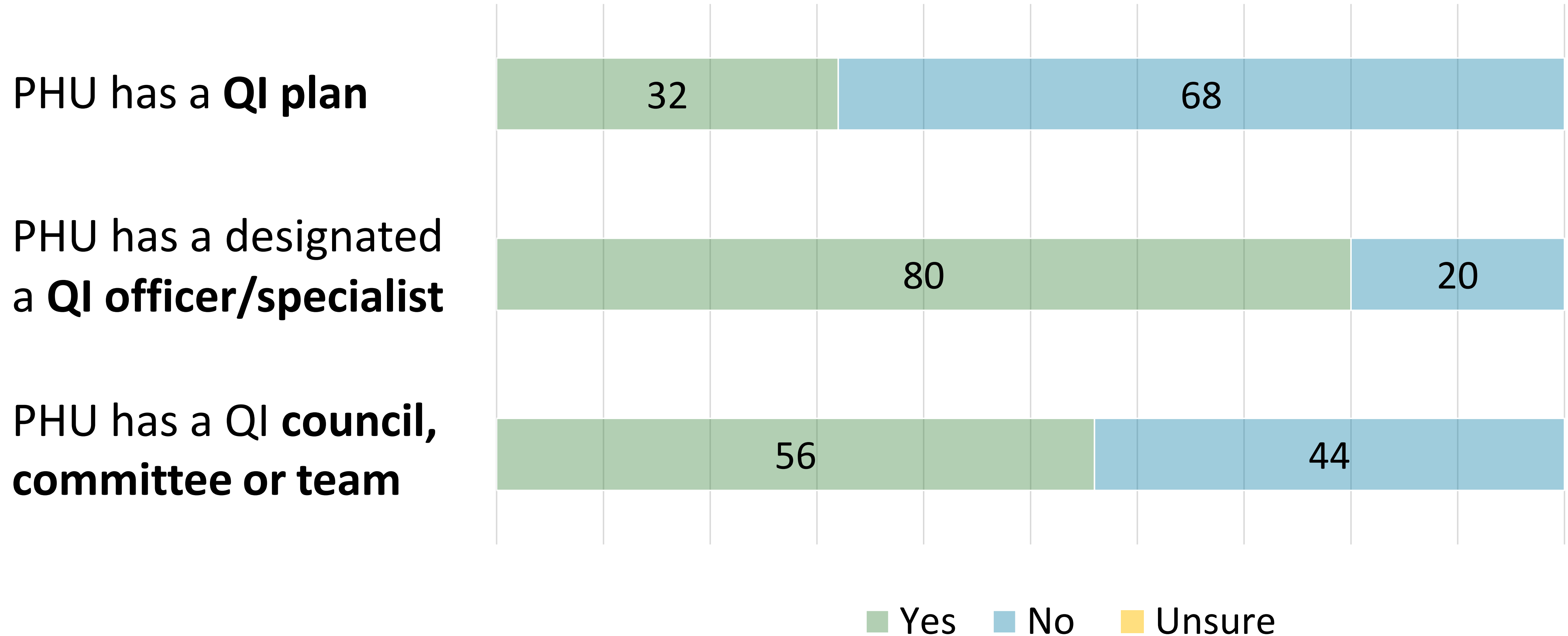
Dimension	2016 (34/36 PHUs)	2025 (25/29 PHUs)	% Change
Average	4.94	4.88	-1.2%
Perceived Value	6.00	6.33	+5.5%
Capacity & Competency	4.58	4.27	-6.8%
Organizational Culture	5.09	5.65	+11%

QI Dimension Score by Region (N=25)

Region	QI Perceived Value	QI Org. Culture	QI Capacity & Competency	Region Average
Central West	6.3	5.9	4.7	5.2
Central East*	6.3	5.7	4.5	5.0
East	6.3	5.5	4.2	4.8
Northeast	5.7	5.4	4.2	4.7
Southwest	6.3	5.3	4.0	4.7
Northwest	7.0	5.5	2.9	4.1
Average	6.3	5.5	3.9	

**Includes Toronto region*

Quality Improvement Structures Across PHUs (N=25)



Note: 2016 results collected at individual level; not aggregated for comparison.

Study Limitations (2025)

- Differing methodological approach from 2016-2025
  - One organizational response per PHU
  - Some submitted individual, single response
  - Time limitations to incorporate guidance into 2025/26 provincial QI Education workshops

System Context: What Changed (2016-2025)

- Number of PHUs changed from 36 (2016) to 29 (2025)
- COVID-19 pandemic disrupted QI staffing and resources across PHUs
- PHU mergers have resulted in leadership change across PHUs

Opportunities for Practice & Implementation

- **Benchmarking QI maturity scores**
  - Allows for benchmarking at the regional and provincial levels
  - Higher QI perceived value scores highlight opportunities
  - Learn from PHUs with high scores to understand what is working
- **Need to prioritize foundational QI education and training**
  - QI competency and capacity as lowest scoring dimension (3.9/7, scores ranging from 2.9-4.7)
- **Further explore the influence of leadership**
  - Leadership influence is an important theme
  - Targeted strategies to sustain momentum during periods of transition

Assessing Quality Improvement Maturity – Public Health Unit Spotlight

PHO Rounds

April 23, 2026

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Public Health Sudbury & Districts

