Which way to quality?
Key perspectives on quality improvement in Canadian health care systems

Health Council of Canada
Conseil canadien de la santé
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“Quality improvement is going to be a series of hard-fought and hard-won moves, both minor and huge, that when all drawn together will hopefully be a high-functioning system with better outcomes. It’s not just flavour of the month or the year.”

Provincial deputy minister, one of many health system leaders interviewed for this report.
# TABLE OF CONTENTS

4 Introduction

7 The quality improvement journey

9 Setting the policy agenda

11 Aligning the system

14 Dedicated quality agencies

19 Legislation

23 Key factors in system-wide quality improvement

23 Leadership

25 Measurement, targets, and accountability

27 Capacity-building (education, training, and facilitation)

28 Evidence-informed care

31 Patient and family engagement

33 Sharing and spreading successful practices

34 Concluding comments

36 Appendices

36 Appendix A: Innovative quality improvement initiatives identified by senior leaders

38 Appendix B: Where senior leaders seek information and collaboration

39 References

42 Methodology and Acknowledgements
I don’t normally begin forewords to Health Council of Canada reports with a personal story. This topic is an exception.

Roughly 10 years ago, early in my days as CEO at The Ottawa Hospital, I was asked by the chair of the board whether the hospital provided high-quality patient care. “Absolutely,” I said, citing good doctors and nurses, the well-meaning staff, the fact that we cared about our patients, and so forth—all the typical things that we believe about ourselves in health care. Then came his kicker: “How do you know?”

I couldn’t answer, and that was the beginning of my involvement in the world of health care quality improvement. I won’t share any more of The Ottawa Hospital’s story—this report is about driving changes from a system perspective, which involves a larger scale and many more players. To learn what is happening across Canada, the Health Council interviewed senior health system leaders to hear more about their experiences with system-wide approaches to quality improvement. One of the most striking observations is that there is quite a range of approaches across Canada, and many jurisdictions think they are on the right path to a better health care system.

That may very well be true. But the board chair’s question comes back to me: How do you know?

For instance, how much do you know about what other provinces and territories are doing or planning to improve quality in their health care systems, and how you can benefit from their experience? Are you confident that you’re using the best possible tools and approaches to realize change? Do you have enough leaders for your efforts, and if you don’t, do you know how to develop them? Do you measure and monitor your performance at all levels in the system?

All of us can benefit from learning more about each other’s quality improvement efforts, sharing what works, and discussing ways to overcome common challenges. Sharing information and innovation among provinces and territories is absolutely the way to go—I’ve seen this in my own quality improvement efforts and we’re all seeing a trend towards greater collaboration, such as the Council of the Federation’s Health Care Innovation Working Group.

In short, we accomplish more when we share ideas and work together. There are a lot of good ideas being tested in this country. I hope this report helps to further the development of our collective knowledge and understanding of quality improvement in health care, and compels us to collaborate on common goals for our health care system.

Sincerely,
Dr. Jack Kitts
Chair, Health Council of Canada
**INTRODUCTION**

If there were such a thing as a national myth, this would be it: Canada has one of the best health care systems among high-income countries. This belief is such an ingrained part of our national identity that in a 2010 national survey, more than two-thirds of Canadians said they were “proud” of our health care system. And in 2013, another survey found that Canadians are more confident in the health care system than at any time during the past decade.

The truth: Despite continued investments to improve the health care system, Canada is still not where it could be—or should be—based on comparisons with other countries. International surveys show that the quality of health care systems in many high-income countries, including Canada, has been improving over time, but our health care system often ranks near the middle or at the bottom in many areas.

Research shows that in countries with better-quality health care systems, governments make it clear that quality improvement is a core strategy. Governments also use quality improvement to counter the escalating costs of health care and to find changes that also achieve cost savings to be reinvested in the system.

In Canada, provincial and territorial governments have recognized the need for better quality in their health care systems, and there has been an increased focus on quality improvement using a wide variety of strategies. For example, seven provincial governments have established health councils, quality councils, or patient safety organizations (described in this report as dedicated quality agencies); Ontario has enacted new legislation, the Excellent Care for All Act, that creates standard requirements for quality improvement planning and accountability; and Saskatchewan is investing significantly in Lean, an approach that focuses on improving health care services and finding efficiencies as a way to improve quality.

In this report, we pull back the curtain to provide insight into what senior health care leaders think about quality improvement from a system-wide perspective, what they believe is working, and the challenges they are facing.

We interviewed a range of health system leaders, including deputy and assistant deputy ministers of provincial ministries/departments responsible for health care, and CEOs or chairs of dedicated provincial quality agencies. Many spoke frankly about their experiences with quality improvement efforts, and this valuable perspective is provided in anonymous quotes throughout the report.

In addition, we sent surveys to each federal, provincial, and territorial ministry or department of health to gain further insight into their quality improvement activities across Canada (see Methodology, page 42.) The resulting overview presented in this report is a useful reference for governments and health care leaders who are guiding their jurisdictions’ efforts.

Many leaders who spoke with us emphasized the enormity of their jurisdictions’ efforts to stimulate and support change in the health care system. In the words of one senior official, quality improvement “is motherhood and apple pie, and no one’s going to disagree with that.” But quality improvement can also be difficult to do. It is fundamentally about changing the culture of health care and shifting the mindset and behaviour of health care leaders, providers, and policy-makers. Quality improvement asks them to move from focusing solely on providing services to also identifying and acknowledging problems, thinking about how they could improve, and then learning how to do it. This can feel threatening if it questions the quality of their current efforts, and overwhelming if it seems to require them to do more.
A key concept underlying quality improvement is that better health care is not just about the interactions between providers and patients; the system needs to change to support a new level of performance. Many senior leaders stressed that people need training and support to think differently and do their work differently.

Moving from a general philosophy of “quality improvement is important” to measurable change takes leadership, persistence, and an investment of both time and resources at every level of the health system. In a time of significant cost constraints and change fatigue from ongoing transformation of the health care system, quality improvement can be particularly challenging work. All of the leaders we interviewed spoke about these factors in one way or another, with each province choosing its own specific areas of emphasis and using a different mix of quality improvement approaches and tools.

Some health system leaders thought this variation was valuable and appropriate, while others were concerned about the waste involved in unnecessary duplication and the need to reinvent the wheel. It was clear that more coordination and awareness among the provinces and territories of each other’s approaches would support everyone’s quality improvement efforts.

To quote one official, provinces should “beg, borrow, and steal shamelessly.” We hope this report contributes to those efforts.

Senior leaders spoke frankly about their experiences with quality improvement efforts, and this valuable perspective is provided throughout the report in anonymous quotes.
“Over the course of these 10 years we’ve really started to segue from individual, organizational, or health care setting approaches to a very explicit province-wide intention around health system quality.”
THE QUALITY IMPROVEMENT JOURNEY

Since the creation of the health accords, governments have been supporting quality improvement in a more focused way. In our interviews with health system leaders, we heard that Canadian provinces are at different stages of development in their quality improvement efforts. However, their stories highlighted a number of common elements in the journey.

The focus on quality improvement stems back to the early 2000s, when several key reports in the United States raised awareness of problems with patient safety and health care quality. A number of national and provincial commissions and reports added to the growing concerns. Several high-profile patient safety campaigns in the US and Canada provided support for leaders and health care providers to take action.

In our interviews, a number of health system leaders mentioned the importance of the Canadian Adverse Events Study published in 2004 and the Safer Healthcare Now! campaign. Several leaders also indicated that a public crisis such as a Clostridium difficile outbreak or lab testing errors spurred a greater commitment to quality improvement efforts in their provinces.

“We actually should have zero errors... in health care we've taken more of the interpretation that happens.” How can [the airline industry] develop systems where their planes aren't falling out of the sky? They've had one or two incidents out of 10 million, whereas our incident rate right now is one out of seven in health care. We want to go to zero and that's driving our change.”

In the last decade, jurisdictions have moved ahead to varying degrees, depending on their priorities and leadership focus. During this time, seven provinces established or expanded dedicated quality agencies. Leaders from some of these provinces said there was initially a lack of understanding in their jurisdictions of the need for a system-wide approach to quality improvement, or how to lead one.

“We started out with a focus around patient safety, which in terms of the timing in 2003...really fit with what was happening both nationally and internationally. Then there was an evolution and broader look around quality—how do we actually support it?”

Some leaders described the cumulative effect of early efforts in their province. A key step in the quality improvement journey was recognizing that it was important to measure performance, report on results, and highlight areas for improvement. Once data showed quality gaps within the system, dedicated quality agencies and other health system partners began to build relationships aimed at making concrete changes, and they established some early initiatives.

As governments realized there were persistent problems with patient safety and other aspects of quality in the system, they began to buy into the idea that there needed to be a system-wide approach to quality improvement with the appropriate supports if they were going to see results.

