PREFACE

There has been increased activity recently focused on improving the quality of care in healthcare organizations across Canada. This activity has involved developing more comprehensive Quality Plans and reporting mechanisms, as well as ensuring alignment of these Plans throughout an organization - from the Board to the ward level.

In addition to the work undertaken by individual healthcare organizations, governments have increased their emphasis on Board accountability and mandatory public reporting on quality performance.

National organizations and provincial quality councils have played important roles in assisting healthcare organizations to respond to these developments. The Canadian Patient Safety Institute and the Canadian Health Services Research Foundation have worked together to provide tools and reference materials. Accreditation Canada released updated governance standards and an updated Governance Functioning Tool (for the Board’s role in quality and safety). The Canadian Institute for Health Information has created a hospital report card which contains performance information. A number of provincial quality councils now issue regular reports on quality performance for the organizations in their jurisdictions.

In 2009, eleven academic healthcare organizations across Canada came together to create the Collaborative for Excellence in Healthcare Quality (CEHQ). The broad goal of this initiative is to develop a framework and set of quality measures that can be used to benchmark performance in academic health sciences centres specifically, and to learn from each other on the best ways to attain higher levels of performance.

In December 2010, a review of the Quality Plans of the eleven CEHQ organizations indicated a great deal of variability in the content and format of these Plans. A further literature review indicated that there were limited standards for developing Quality Plans in healthcare.

These findings led to the creation of this project as part of the overall CEHQ initiative. The objective of this project was to assist organizations in the development of an effective Quality Plan by:

- Developing guidelines for Quality Plans that will create a framework for action and high performance;
- Producing aids and tools that can be adapted and used in varied situations and environments; and
- Facilitating the sharing of sample Plans from various organizations.

Our aim was to produce a practical Guide that will be useful in all types of healthcare organizations in developing effective Quality Plans and reporting mechanisms. We are hopeful that this Guide will play an important role in improving quality outcomes across the country. The individuals who assisted with the project are listed on the following page. We would like to thank them for their contribution to the project.

Laurie Hicks             James Nininger, PhD
Project Co-Chair         Project Co-Chair
Board Member,            Chair, Community for Excellence
University Health Network in Health Governance
ACKNOWLEDGEMENTS

Representatives of all eleven CEHQ organizations, as well as officials from the supporting organizations were invited to participate in the project. They did this by participating in a series of teleconferences wherein they shared their experiences and ideas as well as by critiquing various drafts of the report.

CEHQ Project Team

Laurie Hicks (Co-Chair), Board Member, University Health Network
James Nininger (Co-Chair), Chair, Community for Excellence in Health Governance
Chantal Backman, Senior Project Manager, Collaborative for Excellence in Healthcare Quality
Alan Forster, Scientific Director, Performance Measurement, The Ottawa Hospital
Lisa Freeman, Acting Senior Project Manager, Collaborative for Excellence in Healthcare Quality
Linda Hunter, Director, Quality, Patient Safety and Patient Flow, The Ottawa Hospital
Alycia White-Brown, Project Manager, Collaborative for Excellence in Healthcare Quality

Representatives of Participating and Sponsor Organizations

Jonathan Mitchell, Manager, Policy and Research, Accreditation Canada
Kristen Edmiston, Director of Division Projects & Planning Quality & Healthcare Improvement, Alberta Health Services
Catherine Gaulton, Vice-President Performance Excellence & General Counsel, Capital District Health Authority
Gail Blackmore, Director Performance Excellence, Capital District Health Authority
Linda Hubert, Directrice de la qualité, Centre Hospitalier universitaire de Sherbrooke
Renald Lemieux, Directeur de l’évaluation des technologies, Centre Hospitalier universitaire de Sherbrooke
Jocelyne Frenette, Conseillère cadre à la gestion de la qualité, Centre Hospitalier universitaire de Sherbrooke
Wayne Miller, Vice-President, Quality, Patient Safety and Planning, Eastern Regional Health Authority
Danielle Lemay, Directrice associée, Gestion de la qualité et des risques, McGill University Health Centre
Candice Bryden, Director, Quality Services, Saskatoon Health Region
Patricia McKernan, Director of Risk Management and Quality Improvement, St. Michael’s Hospital
Emily Musing, Patient Safety Officer, University Health Network
Janet Joy, Director, Innovation Funds, Vancouver Coastal Health Authority
Susan Morrow, Project Officer, Winnipeg Regional Health Authority