Accountability Monitoring Plan

2024–2028

Public Health Sudbury & Districts
April 2024

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)

Strategic Priority 4: Healthy and resilient workforce

Performance Measure	2024	2025
4.2 Assessment of quality improvement maturity	Stage 2 of 5: **Emerging***	Stage 3 of 5: **Progressing***

	2024	2025		Change	Change Ratio
1. Leaders (e.g. senior management team, middle managers) of my public health unit are receptive to new ideas for improving unit programs, ser	4.64	5.0		0.37	1.080
2. The board and/or the management team of my public health unit work together for common goals.	5.11	5.3		0.20	1.039
3. Staff consult with, and help, one another to solve problems.	5.23	5.7		0.44	1.084
4. Staff members are routinely asked to contribute to decisions at my public health unit.	4.25	4.2		-0.05	0.988
Organizational Culture	4.81	5.0		0.24	1.050
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.	4.56	4.6		0.04	1.008
6. Staff at my public health unit who provide public health services are trained in basic methods for evaluating and improving quality, such as Pla	4.32	4.3		0.00	1.000
7. Many individuals responsible for programs and services in my public health unit have the skills needed to assess the quality of their program a	4.78	4.9		0.11	1.022
8. My public health unit has objective measures for determining the quality of many programs and services.	4.79	4.8		-0.02	0.995
9. Many individuals responsible for programs and services at my public health unit routinely use systematic methods (e.g., root cause analysis) t	4.25	4.3		0.07	1.017
10. Many individuals responsible for programs and services at my public health unit routinely use best or promising practices when selecting inte	4.75	5.2		0.49	1.102
11. Programs and services are continuously evaluated to see if they are working as intended and are effective.	4.46	4.6		0.18	1.041
12. The quality of many programs and services in my public health unit is routinely monitored.	4.71	4.9		0.15	1.032
13. Job descriptions for many individuals responsible for programs and services at my public health unit include specific responsibilities related	4.75	4.8		0.06	1.014
14. Good ideas for measuring and improving quality in one program or service USUALLY are adopted by other programs or services in my public he	4.29	4.4		0.07	1.016
15. Staff members at all levels participate in quality improvement efforts.	4.51	4.5		-0.03	0.992
16. Accurate and timely data are available for program managers to evaluate the quality of their services on an ongoing basis.	4.44	4.3		-0.16	0.964
17. When trying to facilitate change, staff has the authority to work within and across program boundaries.	3.83	3.8		-0.01	0.997
18. Improving quality is well integrated into the way many individuals responsible for programs and services work in my public health unit.	4.46	4.5		0.06	1.014
19. Public Health unit staff is aware of external quality improvement expertise to help measure and improve quality.	3.95	4.1		0.11	1.027
Capacity and Competency	4.46	4.5		0.07	1.017
20. Spending time and resources on quality improvement is worth the effort.	6.07	6.2		0.14	1.023
21. The key decision makers in my public health unit believe quality improvement is very important.	5.47	6.0		0.52	1.095
22. Using QI approaches will impact the health of my community.	5.89	6.1		0.23	1.040
23. Public health unit staff and stakeholders will notice changes in programs and services as a result of our QI efforts.	5.31	5.4		0.11	1.021
Percieved Value	5.69	5.9		0.25	1.044
Total Quality Maturity Score	4.98	5.2		0.19	1.038
24. My public health unit has a quality improvement council, committee, or team. (% Yes)	89.0%	87%		-0.02	0.978
25. My public health unit has designated a Quality Improvement Officer/Specialist or equivalent staff person. (% Yes)	90.2%	91%		0.00	1.004
26. My public health unit has a quality improvement plan. (% Yes)	89.0%	82%		-0.07	0.925

Findings

- Higher scores demonstrate areas to leverage successful practices
  - Stronger culture, collaboration, learning and psychological safety
  - Leadership support and perceived value of quality improvement
  - Capacity exists to deepen skills and apply more advanced methods

- Lower scores demonstrate areas we want to engage more with
  - QI being perceived as ‘extra work’ rather than part of core practice
  - Limited time to apply QI methods
  - Competing priorities and workload pressures

Next steps

- Aim for higher response rates in future surveys: critical to ensure the findings are representative, credible, and actionable
- Acknowledge and celebrate the everyday QI practices
- Leverage key elements

Leverage key elements

- Embed quality improvement into operations
- Focus on a limited number of high-leverage elements
  - Enables broader system-level improvements, strengthening multiple dimensions of quality maturity concurrently
- Focus on priority areas for improvement
  - Selection of four elements

Top four quality maturity elements for 2026

Staff members are routinely asked to contribute to decisions at my public health unit

Accurate and timely data are available for program managers to evaluate the quality of their service on an ongoing basis.

When trying to facilitate change, staff has the authority to work within and across boundaries.

Improving quality is well integrated into the way many individuals responsible for programs and services work in my public health unit.

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Community of Practice
Continuous Quality Improvement (CQI)

Terms of Reference

Name

- CoP – Continuous Quality Improvement

Purpose

- Bring together committed individuals who have a desire to work collaboratively to learn, share and build capacity for CQI among Health Units

- Meet the professional needs of CoP members through the development and sharing of knowledge, the facilitation of learning and growth opportunities, the promotion of, and access to resources, the building of supportive relationships, and the provision of opportunities to influence practice

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Questions?

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