Sometimes this point in the journey was characterized as a “readiness” to move to the next stage. This was usually indicated by more interest, discussions, and activity around quality improvement; an interest in looking at other dimensions of quality in addition to patient safety; and an increased focus on creating a broader quality improvement approach for the whole system. There was a drive to get all health system stakeholders on board and contributing to quality, with the government playing a leadership role to enable change.

Many leaders said that at the start of their efforts, quality improvement was typically a collection of piecemeal work in the province, often driven by well-intentioned champions. These efforts typically led to “islands of innovation” and “pockets of leadership” but lacked a coherent, coordinated approach. To create alignment and momentum at all levels of the health care system, many governments have created quality agendas or strategic direction documents that outline their plans and expectations for quality improvement activity at the system level.
It’s very, very complex because in order to do [quality improvement] well you have to have a systemic approach—you’re impacting a million parts. Everything needs to be well thought out and orchestrated.”
SETTING THE POLICY AGENDA

In our interviews with senior leaders, we asked them to describe their jurisdictions’ approaches to quality improvement and the priority areas of focus. While all governments see patient safety as a priority, there is growing acknowledgement of the need to address other dimensions of quality as well.

Several leaders said they are working to improve appropriateness and effectiveness through evidence-based assessment and clinical practice standards, while others emphasized the need to improve access to care and wait times. Many leaders said sustainability of the health care system is an important consideration in their quality improvement planning; as a result, their initiatives include a focus on finding efficiencies and reducing unnecessary costs.

“Is it about cost? Is it about appropriateness? Is it about other dimensions of quality? Absolutely. It’s about all of the above.”

When asked about their priorities for quality improvement, some leaders talked about broad system transformation. They do not see quality improvement as a separate stream of work—it is an important part of what is needed to move their health systems forward.

The following policy approaches were described during interviews or noted in jurisdictional responses to the Health Council’s survey:

- **British Columbia, Saskatchewan, and Ontario** all have quality improvement approaches as a core part of their ministry of health’s business plans and related initiatives. BC’s approach aligns with its larger Innovation and Change Agenda. Saskatchewan is building on a variation of the US Institute for Healthcare Improvement’s Triple Aim approach, and the province’s strategic plan includes key priorities and targets for quality improvement. Ontario has an Excellent Care for All Strategy, which includes a variety of levers to stimulate and support quality improvement, including legislation and funding reform.

- **Alberta and Prince Edward Island** are capturing their quality and quality improvement goals within the strategic and business plans of their single health authorities. For example, Alberta Health Services (AHS) has developed a multi-year health plan, quality improvement initiatives, and an operating budget that are aligned with Alberta’s 5-Year Health Action Plan 2010-2015, developed by both Alberta Health and AHS. And Health PEI’s system-level goals are prioritized around quality dimensions and goals/targets for quality improvement.

- **Manitoba’s** provincial government has initiated a Pursuing Excellence initiative with targeted improvement initiatives in three areas: primary care offices (advanced access), inpatient settings (Releasing Time to Care), and regional health authorities (Lean Six Sigma).

- **New Brunswick** has instituted a performance excellence program linked to Lean Six Sigma to enhance quality and accountability throughout the government.

- **The Nova Scotia** government’s approach includes its Patient Safety Act as well as commitments related to quality improvement, such as a health quality indicator framework, in the government’s most recent annual statement of mandate.

- **The Newfoundland and Labrador** Department of Health and Community Service’s strategic plan includes quality and patient safety as one of four key system issues to be addressed.

- At the **federal level**, Health Canada has recently developed a system-wide quality improvement policy framework to guide the work of the First Nations and Inuit Health Branch. The Canadian Forces Health Services is also developing a system-wide quality improvement strategy.

- Among other initiatives, the **Northwest Territories** is in the early stages of developing a territorial patient safety framework.

In addition to these strategic planning efforts, the senior leaders we spoke with outlined additional critical components of their quality improvement approaches. Seven provinces have established dedicated quality agencies such as quality councils, health councils, or...
LEARNING FROM OTHER COUNTRIES

Research shows that a consistent cluster of factors leads to success in creating high-performing health systems through large-scale quality improvement. These factors include (but are not limited to) committed leadership, the use of information to guide quality improvement (including performance measurement), and the development of system-wide capacity for quality improvement.

A 2011 analysis of health care system improvement in Alaska, Utah, and Sweden, commissioned by the Canadian Foundation for Healthcare Improvement, suggested common factors led to success in improving health care systems:

- quality and system improvement as a core strategy;
- leadership activities that embrace common goals and align activities;
- provision of an enabling environment and the buffering of short-term factors that undermine success;
- information as a platform for guiding improvement, including performance measurement;
- development of organizational capabilities and skills to support improvement;
- effective learning strategies and methods to test and scale up improvements;
- robust primary care teams at the centre of the delivery system;
- engagement of patients in their care and in the design of care;
- promotion of professional cultures that support teamwork, continuous improvement, and patient engagement; and
- more effective integration of care to promote seamless care transitions.

Some leaders added that a key element in any system-wide quality improvement strategy is a commitment to stick to the same strategy over the long term; often, it took a few years before they were able to see measurable results.
ALIGNING THE SYSTEM
Alignment is about getting everyone to move in the same direction. This includes government, dedicated quality agencies, and provincial stakeholders at the system level; regional health authorities and health care organizations at the organizational level; and individual health care providers at the front-line or point-of-care.

One official described an overall provincial strategy as something that everyone else “nestles” into. Others said that the use of tools such as legislation and dedicated quality agencies supports alignment in their health care systems.

“In the past it felt like there was a whole lot of different [system reform] happening. There were accountability agreements. There was public reporting. There were quality improvement initiatives or collaboratives, and the Safer Healthcare Now! campaign. There were pay-for-performance incentives. [These] are all great, but people were feeling pulled in many different directions and that was frustrating for them.”

Several leaders noted that British Columbia, Saskatchewan, and Ontario are taking particularly bold steps to increase the alignment of their health care systems and accelerate quality improvement efforts.

• In British Columbia, the Innovation and Change Agenda supports quality improvement and alignment across the entire health system (see page 30).

• Saskatchewan has invested considerable effort to bring together the Health Quality Council, regional health authorities, the Ministry of Health, the Saskatchewan Cancer Agency, and other health care partners to set quality improvement goals and priorities together—part of their goal to “think and act as one system” (see page 13).

• Ontario passed the new Excellent Care for All Act, part of a broader strategy with the same name (see page 21).

“I’ve been impressed by a very deep and wide alignment in all sub-sectors of the health system on the need for change. [This] is really not something that we have to spend a lot of time on anymore. What is now being discussed, dialogued, and sometimes debated—which is great—is the how of that change, and the who, which is the governance.”

Many leaders described the important role of alignment between the provincial government and regional health authorities (RHAs) and, in Ontario, the Local Health Integration Networks (LHINs).

“We’ve provided the resources and the strategic priority to be able to cultivate the change that we’re looking to on the ground. Any of our regional health authorities will talk about the [provincial] strategies that drove them, and what resources made it possible for them to move forward.”

To achieve strategic alignment, the RHAs/LHINs in some jurisdictions have specific quality agendas and plans, complete with targets and metrics, that align to provincial quality improvement priorities while also reflecting local needs: Vancouver Coastal Health was named as one example. Manitoba also noted that the Regional Health Authorities of Manitoba organization has a health quality, patient safety, and risk management network that supports the work of the RHAs.

Direct alignment with RHAs/LHINs is only a piece of the puzzle. Many leaders spoke about the importance—and the challenge—of pursuing quality improvement initiatives in all sectors of health care, including hospitals (acute care), primary health care, long-term or continuing care, and home care. Their goal is not only better-quality care within each sector of the health care system, but an integrated strategy that includes all sectors and transitions between sectors.

When governments set priorities for quality improvement, this can create a mindset about aligning efforts across the health care system.
Practice. In Ontario, primary care has been selected as the next sector that will be required to submit quality improvement plans as defined in the 2010 Excellent Care for All Act. Quality improvement plans were introduced in 2013 for interprofessional team-based primary care models including family health teams, community health centres, clinics led by nurse practitioners, and Aboriginal health access centres.

In long-term care, Ontario has a Residents First program, focused on improving outcomes for residents of Ontario’s long-term care homes. Saskatchewan prototyped a Releasing Time to Care initiative in long-term care in 2011. Nova Scotia is involved in an initiative related to medication reconciliation and the use of restraints for patients with dementia. British Columbia is focused on standards in personal care homes along with continuous quality improvement. Alberta has developed targeted surveys to support quality improvement in continuing care.

In home and community care, a number of governments—including British Columbia, Manitoba, Newfoundland and Labrador, and Nova Scotia—have included quality as a key element of their respective strategies and plans for the continuing care sector (including both home care and long-term care). BC’s Seniors Action Plan includes initiatives to increase quality and standards of care.