For any questions or comments about this document, please contact Chantal Backman at cbackman@toh.on.ca.
EXECUTIVE SUMMARY

Quality and safety is now a recognized strategic imperative of healthcare organizations. To create long-term measurable and sustainable changes in quality and safety, many healthcare providers are either at the early stages of developing a Quality Plan, or are enhancing their current Plans to make them more effective. This Guide was created to assist both types of organizations.

The Guide is an undertaking of the Collaborative for Excellence in Healthcare Quality (CEHQ), which consists of eleven academic health science centres from across Canada, who have come together to improve the quality of care and safety in their organizations. A review of the Quality Plans of the member organizations revealed a great deal of variability, and a literature review indicated a gap in the information available to guide organizations in developing or improving a Quality Plan.

The focus on improved quality and safety has been driven by a variety of organizations including quality councils, national organizations, and provincial governments which have placed increased attention on mandatory reporting.

The CEHQ Working Group that developed this Guide suggests that the following areas be taken into account in developing and using a Quality Plan.

KEY PRINCIPLES
A Quality Plan should be built based on nine key principles. It should be: clearly aligned to the strategic plan; tied to a quality framework; have a natural progression from previous years’ Plan; be clear, easy to understand and interpret; have measurable goals and include targets; be based on resources available; evaluated on an annual basis; and be helpful in influencing permanent cultural change. Section 2 discusses the principles in further detail.

ACCOUNTABILITIES
The development, approval and implementation of the Quality Plan involves groups at various levels of the organization including: the Board of Directors, the Senior Executive Team, clinical leadership, and quality officials. Each group needs to clearly understand its roles and responsibilities. These are outlined in Section 3.

CONSULTATION
A key objective of quality planning is to facilitate the development of a culture of quality and safety for the organization. While the Board’s engagement and the Senior Executive Team’s leadership are essential, gaining acceptance and buy-in into the Plan requires that the process for developing it be broad-based and consultative. This process is examined in Section 4.

MULTI-YEAR PLANNING
Most organizations prepare a Quality Plan which has a one-year life span. Quality initiatives often require resources and an organizational culture change that cannot be reasonably achieved in a single year. For this and other reasons, it is important that Quality Plans take a longer term perspective with respect to quality improvement targets. To accomplish this, health organizations should consider extending the time frame of their Quality Plans. A multi-year timeframe is used by a number of organizations. This is discussed in Section 5.
BUILDING/DEVELOPING THE QUALITY PLAN

Alignment
The Quality Plan needs to be aligned with a variety of internal and external documents which will impact the Plan such as the organization’s strategic plan and government legislation and initiatives. These factors are listed in Section 6.

Key Components of a Quality Plan
There are nine suggested key components to an effective Quality Plan

1. Quality Framework/Dimensions
   Defining quality and developing a quality framework is an important building block for a Quality Plan. Section 6.2.1 describes various dimensions of care that can be included in a quality framework.

2. Strategic Corporate Goals
   The Quality Plan must be aligned with the strategic plan of the organization. This is explored in Section 6.2.2.

3. Background and Context
   This section of the Quality Plan should highlight key background and contextual factors that inform or influence the Plan. These factors include: new legislation, accreditation results, reference to new benchmarks, etc. These factors are listed in Section 6.2.3.

4. Objectives
   Having set the context for the Quality Plan, the next step is to determine specific objectives for the period. It is helpful to tie objectives to the dimensions of the quality framework used by the organization. Examples of objectives are shown in Section 6.2.4.

5. Performance Measures
   Establishing performance measures is one of the most difficult aspects of building an effective Quality Plan. Section 6.2.5 describes different types of indicators including structural, process, outcome and balance indicators, and provides some examples of performance measures.

6. Targets for the Current Period
   Setting performance targets is the next step in developing the Plan. A number of factors need to be taken into account in establishing targets such as prior achievements, new benchmarks and resources available to attain the target. Examples of Performance targets and examples are discussed in Section 6.2.6.

7. Activities
   Activities outline the ‘how’ of the Plan. This section of the Plan describes the specific actions that need to be taken. Key activities will indicate how various parts and levels of the organization will be involved in achieving the performance targets. Activities are examined in Section 6.2.7.
8. Timeframe and Resources
The steps involved in developing the Quality Plan are not sequential. Factors such as
timestamps and resources must be considered as performance targets are established.
The process may also be iterative as draft objectives and targets are examined in the
light of available resources. This topic is covered in Section 6.2.8.

9. Assigning Responsibilities
The final component of the Quality Plan is the identification of individuals or groups that
have specific accountabilities for achieving the desired results. Accountabilities may
exist at various levels of an organization. This is explored in Section 6.2.9.

COMMUNICATION
Once the Plan is finalized and approved by the Board of Directors, it must be communicated
effectively to a variety of internal and external audiences. Discussion of the key aspects of
communications related to the Quality Plan is included in Section 7.

REPORTING
The purpose of a Quality Plan is to bring about change and improvement in quality and safety in
an organization. For this to be effective, it is important that a process for reporting on the
performance of the Plan be put in place. There are various audiences for performance reports
and the frequency and design of the reports will vary. Audiences include the Board of Directors,
the Quality Committee of the Board, staff within the organization at various levels, external
stakeholders etc. This is examined in Section 8.

ASSESSING THE EFFECTIVENESS OF THE QUALITY PLAN
It is critical to spend time each year assessing the effectiveness of the Quality Plan in achieving
its desired aims. This should be done at various levels of the organization. The governing body
needs to undertake this assessment and a report should be presented which outlines the
accomplishments and shortcomings of the Plan along with factors that influenced the
performance of the Plan. The Quality Committee of the Board can play an important role by
leading this assessment. Such an examination should also be undertaken at the Senior Executive
level and perhaps other levels/parts of the organization. This process is explored in Section 9.

EXAMPLES OF QUALITY PLANS AND REPORTING TEMPLATES
Section 10 provides examples of Quality Plans from different types of organizations along with
eamples of reporting templates.

CONCLUSION
Developing a Quality Plan and improving it over time is a critically important and challenging
task for any healthcare organization, regardless of size, complexity or focus. Even though the
overall objective of quality planning and reporting is a shared desire to improve patient care,
each organization has different needs, experiences and culture and accordingly their Quality
Plans and reporting templates will be uniquely reflective of their circumstances. This Guide has
attempted to provide a structured approach to building an effective, actionable and
measureable Quality Plan. Users of this Guide are encouraged to build upon the
recommendations and examples provided and to share their experiences with their colleagues
in the broader health sector so that we assist one another to collectively raise the bar in quality
and patient safety.
# TABLE OF CONTENTS

1.0 INTRODUCTION ........................................................................................................ 7

2.0 PRINCIPLES ............................................................................................................... 9

3.0 ACCOUNTABILITIES .............................................................................................. 10

4.0 CONSULTATION ..................................................................................................... 12

5.0 MULTI-YEAR PLANNING .................................................................................... 13

6.0 BUILDING/DEVELOPING THE QUALITY PLAN .................................................. 14
   6.1 Alignment .............................................................................................................. 14
   6.2 Key Components ................................................................................................. 15
   6.2.1 Quality Framework/Dimensions .................................................................. 15
   6.2.2 Strategic Corporate Goals ........................................................................ 17
   6.2.3 Background and Context ......................................................................... 17
   6.2.4 Objectives ....................................................................................................... 18
   6.2.5 Performance Measures ............................................................................. 19
   6.2.6 Targets ............................................................................................................. 22
   6.2.7 Activities .......................................................................................................... 23
   6.2.8 Timeframe and Resources .................................................................... 24
   6.2.9 Assigning Responsibilities ..................................................................... 26