“We’d like to see... [all sectors] have certain common targets that they work on together. For example, ‘Let’s all work together to reduce alternate level of care or readmission rates.’”
System alignment "to think and act as one" quality improvement in Saskatchewan

"For the first time in the 20 years that I've worked in Saskatchewan's health care system we have a collectively owned health system strategic plan. [It is] the expression of discussions involving front-line workers, managers, and the leaders of all the regional health authorities, the cancer agency, the ministry and a number of other organizations, including the Health Quality Council ... [We have transitioned] to a health system plan that says we have to think and act as one."

Saskatchewan is taking a comprehensive approach to system-wide quality improvement with the intent of aligning the system and getting everyone in health care to "think and act as one."

The province has defined its strategic intent with a small set of aims built on the US Institute for Healthcare Improvement's Triple Aim approach (better health, better care, better value), with a fourth aim of better teams.¹⁴

To accomplish these goals, Saskatchewan is the first jurisdiction in Canada to apply Lean methodology as a formal capacity-building approach across its entire health system.

The province uses hoshin kanri, a Lean-based approach to planning that involves identifying a common vision, setting goals, tracking progress towards those goals, and changing direction as required. Using a "top-down and bottom-up" approach, hoshin kanri incorporates feedback from people working at all levels of the system and within a range of organizations. (Japanese terms are common in Lean, as the methodology was developed in Japan.)

Breakthrough projects, called hoshins, are helping to accelerate large-scale change. In Saskatchewan, these hoshins focus on strengthening patient-centred primary health care (primary health care hoshin); patient and staff safety (safety hoshin); and transforming the surgical patient experience (surgical hoshin). The surgical hoshin is being implemented through the Saskatchewan Surgical Initiative (sasksurgery.ca).

Building capacity for quality improvement and measuring results at all levels of the system are other important aspects of Saskatchewan's approach to quality improvement. The province is implementing and evaluating a Lean Management System, with the goal of facilitating change throughout the health care system.

For example, under the Lean Management System, a Provincial Surgical Kaizen Operations Team has been put in place to support the Saskatchewan Surgical Initiative.¹⁶ It includes participation from the health regions, the Ministry of Health, and the Health Quality Council, and provides support to leaders and providers at all levels to help them apply Lean principles.¹⁷

The Health Quality Council also supports the Saskatchewan Surgical Initiative by measuring and reporting on surgical wait times through its Quality Insight performance reporting website (qualityinsight.ca), as well as by sponsoring a working group to help surgeons agree on and use best practices and to address surgical variation where appropriate.

More information on the Saskatchewan Surgical Initiative and other innovative practices is available on the Health Council of Canada's Health Innovation Portal at healthcouncilcanada.ca/innovation.
We also heard about challenges related to the way the health system is currently organized. One leader said that primary care does not fit neatly within the funding and planning of regional health authorities, or is only mildly aligned, and provinces are trying to figure out how to create that alignment. Another leader said that long-term care falls under a ministry or department other than health in their jurisdiction, and they recognized that departmental silos will cause some challenges when they turn their attention to quality improvement in long-term care next year. We also heard about initiatives to reform funding methods, which will help to support system-wide quality improvement.

In the opinion of many leaders, aligning the system across all sectors is the only way to create culture change in health care and lasting momentum for system-wide quality improvement. In some cases, they said there may be a great deal of interest in quality improvement and many people involved, but the efforts will not get far if there are scattered priorities, insufficient resources, and a lack of direction. Alignment is needed to move everyone forward.

DEDICATED QUALITY AGENCIES
Seven Canadian provinces have established a dedicated quality agency to support quality improvement. Many senior leaders said that the existence of this type of agency sends a clear message to the health system and the public that quality improvement is a priority.

Although the quality improvement roles of dedicated quality agencies vary across the seven provinces (See Figure 1, pages 16–17), senior leaders said these agencies shine a light on key issues and help to raise questions about the level of quality in the system.

“Our goal is to help the system to get better, faster results than they would if we didn’t exist.”

Several leaders said that a dedicated quality agency brings a transparent, accountable, and systemic approach to driving change. As one example, the Health Quality Council of Alberta created a Health Quality Network with broad membership that included government, the health authority, and other health care partners; one of its first tasks was to develop a common definition for quality, resulting in the Alberta Quality Matrix for Health.22

Some leaders spoke about the evolution of their dedicated quality agency from an organization that reached out to health care providers, some of whom weren’t interested in or ready for quality improvement, to an agency that is now a valued part of the health care system.

“Our dedicated quality agency has provided some unique opportunities to delve very deep into specific aspects of care and to highlight deficiencies or weakness, and then try to set a new course of action for the government and for the health care system.”
“In 10 years we [dedicated quality agency] have gone from pushing a quality agenda on the system, saying, ‘You need to think about quality and what does improvement look like to you?’ to the health system now saying, ‘This is what quality needs to look like in our health system, and, dedicated quality agency, we need you as a pivotal partner in helping us achieve those ambitions.’”

Research evaluations show that dedicated quality agencies can play an important role in system-wide efforts in Canada.8,23,24 Depending on the province, dedicated quality agencies may:

- **Measure/monitor performance and report on health system outcomes** to governments and the public. For example, the Health Quality Council of Saskatchewan provides ongoing measurement and reporting on health system performance through a publicly accessible website (qualityinsight.ca). Health Quality Ontario and Quebec’s Health and Welfare Commissioner also conduct extensive measuring and public reporting. In addition, the Health Quality Council of Alberta and the New Brunswick Health Council report on patient satisfaction and the care experience.

- **Support continuous quality improvement through capacity-building.** This may include supporting a government’s quality agenda by cultivating leadership and supporting the development of quality improvement capacity through targeted training programs and people who serve as quality improvement facilitators. Dedicated quality agencies with a capacity-building role include Health Quality Ontario, the BC Patient Safety & Quality Council, and the Health Quality Council of Saskatchewan.

- **Engage the public** through activities such as public forums. Examples include the Quebec Health and Welfare Commissioner’s public consultation process, patient safety forums held by the Manitoba Institute for Patient Safety, and the New Brunswick Health Council’s 2012 public dialogue series, Rebuilding Health Together.

- **Collaborate and broker relationships with quality improvement partners.** For example, the BC Patient Safety & Quality Council and the Health Quality Council of Saskatchewan are engaging their stakeholders through social media.

- **Undertake evidence-based assessment** and/or provide advice on clinical standards of care (Health Quality Ontario) and/or drug prescribing practices (Health Quality Council of Saskatchewan) to determine which are necessary or inappropriate based on the evidence.

- **Provide recommendations** to the Minister of Health and conduct studies or investigations. The New Brunswick Health Council and the Health Quality Council of Alberta are examples of dedicated agencies with legislative authority to carry out this role.

- **Identify best practices and share health innovations** through a variety of mechanisms such as conferences, publications, and online portals. All dedicated quality agencies do this.

The existence of a dedicated quality agency sends a clear message to the health system and the public that quality improvement is a priority.
Quality improvement roles

- Collaborate
- Identify best practices and share health innovations
- Engage patients, families, and the public
- Report for accountability
- Measure/monitor performance
- Build capacity
- Undertake evidence-based assessment
- Investigate

**About the figures**

These figures show the quality improvement roles of provincial dedicated quality agencies and pan-Canadian health organizations. This information was identified through interviews with senior leaders of governments and dedicated quality agencies; surveys of ministries/departments of health; and reviews of the literature, strategic plans, and other publicly available documents. Findings were confirmed or updated by these agencies and organizations. The figures do not include information about the quality improvement work of governments that occurs outside of these agencies and organizations.

**Figure 1A** provides a collective view of the quality improvement roles of provincial dedicated quality agencies and pan-Canadian health organizations, highlighting the most- and least-common functions.

**Figure 1B** provides an at-a-glance snapshot of the variation in quality improvement roles among provincial dedicated quality agencies and pan-Canadian health organizations. The figure does not show the extent of each organization or agency’s activities.

- **Collaborate**
  Participation in, or support of, informed dialogue and brokering of relationships among health care system partners for quality improvement and transformational change. Activities may include hosting forums for knowledge exchange, and organizing quality/quality improvement networks, collaboratives, or partnerships with governments, organizations, or individuals in the jurisdiction, country, or internationally.