7.0 COMMUNICATIONS ............................................................................................. 28

8.0 REPORTING ............................................................................................................ 30

9.0 ASSESSING THE EFFECTIVENESS OF THE QUALITY PLAN ......................... 33

10.0 HIGHLIGHTS OF QUALITY PLANS .................................................................. 35

11.0 CONCLUSION ...................................................................................................... 42

12.0 REFERENCES ........................................................................................................ 43

APPENDIX 1: EXAMPLES OF QUALITY FRAMEWORKS ........................................... 44
1.0 INTRODUCTION

The intent of this Guide is to assist organizations to develop effective, measureable Quality Plans. For the purposes of this document, the CEHQ Working Group defined a Quality Plan as a Plan to drive higher performance in quality and patient safety in a healthcare organization.

The rationale and impetus for improving the focus and effectiveness of Quality Plans are discussed in the Preface, however beyond responding to external pressures that are a driving force for change, the development of a Quality Plan can serve multiple purposes within an organization such as:

- Promoting organizational commitment and accountability for quality patient care through the selection of priority patient-care initiatives that are aligned with required, existing and emerging quality issues;
- Ensuring sufficient allocation of appropriate resources for quality improvement processes, by identifying the intellectual, physical, material and fiscal resources required for implementing, measuring and monitoring quality initiatives;
- Communicating and disseminating corporate quality goals, objectives and action plans to all staff and physicians; and
- Documenting and reviewing current performance in a variety of areas in order to see targeted areas for improvement and to chart progress.

(The Ottawa Hospital Quality Plan Framework 2011-2114)

The focus of this Guide is largely directed at the internal needs, impact and benefits of a strong quality planning process. Compliance with any externally mandated quality measurement and reporting must factor into any Quality Plan the organization undertakes. However, since mandated requirements are still evolving and may differ from one jurisdiction to another, this Guide assumes that the scope of an effective Quality Plan will address these requirements as a minimum but not necessarily be limited by them.

The audience for this Guide will vary depending on the organization. Examples of the audience could be:

**Board of Directors**
- The Board of Directors has overall responsibility for the Quality Plan and for reporting on its performance.

**Senior Executive Team**
- The Senior Executive Team oversees the work of developing the Quality Plan for approval by the Board.

**Clinical Leadership**
- The clinical leadership (e.g. medical leads, expert clinicians, clinical leaders) provides clinical expertise on what should be included in the Quality Plan.
**Quality Officials**

- The Quality Officials (e.g. Director of Quality/Performance Measurement or other management charged with the responsibility for quality) within the organization facilitate the development of the Quality Plan and provide expertise on quality improvement and performance measurement.

It is recognized that the scope and complexity of a Quality Plan will be impacted by the size and characteristics of the organization. Regional health authorities will have a broader set of quality indicators and initiatives than a community-based hospital. However, the principles of an effective Quality Plan can be adapted across the spectrum of healthcare organizations to suit specific needs and circumstances.

**HOW TO USE THE GUIDE**

This Guide is intended to serve as an aid for organizations in all sectors of healthcare in their journey toward improving their Quality Plans. For organizations in the early stages of developing their Quality Plan, the Guide will help in ensuring that all of the components of a Plan are considered and addressed. For organizations more experienced in working with Quality Plans, the Guide will serve as a useful benchmark for taking their Quality Plan to the next level.

The Guide is divided into two main areas:

1. Topics related to the structure of the Plan that will lay the foundation for a Quality Plan are included in the following sections: Principles, Accountabilities, Consultation and Multi-Year Planning; and
2. Topics related to building the Plan itself as well as to the roll-out of the Plan are included in the following sections: Building/Developing the Quality Plan, Communicating, Reporting and Assessing the effectiveness of the Plan.

At the end of the Guide, there are examples of Quality Plans and reporting templates that highlight the points raised in the document.