- **Engage patients, families and the public**
  The active engagement of patients, families, and the wider public to provide input into health planning, reporting, and delivery, and/or to support citizens to become more informed, active participants in their care. Activities may include hosting public

- **Identify best practices and share health innovations**
  The promotion, dissemination, or exchange of information about innovative programs or initiatives that have brought about an improvement in patient safety or other dimensions of quality. This may be achieved through a variety of mechanisms such as conferences, publications, or online portals. Best practices may also be shared within jurisdictions, across Canada, or internationally.
FIGURE 1B: MANY PLAYERS, DIFFERENT ROLES
An at-a-glance snapshot of quality improvement roles of dedicated quality agencies and pan-Canadian health organizations

Dedicated quality agencies
1 British Columbia Patient Safety & Quality Council
2 Health Quality Council of Alberta
3 Health Quality Council of Saskatchewan
4 Manitoba Institute for Patient Safety
5 Health Quality Ontario
6 Health and Wellness Commissioner (Quebec)
7 New Brunswick Health Council

Selected pan-Canadian health organizations
8 Accreditation Canada
9 Canadian Agency for Drugs and Technologies in Health
10 Canadian Foundation for Healthcare Improvement
11 Canadian Institute for Health Information
12 Canadian Partnership Against Cancer
13 Canadian Patient Safety Institute
14 Health Council of Canada
15 Institute for Safe Medication Practices Canada
16 Mental Health Commission of Canada

- Measure/monitor performance
  The assessment of performance and/or the degree to which health care system quality meets specific standards, benchmarks, or targets. Activities may include the identification of performance indicators, the establishment of targets, and the collection or assessment of data regarding patient safety and quality of health services, processes and outcomes of care, population health, experience of care, and/or satisfaction.

- Build capacity
  The development of quality improvement capabilities and expertise in individuals and organizations. Activities may include delivering education or training programs that foster knowledge of quality improvement methodologies or change management theories, organizing knowledge exchange networks, supporting initiatives to cultivate leadership, and project management.

- Investigate
  Conducting retrospective evaluations of critical incidents, complaints, or issues related to poor safety or other dimensions of quality. Investigative activities may be undertaken upon the request of government (or be self-initiated) to assess the adequacy of current practice and to make recommendations for improvement.
Three provinces—Nova Scotia, Prince Edward Island, and Newfoundland and Labrador—do not have dedicated quality agencies. When asked why they had not established agencies in their jurisdictions, one senior leader said doing so would be costly, given competing priorities. Another leader noted that the government is monitoring the experience of provinces with dedicated quality agencies before they would consider one of their own. Some replied that they had created provincial quality and patient safety committees (or the equivalent) and did not need to create a separate organization to collaborate with improvement groups. They specifically identified the Nova Scotia Quality & Patient Safety Advisory Committee, the Newfoundland and Labrador Vice-Presidents of Quality and Patient Safety Advisory Committee, and Health PEI’s Quality and Safety Council. The Atlantic provinces are also participating in the Atlantic Health Quality and Patient Safety Collaborative to support their quality improvement work. Leaders indicated these structures are supporting change throughout their provinces.

Various pan-Canadian organizations also play supportive roles in quality improvement as part of their broader mandates. Senior leaders pointed to Accreditation Canada’s role in accrediting health care organizations and regional health authorities, and several spoke of their participation in the Canadian Patient Safety Institute’s (CPSI) initiatives, including ongoing involvement in Safer Healthcare Now!

CPSI is also a key partner in the Atlantic Health Quality and Patient Safety Collaborative, in which all four Atlantic provinces participate. In 2012, the Canadian Foundation for Healthcare Improvement (CFHI) and the regional health authorities in the Atlantic provinces announced the creation of an Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease. CFHI also runs the Executive Training for Research Application (EXTRA) program, providing leaders with training in better management and use of evidence for quality improvement.

The Canadian Institute for Health Information (CIHI), which plays an important role in data collection, measurement, and reporting on health care system performance across Canada, was also mentioned by senior leaders. One described the efforts of his jurisdiction to reduce duplication by coordinating provincial performance measurement efforts with CIHI’s work.
Provinces also look to initiatives of the Canadian Agency for Drugs and Technologies in Health for guidance, such as the common drug review and associated formulary listing recommendations for Canada’s publicly funded drug plans. The Canadian Partnership Against Cancer also contributes to quality improvement through a number of its pan-Canadian initiatives, such as the development of a set of indicators to measure and report on the performance of the cancer control system. Health system leaders also identified a range of organizations and collaboratives—local, regional, national, and international—with which they share, learn, and participate as part of their quality improvement activities (see Appendix B, page 38).

**LEGISLATION**

Several health system leaders said that legislation is an important tool for quality improvement for two main reasons: It sends a very clear message about the priorities and expectations the government has for quality improvement, and it helps to bring about alignment in the system. Legislation is not the only way to do this, but it does communicate that all the players in the system must work together.

“As the ultimate instrument of governing, legislation provides that very clear signal that this is very important to a government and to its citizens. It can lay out the constructs of what equals a high-functioning quality system, and it identifies for citizens what should be a vision and an expectation from the health care system and from its government and health care providers.”

Health system leaders noted that legislation can be used in a number of different ways to support quality improvement. In five of the seven provinces with dedicated quality agencies, senior leaders have used legislation to establish the agency’s mandate and independence, and to send a message that the government is serious about quality improvement:

- Alberta: *Health Quality Council of Alberta Act*[^31]
- Saskatchewan: *Health Quality Council Act*[^32]
- Ontario: *Commitment to the Future of Medicare Act*, *Excellent Care for All Act*[^33]
- Quebec: *An Act Respecting the Health and Welfare Commissioner*[^35]
- New Brunswick: *New Brunswick Health Council Act*[^36]

Each province’s legislation differs, sometimes significantly. For example, only the *Health Quality Council of Alberta Act* provides the authority to establish a public inquiry. The lieutenant governor in council sets out the nature and scope of an inquiry, and the board of the Health Quality Council of Alberta appoints a panel to conduct the inquiry and provide administrative support. Ontario’s *Excellent Care for All Act* was also cited as broader, overarching legislation that expands the role of Health Quality Ontario and provides direction and support for quality improvement by health care organizations.

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[^31]: Alberta: *Health Quality Council of Alberta Act*
[^32]: Saskatchewan: *Health Quality Council Act*
[^33]: Ontario: *Commitment to the Future of Medicare Act*, *Excellent Care for All Act*
[^35]: Quebec: *An Act Respecting the Health and Welfare Commissioner*
[^36]: New Brunswick: *New Brunswick Health Council Act*
“Legislation really lays the groundwork or the foundation for a more unified commitment by everybody in the sector—something they can get behind because the government has put it out there as a bit of a beacon, and it also provides a bit of a shared vision.”

In British Columbia and Manitoba, dedicated quality agencies were not established by legislation. Generally, this was not seen as a gap. One leader said that not having legislation is reasonable “in keeping with its role as a partner in the system rather than an auditor.”

According to some leaders, another type of legislation that helps to support quality improvement is focused on the role of regional health authorities. British Columbia and Saskatchewan were identified as examples; in these provinces, regional health authorities are required to align their work with the overall provincial strategies, which health system leaders said helps to increase the focus on quality improvement across the system and produce the kinds of outcomes that are expected. Regional health authority legislation in Manitoba requires that all regional health authorities be accredited and post their reports publicly.

“If you take a look through [regional health authority legislation], it actually allows the minister to direct health authority boards [to] set their strategic plans ... and their budgets ... to be able to drive a kind of a particular direction.”

Interviews and surveys for this report focused on legislation to enable dedicated quality agencies, but there is other significant legislation and policy related to the reporting of patient safety events, the protection of privacy of personal information, disclosure to patients, and the review of adverse events. These are also important elements of a system-level approach to quality improvement. Two examples provided for this report include Nova Scotia’s 2012 Patient Safety Act, which requires public reporting of patient safety quality indicators such as hand hygiene rates, and legislation in Manitoba which enables no-blame critical incident reporting to support a culture of openness when addressing patient safety issues.

Senior leaders also mentioned legislation that requires provincial health professional regulatory bodies to develop and implement mandatory quality assurance programs (e.g., as in Newfoundland and Labrador), as well as legislation that gives patients and families a defined complaints mechanism for identifying quality issues (e.g., British Columbia’s Patient Care Quality Review Board Act). They said that both types of legislation support quality improvement efforts.

In several provinces, regional health authorities are required to align their work with overall provincial strategies.
"A huge culture shift:" Ontario's Excellent Care for All Act

"The primary driver of culture change in Ontario was certainly the legislation because this is going to be universal, and because it was backed with the creation of a body that was to give support to it. The legislation is not just hospital-focused. Every organization that delivers health care services will have to do quality planning. That’s a huge culture shift."

Ontario’s Excellent Care for All Act (ECFAA), enacted in 2010, is the first step in implementation of the province’s Excellent Care for All Strategy, designed to improve the quality of patients’ experience and deliver evidence-based health care." The strategy focuses on aligning health care sectors to improve measurement and accountability among service providers, and embedding a culture of evidence-based care.

The ECFAA supports a shift towards a system-level approach to quality improvement in Ontario by requiring a set of commitments from health care providers and organizations. They are required to:

- establish quality committees that report to the organization’s board on quality-related issues;
- produce annual quality improvement plans (QIPs) with clear indicators and targets, and make those plans available to the public;
- link executive compensation to the achievement of targets outlined in annual QIPs;
- establish evaluation protocols, such as patient/provider satisfaction surveys;
- ensure that a declaration of values is developed following public consultation; and
- establish a process to address and improve the patient experience.518

Hospitals were the first health care organizations required to implement the legislation. Under the ECFAA, every hospital is required to submit an annual quality improvement plan based on areas of focus, priorities, and measures outlined by the Ministry of Health. The quality improvement plan is a key tool that enables health care organizations in a sector to develop and achieve quality improvement objectives in a standardized manner.

Primary health care is next. Quality improvement plans were introduced in 2013 for interprofessional team-based primary care models, including family health teams, community health centres, clinics led by nurse practitioners, and Aboriginal health access centres. The province’s long-range goal is to incorporate all health care sectors, including long-term care and home care, so that quality improvement planning becomes system-wide across Ontario.

The Excellent Care for All Act also expanded the role of the province’s quality council, merging five programs and organizations into a new dedicated quality agency, Health Quality Ontario (HQO). HQO is mandated to support the implementation of the act. For example, the agency has developed an online resource (iMap) to help organizations develop and evaluate their annual quality improvement plans. HQO analyzes all the plans submitted each year and uses the findings to highlight leading organizations and practices, as well as to identify key challenges and provide guidance for future improvement.

Under the ECFAA, Health Quality Ontario also has a role in advancing evidence-based care. The agency can recommend the adoption of clinical practice guidelines or other evidence-based standards of care, and it can recommend whether health care interventions (new or existing) should be funded, to ensure practices are consistent with the best evidence.526
We’re talking about a significant culture shift in how we need to work, and at a system level people are exposed to information they [have] never seen before. It’s a multifaceted kind of challenge, but a great opportunity because the momentum tends to be building in the right direction.”
KEY FACTORS IN SYSTEM-WIDE QUALITY IMPROVEMENT

Current efforts in system-wide quality improvement across Canada are built on research and analysis of factors that lead to success (see Learning from other countries, page 10). When senior leaders were discussing key factors in their system-wide efforts, we heard most about the importance of:

- strong and committed government leadership and continued oversight;
- clinical champions, including physicians;
- building capacity to support quality improvement efforts across the system;
- measuring and setting targets for accountability;
- focusing on evidence-informed care; and
- engaging patients and families in quality improvement efforts.

Senior leaders discussed why these consistent factors make a significant difference to quality improvement, and shared their experiences with efforts in their jurisdictions to put these factors in place.

LEADERSHIP

Leadership at all levels of the system is critical for successful quality improvement. Health system leaders discussed the importance of commitment, buy-in, and oversight by ministers of health and senior government officials as well as senior executives, boards, and clinical champions in regional health authorities, hospitals, and other health organizations. Buy-in was described as recognizing the importance of quality improvement as well as understanding what they need to do to make it happen over the long term.

“[Most] front-line people in health care have never been trained in quality improvement. They don’t really truly understand it, so we have a whole generation of people that need to be trained. In order to do that you need committed resources to train them, and you need leadership to say, ‘We absolutely know what we need to accomplish. We know the steps in order to get there. We know what we need to build.’ So often for me it comes down to [whether] leadership has a clear vision, a clear pathway. Does it make sense? Is it doable?”

Many leaders talked about the need to change the health care culture to one in which people understand that quality improvement is ongoing and is part of their everyday work. Several stressed that it is important for leaders to set priorities and a clear direction for quality improvement initiatives to avoid change fatigue and burnout, which one described as “death by a thousand different improvement approaches.”

“Everybody is so busy doing what they’re doing. No one seems to be aware that as a system we’re not addressing what we want to be addressing. We’re not making the progress where we want to be making that progress. So culture change is required to get that discipline into our management—that change management capacity.”
Senior leaders told us that sometimes there is a lack of understanding at the senior level about what needs to be put in place to stimulate culture change and support the work of providers trying to implement quality improvement activities. One said that developing leaders with change management skills who could lead culture change was a “big, big hurdle;” another said that front-line (point-of-care) staff were sometimes ready to move ahead with quality improvement before senior management.

“We saw many examples where teams became quite frustrated because they weren’t being supported in the ways they needed to be, but I think it just came down to knowledge and understanding and experience about what it means to actually support this kind of work.”

Several leaders noted that it is important to foster a “bottom-led, top-enabled” approach. Doing so builds on front-line expertise, while leadership involvement contributes to broader culture change. This is a form of leadership that enables, rather than directs, change; many leaders need to learn how to do this. British Columbia and Saskatchewan noted the success they have had with leadership training and engagement resources such as the Quality Academy (BC) and the Quality as a Business Strategy Leadership Learning Collaborative (Saskatchewan).

Health system leaders stressed the importance of physician leadership. Clinical leaders or champions combine enthusiasm with clinical credibility and command respect from colleagues. Many leaders said that engaging physicians in quality improvement was a significant challenge in their jurisdictions.

“I would never say that physicians aren’t interested or wanting to be engaged. Every high-performing system has very visible and broad physician leadership and presence as part of their transformation, and I think it’s not been easy to date. Structurally we don’t make it easy for that to happen, and that’s going to require a very different way of working.”

“I think the big barriers [are] around fully engaged clinical teams who take responsibility for their own performance. If we can get the system to that level, that would be amazing.”

When provinces are able to involve clinicians, particularly physicians, in quality improvement efforts, further success followed. Saskatchewan’s work in quality improvement training for leadership among primary care physicians and nurses was offered as an example, as was the work of the Clinical Care Management program in British Columbia. In that program, physicians and other health professionals have leadership roles in each of the areas where the province is supporting evidence-based change.

The senior leaders we interviewed also spoke about the importance of building relationships with other health care leaders in all levels of their systems: government, health care organizations, and the front-line or point-of-care. Some said they were successful in creating a commitment to quality improvement among senior system leaders through activities such as monthly meetings between the deputy minister and the CEOs of key health organizations, through quality advisory committees or quality improvement teams, and by involving high-profile researchers and health system leaders to help support governments and stakeholders in their approaches to improvement and change.
**MEASUREMENT, TARGETS, AND ACCOUNTABILITY**

Governments and organizations need reliable data, valid health indicators, defined targets, and regular and timely measurement to support quality improvement. Public reporting of the performance of the health care system in meeting—or not meeting—targets means that governments and organizations are required to be transparent, and are held accountable for results.1,47,48

“There’s measurement for research. There’s measurement for accountability, and there’s measurement for learning and improvement, and certainly our [dedicated quality agency] contribution is helping build the metrics and the information, the skills for learning and improvement. It’s not an either/or by any means. You need all of these domains to understand and improve your health system.”

Senior leaders in all provinces said that establishing and collecting data was an important lever and facilitator of quality improvement—and a challenge for most of them. In particular, the lack of good-quality data and real-time clinical data were identified as ongoing challenges, particularly in primary health care.

“A key success factor was setting up measurement. It wasn’t elegant and nor is it today, but it was crude and quick and we managed to initiate, and we are massaging it as we move forward.”

One leader said it is important to continue collecting data to sustain improvements that have been identified and implemented; otherwise these can fall by the wayside when attention is diverted to something else. Another talked about the stumbling blocks caused by a lack of electronic health records to share information to inform quality improvement.

**COMMON CHALLENGES TO SUCCESS**

Senior leaders have identified challenges to ensuring quality improvement is maintained as a core part of their transformation efforts. The challenges, which were similar across many jurisdictions, include:

- insufficient capacity-building and culture-change initiatives;
- difficulty in spreading good practices and quality improvement work throughout the health care system;
- limited physician leadership or support for quality improvement;
- a lack of funding for quality improvement efforts;
- a lack of focused priorities;
- a lack of data to measure quality improvement efforts; and
- change fatigue and exhaustion among health care providers.

Many leaders said that engaging physicians in quality improvement was a significant challenge in their jurisdictions.
“The ability to have data around key process indicators as well as good outcome data is a significant issue for us, and [the lack of] linkages between electronic health records, between GP offices, and between the health authorities and things like that. How we actually have information in a timely way around quality indicators to drive real-time improvement is a significant challenge.”

Senior leaders also talked about the critical importance of measurement and reporting to define what needs to be improved, and to track progress of quality improvement efforts over time. Some senior leaders described the need for cascading approaches to reflect their efforts to align measurement and reporting up and down the system. They stressed the importance of setting targets, including global targets for quality at the system level.

Several leaders said they were taking steps to set global targets for improvement on some key metrics. We learned about numerous initiatives to develop sets of health indicators, including plans to develop a standard Atlantic Balanced Scorecard to be used by members of the Atlantic Health Quality and Patient Safety Collaborative.