Throughout the Guide, you will find **GREY boxes** which contain quick facts or supplemental reference information on selected topics and **BLUE boxes** which contain key concepts. As well, figures are provided to help illustrate content examples of a Quality Plan.
2.0 PRINCIPLES

As an initial step to developing this Guide, the CEHQ Working Group identified the need for a set of common principles that an organization should consider using as fundamental guideposts to the development of their Quality Plans.

The Working Group agreed that the principles must fit the definition of being “a guiding theory or belief or a fundamental or general truth” and be equally applicable across any size or type of healthcare provider organization. The following, which were arrived at by consensus, are the principles to guide the development of an effective Plan:

**KEY CONCEPTS**

A Quality Plan is:

- Clearly aligned with the organizational strategic plan
- Tied into the quality framework selected by the organization
- A natural progression from previous years’ Quality Plans (if available)
- Described in terms that are clear, easily understood and easily interpreted by all stakeholders (including the public)
- Designed to have measurable goals where possible
- Designed to have a set of targets for the indicators measured where appropriate
- Evaluated in a formal manner at least annually
- Feasible - based on the resources available
- Helpful in influencing permanent cultural change in quality

These key principles have also served as a foundation for the development of this Guide.
3.0 ACCOUNTABILITIES

When embarking on the development of a Quality Plan, there are roles and responsibilities at several levels. Each group needs to understand their obligations and expected contribution and to participate accordingly.

Whether the development of a Quality Plan is mandated by the provincial funding authority or is a voluntary exercise, the ultimate accountability for the quality of care provided in an institution rests with the Board of Directors. Therefore, the Board has accountability for the development, implementation and monitoring of the Quality Plan. However, both the Senior Executive Team and clinical leadership play a pivotal role in quality planning.

A summary of the key roles and responsibilities is outlined below:

**Board of Directors**
The Board will normally delegate much of the responsibility for the Plan to the CEO, however, an engaged Board will play an active role by:
- Ensuring quality and safety are at the core of the organization’s vision;
- Ensuring that quality and safety values are embedded in guiding the organization’s strategic plan;
- Ensuring that the Quality Plan is aligned with the strategic plan;
- Setting key overarching quality priorities to guide the Quality Plan;
- Approving the Quality Plan;
- Allocating appropriate resources for the implementation of the Plan;
- Providing ongoing monitoring of progress and performance against the Plan; and
- Championing the quality agenda, both internally and externally.

Many Boards have a Quality Committee as a sub-committee of the Board. Where this structure exists, the Quality Committee of the Board is typically involved in the development of the Quality Plan before it is presented to the Board. The Quality Committee, working with the Senior Executive Team, traditionally reviews and approves the broad parameters of the Plan before detailed work is undertaken. The Quality Committee then presents the Quality Plan to the Board for approval.

**Senior Executive Team**
The CEO and the Senior Executive Team are responsible for:
- Establishing the quality framework for the organization;
- Establishing the process for the development of the Plan;
- Setting the scope, priorities, guidelines and parameters for the Plan, including ensuring the Plan is aligned with strategic priorities;
- Ensuring the Plan is cohesive and feasible to implement with available resources;
- Ensuring provincial mandates are adhered to;
- Motivating and supporting staff to achieve Plan targets;
- Determining how to measure progress; and
- Monitoring the effectiveness of the Plan and the achievement of results.
Clinical Leadership
The clinical leadership team is responsible for:

• Providing expertise on setting appropriate goals, objectives and initiatives for the Quality Plan;
• Providing clinical input for targets related to clinical outcomes;
• Carrying out the tasks to meet the objectives of the Quality Plan;
• Motivating and supporting staff to achieve targets;
• Reviewing the reports to ensure that the measures are reaching their targets;
• Acting upon identified areas for improvement; and
• Assessing the effectiveness of the Plan and its implementation as well as making changes as required.

Quality Officials
The quality officials are responsible for:

• Coordinating and facilitating the process for the development of the Quality Plan;
• Writing the drafts of the Quality Plan;
• Creating a communication strategy for the Quality Plan for all staff and physicians;
• Providing education about the Quality Plan;
• Supporting programs, departments, and staff in their Quality Plan objectives; and
• Monitoring the Plan in conjunction with committees such as the quality council and other senior executive committees.
4.0 CONSULTATION

A key objective of quality planning is to influence the culture of an organization such that quality and safety measures migrate away from being ‘tasks’ and become embedded in the psyche and routine of every staff and physician. Therefore, while the Board’s engagement and the Senior Executive Team’s leadership are critical, leading organizations have found that gaining acceptance and buy-in into the Plan requires that the process for developing it be broad-based and consultative (Nolan, 2007; Hunter et al., 2011).

Specifically, best practice suggests that:

- The development of the Plan includes bottom-up input, so that front-line staff can provide input into areas of risk, priorities, target setting and implementation approaches;
- Clinical and non-clinical staff are included in the consultations;
- All staff become educated about quality objectives and accountabilities;
- Quality initiatives directed by the Plan be cascaded down so that every staff member understands their role in achieving targets;
- A communication plan for both the roll-out and the progress reports on the Plan is shared with the organization as a whole; and
- The broader community of external stakeholders are also consulted either as part of their strategic planning exercise or specifically for the development of the Quality Plan.

Engagement of a broad base of stakeholders is expected to result in greater commitment to more sustainable improvements and enhanced quality of care. Several strategies can be used for consultation with staff and physicians including surveys, focus groups and key informant interviews.

Some organizations choose to embed their Patient Declaration of Values or a similar Patient Bill of Rights, into their Quality Plan which allows them to include a patient perspective.

QUICK FACTS

The following are some activities that can be performed to obtain input on the Quality Plan:

- Survey of the Senior Executive Team and the clinical leadership to obtain input on the strategic goals
- Perform key informant interviews to obtain perspectives on critical and emerging quality challenges
- Consult with clinical and support teams
- Analyze the data to identify themes and to prioritize goals based on the quality framework
- Implement an iterative process to finalize and approve the corporate strategic goals
- Create supporting objectives, action plans with timelines, measures and accountabilities to support the achievement of these strategic goals

(Hunter et al., 2011)
5.0 MULTI-YEAR PLANNING

The development of a Quality Plan may be a new undertaking for many organizations and early Plans may be largely focused on a one-year horizon. However, some quality initiatives require resources and an organizational culture change that cannot reasonably be achieved in a single year or have dependencies on other accomplishments before they can be reached. Also, some changes require an incremental approach to achieve targets if the desired performance is unrealistic to attain from the current state in a one-year step. Regulatory or funding organizations may also impose longer term quality and safety compliance requirements that need to be incorporated.

Most importantly, and as noted previously, quality planning is aimed at motivating a cultural shift which requires both spread of the desired behaviours throughout the organization and sustained performance over a long period of time. This is often a challenge to accomplish through initiatives that span a single year and therefore commitment to a longer vision may become necessary.

Accordingly, as quality planning processes mature, the Quality Plan will need to include an overview of the longer term view of the organization’s strategic quality priorities and directions.

For the purposes of this Guide, the focus is primarily on single year planning; however, most of the concepts are equally applicable to multi-year Plans. An example of a multi-year Plan can be found in Section 10.
6.0 BUILDING/DEVELOPING THE QUALITY PLAN

This section of the Guide contains a discussion of suggested content to be included in a Quality Plan as well as some overall considerations when developing a Plan.

6.1 Alignment

When organizations undertake to develop a Quality Plan, there are many existing internal and external factors and influences that have to be taken into account. Organizations will be much more successful with the implementation of quality initiatives if their Plan fits in harmony with these influences. Accordingly, a fundamental tenant of the Quality Plan is alignment. Without it, the focus and resources of the organization may become scattered and ineffective.