Health system leaders also discussed the political nature of some quality improvement targets and the effect of this on overall efforts. One leader described how high-profile initiatives and the need to meet associated targets can distract people from other quality improvement activities, particularly if they lack a health system culture that understands and supports continuous quality improvement. Another leader voiced concerns about the politicized nature of the government bureaucracy in health care and about the effect of this on setting and achieving targets.

“I’m not a huge fan of benchmarks and targets because I think fundamentally while it’s necessary to measure, when we’re measuring for benchmarks and for accountability at a government level we’re often driving people to reach targets [and they might] make the data look better than it really is.”

“When you have a culture that’s very mobilized towards a political agenda, [it] tends to react on an ongoing basis. It makes it very difficult to have the level of sustained focus required to either identify the targets, communicate why we need to hit those targets, [and support] what will move people towards those targets. Quite fundamentally, it makes it difficult for proper change management to occur.”

Some leaders said the way they use data and measurement has evolved over time. Initially, the key emphasis was on using data, health indicators, and reporting to identify quality gaps and set priorities for quality improvement. This allowed the jurisdiction to establish a quantitative baseline of health care quality at a point in time.

After the baseline had been established, several leaders said their focus moved to measurement, reporting, and gathering information that allowed health care providers to determine whether a change was an improvement, and to follow up on poor performance. Saskatchewan’s Quality Insight website (qualityinsight.ca) was identified as a leading example of measurement and reporting for quality improvement.
Which way to quality?

Quality improvement requires knowledge of quality improvement science such as Plan-Do-Study-Act cycles and/or methodologies such as Lean Six Sigma, adapted from the manufacturing sector. Building the capacity for quality improvement may also include creating coaching and mentoring opportunities, using learning collaboratives, and using networks to support their efforts.

“We don’t have the skills in the system to improve. We don’t have the change management; we don’t have quality improvement skills, so people may want to do that, but they don’t know actually how to fix things.”

“How do you really get your front-line people to realize that quality improvement in patient safety is part of their work? It’s not an add-on. It’s for the patient or patient group or residents that are in front of you, and that’s a hard place to get to.”

Providing the training and support needed to build both capacity and capabilities helps health care workers put quality improvement theory into action, and cultivates leaders. Some leaders noted that it is important to have specific capacity-building initiatives for physicians.

“Just being a great clinician isn’t sufficient anymore. You need to be a great clinician, and you need to be skilled and able to facilitate and do continuous improvement and understand improvement science to daily improve your work.”

Provisioning the training and support needed to build both capacity and capabilities helps health care workers put quality improvement theory into action.
Capacity-building takes place in a variety of ways across the provinces. In some cases, a dedicated quality agency delivers the programs. In others, the government sponsors the training. Sometimes capacity-building is the responsibility of the regional health authority or a health organization.

Across Canada, different priorities have been placed on capacity-building. In our conversations with senior leaders, some said they had a capacity-building strategy in their system-wide approaches to quality improvement, while others did not mention capacity-building at all.

“You can do templates that help to guide the planning. You can support the planning with best practice information and so on. All of that is important, but you’ve got to be able to provide support to actually do it on the ground. We have to be able to train enough people at the organizational levels to be able to do the support for the actual implementation of the quality goals because it’s not a one-shot thing. It’s continuous.”

Some of the province-wide initiatives identified by senior leaders include the BC Patient Safety & Quality Council’s Quality Academy, a six-month professional development program which trains participants to lead quality and safety initiatives; the Improving and Driving Excellence Across Sectors (IDEAS) strategy in Ontario, slated for launch in fall 2013, which builds on the Intermountain Healthcare Advanced Training Program model; and Saskatchewan’s Lean Management System approach, with plans to train and certify health system leaders in Lean principles and methodology.

Manitoba and Prince Edward Island are also using Lean Six Sigma strategies to support their capacity-building. Leaders from Manitoba noted that their original objective was a return of $4.1 million on a training investment of $1.15 million, and the province has already surpassed this savings goal.

“You’ve got to build quality improvement capacity. You’ve got to have armies of people out there who understand Lean Six Sigma or process improvement or Plan-Do-Study-Act cycles or rapid cycle improvement or who really can understand and pick apart a system. That’s been a huge weakness, and a big part of our activities over the years is trying to foster the development of that.”

EVIDENCE-INFORMED CARE

Many jurisdictions are working to ensure that care is effective and appropriate. The Institute of Medicine defines concerns related to quality and appropriateness as those that include overuse (providing treatment of no value, based on evidence, or providing a health care service in circumstances where its potential for harm exceeds its benefit); underuse (failing to provide needed evidence-based treatment); or misuse (errors and defects in treatment). To address these concerns, some senior leaders said there is a growing emphasis on evidence-informed care in their system-wide approaches to quality improvement.

“We’re trying to strengthen the evidence base about what works and what doesn’t to improve quality, and that’s like a second pillar of our work.”

“The ministry has asked us to [work] on identifying inappropriateness in the system, and right now for the first time we’re going through a laundry list of different services or procedures or lab tests where under certain circumstances, according to the evidence, it has no value. We can make recommendations about how to eliminate those.”
Senior leaders noted that the end goal of this work is ensuring that evidence and knowledge are properly evaluated before a government agrees to adopt and fund new clinical practices or technologies—or continues to fund existing ones.

Evidence-based assessment activities by Health Quality Ontario (which they call evidence-based analysis), as well as an initiative to update the health technology decision process in Alberta, were given as examples of work to support efforts towards achieving more appropriate care. A number of leaders mentioned their jurisdictions’ work in health technology assessment (HTA), which contributes to the quality and appropriateness of care and also to finding efficiencies in the system. There is considerable HTA being done across the country. Senior leaders mentioned the Canadian Agency for Drugs and Technologies in Health as an organization with which they share information and learn about health technology assessment. Quebec’s Institut national d’excellence en santé et en services sociaux also does similar work. As well, we heard that a number of jurisdictions are collaborating to share some of this work as part of the larger activities of the Council of the Federation’s Health Care Innovation Working Group.

“Any decisions about patients should be driven by the best evidence and standards. That’s a really key plank for us. The system is really now focused on the quality of care and the best use of resources because there is evidence to drive change by stopping what doesn’t need to be done based on sound evidence, and doing things that aren’t being done based on sound evidence.”

Some leaders also described their jurisdictions’ plans and current efforts to increase the standardization of the clinical care provided to patients, which can improve its reliability and effectiveness across the system. They named recently initiated approaches such as the Clinical Care Management program in British Columbia (see page 30) and Strategic Clinical Networks in Alberta. These networks are the mechanism for collaboration used by Alberta Health Services to develop and implement health improvement strategies that are evidence-informed, led by clinicians, and delivered by teams.

“The concept of [Strategic Clinical Networks], I think, is probably the right one when you’re dealing in as big a playing field as an entire province. It’s almost like a program-based model of delivery where you get a group of health care professionals, largely physicians—but not exclusively—together to talk about how they can systematically standardize the care for important populations of patients, and how they can measure that, and then how they can start, through standardization, to make improvements to the care.”

We also heard that it is not sufficient to simply choose the best practice and implement it. Governments and their stakeholders also need to develop evidence-informed strategies, promote the uptake of practices, evaluate their impact, and ensure their long-term sustainability.

“Once you develop the clinical pathway as to what is appropriate, how do you provide that information to all clinicians so that they understand whether they’re practising the pathway or not? And if they’re not, what evidence do they have to support why they’re doing something that may be out of the boundaries of it?”

“Any decisions about patients should be driven by the best evidence and standards. That’s a really key plank for us.”
Supporting system-wide quality improvement in BC

"The overall objective of the [Innovation and Change] agenda is really to bend the cost curve while maintaining quality and access and all of those kinds of things. [One initiative aligning with the agenda is] clinical care management, which is about trying to implement best practice protocols system-wide across BC in a consistent manner, and measuring implementation progress as well as outcomes."

In British Columbia, a strategy called the Innovation and Change Agenda supports quality improvement across the entire health system and identifies four high-level goals:

- effective health promotion, prevention, and self-management;
- high-quality community-based health care and support services;
- access to high-quality hospital services; and
- improved innovation, productivity, and efficiency in the delivery of health services.

Numerous quality improvement initiatives at the provider level are being designed to align with these strategic goals. One example is the Clinical Care Management (CCM) program, which aligns with the agenda’s goal of access to high-quality hospital services. The purpose of the CCM initiative is to implement an evidence-based guideline-driven clinical care management system to improve the quality, safety, and consistency of key clinical services and patients’ experiences of care. It is a ground-up initiative, driven by clinicians, to improve the quality of care in specific areas and to ensure provincial implementation and standardization of best practices. To date, clinical care guidelines have been developed for 11 clinical care areas, along with indicators to measure improvement and principles for setting targets.