KEY CONCEPTS

To be effective, the Quality Plan should be aligned with the:

- Vision and mission of the organization
- Organizational strategic plan
- Best practices
- Governing legislation
- Mandated regional or provincial initiatives
- Accreditation recommendations
- Quality initiatives that the organization may be participating in (e.g. accreditation, Safer Healthcare Now!)
- Emerging trends
6.2Key Components

The CEHQ Working Group spent considerable efforts at identifying the recommended content or key components of an effective Quality Plan. The suggested key components are:

- Quality Framework/Dimensions
- Strategic Corporate Goals
- Background and Context
- Objectives
- Performance Measures (outcome and process measures)
- Targets
- Activities
- Timeframe and Resources
- Assigning Responsibilities

In some jurisdictions, the content and/or format of the Quality Plan may be mandated. However, even if such a standard is available, an organization may have latitude to tailor the content and format to suit their needs and elect to apply some of the guidelines provided in this document.

6.2.1Quality Framework/Dimensions

Defining quality and an organizational quality framework is an important initial step for an organization to consider prior to the development of a Quality Plan. The framework:

- serves as the foundation for monitoring quality;
- guides the areas of focus, the priorities, the measures of progress and reporting; and
- facilitates communication both internally and externally.

Recent healthcare literature focuses on the development of quality frameworks that incorporate various dimensions of care. These dimensions include access, safety, efficiency, effectiveness, and patient centredness, among others. Most frameworks are (1) guided by alignment with organizational strategy, (2) evidence-based, (3) supported by strong leadership, and (4) aimed at promoting excellence in all levels of an organization (Caramanica et al. 2003).

Many frameworks being used in Canadian institutions are based on models developed by Accreditation Canada, provincial quality councils, or the Institute of Medicine (IOM). Some commonalities between these various dimensions are found in Table 1:
## Table 1: Comparison of various quality frameworks

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Accreditation Canada</th>
<th>IOM</th>
<th>BC Patient Safety &amp; Quality Council</th>
<th>Health Quality Council of Alberta</th>
<th>Health Quality Ontario</th>
<th>New Brunswick Health Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population focus</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Accessibility</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Safety</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Work life</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Patient/Family-mediated</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Continuity of services</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Efficiency</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Equitable</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Timely</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Acceptability</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Appropriateness</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Appropriately Resourced</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Integrated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Some organizations may choose to modify such frameworks and dimensions to suit their specific environments. For example, research and/or education are not included as dimensions in most published frameworks but may be relevant to add as quality dimensions for some institutions.

There are also variations on published frameworks for sub-sectors and/or different interpretations of the definitions of dimensions (Chao et al., 2005; Steering Committee Responsible Care, 2007).

Because of its importance, it is highly recommended that an overview of the framework used within the organization is included as an introduction to the Quality Plan. The section might include a brief overview of the quality framework used with reference, where applicable, to the model it is based on and a brief definition of each dimension. If a diagram or model has been developed to illustrate the framework in your organization, it could be included or appended. Examples of frameworks (including the dimensions and definitions) are included in Appendix 1.
6.2.2 Strategic Corporate Goals

The first step in building a Quality Plan is to set the overarching strategic direction for quality improvement within the organization and the specific objectives for the current year. The Board and the Senior Executive Team should be involved in setting this direction and ensuring it is in alignment with the strategic plan. The direction is articulated in a set of high level goals and priorities that may be single year or multi-year in their focus. If they are multi-year, there will also be current year objectives articulated as interim steps towards achievement of the longer term goals.

The strategic direction and goals may remain constant for two or more years; however, they may also be reviewed and adjusted annually to reflect the need to direct focus to a pressing or emerging quality issue.

Initially, some organizations struggle with a desire to address many improvement opportunities. However, the effort to attain cultural change and sustainability can be considerable and focus on a small number of goals, done well, may have more impact in the end than a broad set of goals that overwhelm the organization.

6.2.3 Background and Context

This section of the Quality Plan highlights any key background and contextual factors that informed or influenced the development of the current year Quality Plan. The narrative in this section may be broad or narrow depending on the unique situation of the organization.