The Clinical Care Management program has been designed as a province-wide quality improvement effort involving collaboration among BC’s Ministry of Health, regional health authorities, the BC Patient Safety & Quality Council, and 11 clinical expert groups (one for each care area). It provides a provincial forum for each clinical care area, connecting physicians, nurses, pharmacists, and infection control specialists with provincial decision-makers and quality improvement supports. Each clinical care area has a provincial quality lead at the council to speak on behalf of the clinical expert group that champions the implementation of guideline-driven care in a specific care area.

The role of the BC Patient Safety & Quality Council is to support implementation across the health care system, including engaging clinicians and other health professionals and working with each of the 11 clinical expert groups. As an independent, impartial organization, it can facilitate open discussions with clinical experts and then carry that information forward to the BC Ministry of Health to support province-wide implementation. The BC Patient Safety & Quality Council is viewed as the necessary linchpin between the CCM clinical expert groups and the BC Ministry of Health because of the council’s expertise in change management, communications, and engagement.

More information about the Clinical Care Management program and other innovative practices is available on the Health Council of Canada’s Health Innovation Portal at healthcouncilcanada.ca/innovation.
PATIENT AND FAMILY ENGAGEMENT

Many leaders said that patient and family involvement was an important part of their system-wide approach to quality improvement, while others said they have not moved as far ahead in this area as they would like.

One senior leader said that health care leaders in his province had not “evolved to the point of seeing the true value of engaging patients.” In contrast, a leader in Saskatchewan shared information about the 2009 Patient First Review, which provided health care leaders with a much-needed wake-up call about the patient and family perspective of health care, as well as a “dose of humility.”

“The Patient First Review really gave the clinical and administrative leaders that sobering reality that what we think is quality health care is [only] what we think is quality health care. Unless you ask those who actually receive the service and get their input into it, you are limited in your expression of what patient-centred care really looks like. The Patient First Review was that catalyst that said, “Wow, we thought we were doing a pretty good job, but”... When you really listen and listen carefully to the voice of those that you serve, you’ve got a heck of a lot of work to do.”

“When you’ve had [the involvement of] a patient—a real patient, someone who’s been through the service—they’re informing your improvement work. That’s gold. In terms of success factors that’s probably the biggest difference that we’ve had.”

It’s important to note that there are two types of patient engagement: the type that happens at the front-line or point-of-care between a patient and health provider, and patient and family engagement at the organizational or health system level.

Some leaders specifically identified ways they are engaging patients at this broader level, often by working with them to determine priorities and listening to what they need through mechanisms such as patient experience surveys, patient representatives on specific initiatives, broader patient advisory councils, and public forums that incorporate patients’ perspectives and priorities into quality improvement planning.

Leaders in Saskatchewan described the province’s efforts to embed patient and family engagement in its health system quality improvement activities; other examples are Alberta’s Patient/Family Safety Advisory Panel and British Columbia’s Patient Voices Network. Some of these approaches are discussed in the Health Council of Canada’s 2011 report on patient engagement.

A number of leaders also noted that using patient stories to start meetings has been a successful strategy to help health providers understand the significance of their quality improvement work.

“Even a few years ago it was sort of scary to think that you’d actually go and open yourselves up to hearing people who have stories. There are bad stories out there, but it’s a way of acknowledging that things don’t always go right, but some things go really well. We need to talk about it and as the public be able to talk about that.”

Saskatchewan’s Patient First Review provided a wake-up call about the patient and family perspective, as well as a “dose of humility.”
If there’s an evidence-based change that developed in [another region or province], why do we have to reinvent the wheel here and restudy that? If we wish to adopt it, and if the evidence is there, we should adopt it, and vice versa.”
SHARING AND SPREADING SUCCESSFUL PRACTICES

There are many quality improvement initiatives and methodologies in use in Canada. Many jurisdictions are looking to others to learn more, build on their successes, and adapt successful practices to the local context. Senior leaders were asked to identify programs or initiatives they believe are examples of the success of their system-wide quality improvement efforts (see Appendix A, page 36).

Many leaders said they were experiencing challenges in spreading good practices across their provinces. One noted that a positive experience with a single or regional initiative was a catalyst for expanding it more widely.

Health system leaders in Saskatchewan and British Columbia said they are now approaching the spread of good practices with the idea of starting with prototypes or model lines that will be subject to small tests of change and will evolve, instead of using an all-or-nothing approach with a pilot study. And the Atlantic Health Quality and Patient Safety Collaborative is involved in a multi-year project with the Canadian Patient Safety Institute to look at sustainability and spread.

“We all know it takes 15 to 20 years for best practices to be adopted into mainstream practice, for a whole variety of reasons ranging from they didn’t know that’s what they were supposed to do, or were so rushed that they ran out of time. The way care has been designed doesn’t make it easy for people to do the right thing at the right time, so brokering improvement [means] using quality improvement methodologies, and spreading them through the system as quickly as possible so that we can accelerate the update of best practices.”

Several senior leaders questioned the amount of duplication and said it did not make sense to keep reinventing the wheel by creating similar programs. We heard that there is increasing collaboration among provinces, including the current work of the Council of the Federation’s Health Care Innovation Working Group and discussions among dedicated quality agencies about sharing work and learning about each other’s quality improvement initiatives. However, evaluation of these approaches is still in the early stages, and the lack of a comprehensive platform to share information across Canada about innovative quality improvement practices is an issue. The Health Council of Canada’s Health Innovation Portal, launched in 2012, is intended to help fill this gap.

SHARING PRACTICES THROUGH THE HEALTH INNOVATION PORTAL

In the fall of 2012, the Health Council of Canada launched a new Health Innovation Portal to provide health system leaders, managers, and providers with information on innovative health care practices, policies, programs, and services.

The Health Council’s goal is to support the identification, sharing, and spread of innovative practices that have been demonstrated to strengthen Canada’s health care system. The Health Council developed an Innovative Practices Evaluation Framework that is used to categorize practices as emerging, promising, or leading.

New practices are posted regularly. Bookmark the Health Innovation Portal as a resource for innovative programs and practices in quality improvement and other health care themes (healthcouncilcanada.ca/innovation).
CONCLUDING COMMENTS

“I’ve always been curious as to why the provinces can’t get more alignment on a vision of what to improve and how to do it. We’re not that big a country to be having 13 different strategies on how to improve health care.”

In this report, we have presented what we learned from health system leaders about approaches, success factors, and challenges for quality improvement across Canada’s health care systems.

Some health system leaders described a narrow focus on specific issues or quality improvement initiatives, while others clearly had strong provincial leadership overseeing broad health system transformation, including integration, system alignment, and culture change. They do not see quality improvement as a separate stream of work—it is an integral part of what is needed to move their health systems forward.

We also heard that some governments have a strong focus on finding efficiencies and cost savings through their approaches to quality improvement, with the goal of reinvesting these savings back into the system.

There were different opinions about the value of taking unique approaches to quality improvement in each province or territory. Some senior leaders thought it was appropriate to tailor their quality improvement approaches to their regional needs, while others thought provinces and territories should learn more about each other’s successes and adapt them, rather than reinvent the wheel with their own approaches. It was clear that there is no agreement on the best options for system-wide approaches for quality improvement, and little evaluation to date of Canadian efforts, which would provide some further insight.

Most provinces are looking to others to learn more about ways to overcome their challenges, build on their successes, and adapt innovative practices to their local contexts. At the same time, health system leaders in many jurisdictions implied that their particular approach to quality improvement was the right one. As there are different contexts and challenges across Canada, there is certainly room for different approaches to quality improvement, as long as governments are asking themselves the following fundamental questions:

• Have we set a policy direction and developed a system-wide strategy for quality improvement?

• Are we confident that we are applying the best possible approaches? Do we know enough about other quality improvement approaches in Canada and internationally to make that assessment? Are we evaluating our approaches?

• Does our quality improvement approach cover all sectors of the health care system?
• Who are the quality improvement leaders and do we have a plan to develop leadership at all levels of the system—governmental, organizational, and clinical?

• Is capacity-building a core part of our approach to quality improvement, both to develop leaders and train providers in quality improvement methodology?

• Have we set targets? How are we measuring for success? Are we getting good results?

• Who is accountable for quality improvement at the provincial and regional levels? Who is accountable for each component of the plan?

Although every jurisdiction should be asking those questions, we should also be asking them collectively as a country.

We believe there are many lost opportunities because of the lack of alignment and collaboration among provinces in their health care quality improvement efforts, although this is beginning to change. There are several new initiatives in Canada to facilitate this kind of collaboration in health care, including the Council of the Federation’s Health Care Innovation Working Group.

The Health Council believes that it is time for Canada’s senior leaders to come together to establish common and measurable goals for quality improvement. Doing so will help to focus everyone’s efforts on improving the performance of our health systems across Canada. If we make better use of our collective knowledge, energy, and activity, we can vastly improve the quality of health care delivered to Canadians. This is what they expect—and this is what the health system is charged to deliver.

**It is time for Canada’s** senior leaders to come together to establish common and measurable goals for quality improvement.
APPENDIX A

INNOVATIVE QUALITY IMPROVEMENT INITIATIVES IDENTIFIED BY SENIOR LEADERS

The following list presents senior leaders’ answers to the question, “What current innovative quality improvement practices/initiatives in your province or territory illustrate the successes of your system-level approach/strategy?” Selected practices are profiled in more detail on the Health Council of Canada’s Health Innovation Portal (healthcouncilcanada.ca/innovation).

BRITISH COLUMBIA

• Clinical Care Management Program
• National Surgical Quality Improvement Program
• Divisions of Family Practice
• Practice Support Program
• Physician Quality Assurance Action Plan
• British Columbia Patient Safety & Learning System (adverse event reporting tool)
• Patient Care Quality Review Boards
• Patient Voices Network
• Evidence 2 Excellence
• BC Patient Safety & Quality Council: Quality Academy
• BC Patient Safety & Quality Council: BC Health Quality Network

ALBERTA

• Strategic Clinical Networks
• update of the Alberta Health Technology Decision Process
• estimated emergency department wait times online
• Primary Care Networks
• Alberta AIM (Access. Improvement. Measures.)
• Alberta Health Services Improvement Way
• Health Quality Council of Alberta (HQCA): quality assurance reviews, systematic systems analysis methodology
• HQCA: Patient Safety Framework for Albertans
• HQCA: population-based surveys on satisfaction and experience with the health care system

SASKATCHEWAN

• hoshin kanri
• Lean Management System
• Saskatchewan Surgical Initiative, and the Variation and Appropriateness Working Group
• Health Quality Council (HQC): Quality Insight Online (qualityinsight.ca)
• HQC: Clinical Practice Redesign initiative, and the Transform My Practice web application
• HQC: Releasing Time to Care
• HQC: Quality as a Business Strategy (QBS) and QBS Leadership Learning Collaborative
• HQC/University of Saskatchewan: Research Chair in Health Quality Improvement Sciences

MANITOBA

• Pursuing Excellence initiative:
  - Lean Six Sigma Strategy
  - Releasing Time to Care
  - Advanced Access
• Physician Integrated Network
• Cancer Patient Journey Strategy
• Manitoba Institute for Patient Safety: Self-Advocacy for Everyone (SAFE) tool kit
• public patient safety forums
• participation in Safer Healthcare Now! interventions

ONTARIO

• Excellent Care for All Act
• Quality improvement plans: hospital sector, primary care
• patient safety indicators and Public Reporting Initiative
• IDEAS strategy – Improving and Driving Excellence Across Sectors
• Health system funding reform: patient-based funding
• Health Quality Ontario (HQO): Residents First initiative
• HQO: evidence-based analysis
• HQO: improvement initiatives in advanced access, efficiency and chronic disease management in primary care
NOVA SCOTIA
• Patient Safety Act
• Health Quality Indicator Framework (draft)
• standardizing and integrating the Department of Health and Wellness
• 5S implementation of Lean in the emergency department
• Infection Prevention and Control Nova Scotia – Service Provider Networks
• participation in the Atlantic Health Quality and Patient Safety Collaborative and the Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease

NEW BRUNSWICK
• Government Performance Excellence Program linked to Lean Six Sigma
• implementation of primary health care reform
• comprehensive diabetes strategy
• New Brunswick Health Council care experience surveys
• New Brunswick Health Council public dialogue series
• participation in the Atlantic Health Quality and Patient Safety Collaborative and the Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease

NEWFOUNDLAND AND LABRADOR
• Provincial Wait Time Strategy: endoscopy services
• strategy to reduce hip and knee joint replacement surgery wait times
• provincial electronic occurrence reporting system
• regional health authorities quality/patient safety indicators and reporting templates
• Patient Safety Education Program
• Adverse Event Management Framework: provincial deployment
• participation in Safer Healthcare Now! interventions
• participation in the Atlantic Health Quality and Patient Safety Collaborative and the Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease

PRINCE EDWARD ISLAND
• Collaborative Model of Care
• Lean Six Sigma implementation across Health PEI
• 18 quality improvement teams within Health PEI
• Advanced Clinical Access pilots
• Wait Time Strategy
• Utilization Management Strategy: physician profile, enhanced discharge planning for safe transitions
• participation in Safer Healthcare Now! interventions
• participation in the Atlantic Health Quality and Patient Safety Collaborative and the Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease

NORTHWEST TERRITORIES
• strategic plan and annual reporting of 36 system-level quality indicators and targets
• NWT Patient Safety Framework
• NWT client surveys
• NWT health forums
• Lean Six Sigma activities

HEALTH CANADA—FIRST NATIONS & INUIT HEALTH BRANCH
• Quality Improvement Policy Framework
• First Nations and Inuit Home and Community Care Quality Resource Kit

DEPARTMENT OF NATIONAL DEFENCE—CANADIAN FORCES HEALTH SERVICES
• Patient Safety Program (under development)
• Lean methodologies and philosophies (exploratory phase)
APPENDIX B
WHERE SENIOR LEADERS SEEK INFORMATION
AND COLLABORATION
Health system leaders across Canada were asked to
name the organizations, collaboratives, and jurisdictions
that they turn to for sharing, learning, and/or collaboration
related to quality improvement.

CANADA
• Accreditation Canada
• Atlantic Health Quality and Patient Safety Collaborative
• Canada Health Infoway
• Canadian Agency for Drugs and Technologies in Health
• Canadian Foundation for Healthcare Improvement (formerly
  the Canadian Health Services Research Foundation)
• Canadian Healthcare Association
• Canadian Institute for Health Information
• Canadian Institute of Actuaries
• Canadian Patient Safety Institute, Safer Healthcare Now!
• Canadian Standards Association
• Community and Hospital Infection Control Association –
  Canada
• Conference Board of Canada
• Council of the Federation Health Care Innovation
  Working Group
• Government of Canada—Correctional Service of Canada
• Government of Canada—Health Canada
• Government of Canada—House of Commons Standing
  Committee on Health
• Government of Canada—Public Health Agency of Canada
• Health Council of Canada
• Institute for Safe Medication Practices Canada
• Joint Health Councils/Accreditation Canada Collaborative
• National Collaborative for Excellence in Healthcare Quality
• National/provincial professional associations (nursing,
  social work, physicians)
• Provincial health/quality/patient safety councils/institutes
• Ontario Provincial Infectious Disease Advisory Committee
• Western (Canada) health quality organizations (group
  meetings)

INTERNATIONAL
• Affinity Health System (Wisconsin)
• Australian Commission on Safety and Quality in
  Health Care
• CareOregon
• Clinical Excellence Commission (Australia)
• Dana-Farber Cancer Institute (Massachusetts)
• Global Sepsis Alliance
• Group Health Cooperative (Washington)
• Institute for Healthcare Improvement (Massachusetts)
• Institute for Patient- and Family-Centered Care (Maryland)
• Intermountain Healthcare (Utah)
• International Association of Healthcare Central Service
  Materiel Management
• Jonkoping County Council (Sweden)
• Kaiser Permanente (California)
• National Health Service, including the Institute for
  Innovation and Improvement (UK)
• Seattle Children’s Hospital (Washington)
• Southcentral Foundation/Alaska Native Medical
  Center model
• ThedaCare (Wisconsin)
• Veterans Health Administration (US)
• Virginia Mason Hospital and Medical Center (Washington)
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**ACKNOWLEDGEMENTS**

The Health Council of Canada would like to thank the health system leaders in the federal, provincial, and territorial governments and dedicated quality agencies who participated in interviews and/or submitted written survey responses for this report, and who reviewed and provided additional commentary on our findings. The Health Council also gratefully acknowledges the contributions of an advisory panel.

The final analyses and conclusions of this report are those of the Health Council of Canada, and do not necessarily reflect the opinions of advisory panel members, external contributors and reviewers, or the organizations with which they are affiliated.

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**METHODOLOGY**

Qualitative data were gathered through interviews with health system leaders, including deputy ministers or assistant deputy ministers in provincial governments and CEOs or their designates of dedicated quality agencies.

Interviews were audio-recorded, transcribed, and coded for response themes.

To complement these data, we asked for written survey responses from federal/provincial/territorial ministries or departments of health.

An advisory panel provided input into the interpretation of the preliminary findings. Additional feedback on the report was gathered from senior leaders in provincial/territorial governments, dedicated quality agencies, and selected national organizations with a role in quality improvement.
The Health Council of Canada would like to acknowledge funding support from Health Canada. The views expressed here do not necessarily represent the views of Health Canada.

**Recommended citation format:**

ISBN 978-1-926961-74-3 PDF
ISBN 978-1-926961-73-6 Print

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