Examples of contextual factors include:

- Legislation that relates to quality;
- Ongoing quality improvement accreditation results and recommendations;
- Changes to programs/services that add or remove the need for specific quality objectives (e.g. decision to outsource, expand or downsize a program, etc.);
- Local, regional or national initiatives in which the organization is participating;
- Feedback from patient satisfaction surveys, if it is directing quality initiatives;
- Major events or incidents that sparked new areas of focus (e.g. disease outbreak, a merger or partnership with another organization);
- New research or best practice that has been published that highlights patient care quality opportunities;
- Emerging trends (clinical or non-clinical) that impact quality; and
- Any other change in the environment that has contributed to the shaping of the current year Plan.

This section may also include commentary on any of the following, if relevant:

- Progress or challenges meeting quality objectives in the previous years;
• Any changes in indicators or measurement approach that might impact interpretation of the results presented (e.g. using more sensitive testing to identify hospital acquired infections); and
• Reference to any new benchmarks or comparators that have emerged and how those have guided the Quality Plan.

In summary, the content of this section of the Plan sets the backdrop for the current year Plan and will be highly unique to each organization. It explains why goals, objectives, performance measures and targets may have changed from the previous year(s) and confirms that the organization is constantly seeking to enhance its approach to managing quality and patient safety.

6.2.4 Objectives

Having set the ‘big picture’ for the quality focus, the next step is to determine specific objectives for the Plan. Thus, the objectives should be guided by the overarching corporate goals.

**QUICK FACTS**

The statement of objectives can be guided by the SMART mnemonic:

- **Specific**
- **Measurable/meaningful**
- **Attainable**
- **Relevant/results oriented**
- **Time-bound**

Examples of objectives in three quality dimensions are found in Figure 1.0:

**Figure 1.0 – Example of Objectives**

<table>
<thead>
<tr>
<th>Quality Dimensions</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESS</td>
<td>Reduce wait times in the ED by 15% for admitted patients by March 31, 2012.</td>
</tr>
<tr>
<td>EFFECTIVENESS</td>
<td>Reduce unnecessary hospital readmission from 10.80% to 10.70% for General Medicine patients by March 31, 2012.</td>
</tr>
<tr>
<td>SAFETY</td>
<td>Reduce <em>Clostridium difficile</em> associated diseases (CDI) from 0.62 to less than 0.42 per 1,000 patient days by March 31, 2012.</td>
</tr>
</tbody>
</table>
In setting the goals and objectives for the current year, several factors should be taken into consideration:

- How much progress has been made in previous years towards the goals and were the objectives of previous years achieved?
- What is a reasonable amount of progress to aim for?
- Are there emerging quality issues/priorities that were not contemplated in the original long term goals but which need to be added as points of focus?

It is critical to engage clinical, medical, support and administrative staff at all levels of the organization and to solicit their input in determining the objectives for the year. Front-line staff have direct and often very creative insights into what the most pressing needs are, what enablers are required, what is feasible to achieve and what is the most effective way to move progress forward.

When setting the goals and objectives for the Plan, sustainability should be a key anchor. Many organizations are able to drive a surge of activity to reach a goal but over time, support falls off and old behaviour patterns return. The best way to avoid this pitfall is to set goals that realistically effect a permanent change of culture.

### 6.2.5 Performance Measures

Developing an approach to tracking performance against quality goals is a crucial aspect of a Quality Plan and can be one of the most challenging elements to complete. Identifying indicators that will be used to measure progress requires thoughtful consideration of many factors and the approach to measurement must be decided before targets can be set.

The following section provides an overview of the types of performance measures and their characteristics; however, it not intended to be a comprehensive resource or to replace the expertise of performance measurement specialists.

Measures are significantly influenced by the availability of reliable data. It is better to have fewer indicators that are strong and reliable and which have credibility with stakeholders than to introduce too many metrics that become so cumbersome to administer that the quality and reliability of the metric itself is called into question.

Indicators must be carefully chosen to be:

- Valid and reliable measures or proxies for the goal(s) and objective(s);
- Actionable;
- Feasible - to obtain the data required on a timely basis;
- Easily understood – to provide transparency to stakeholders;
- Based upon agreed definitions; and
- Evidence-based.
QUICK FACTS

Types of Indicators
Indicators can be related to structure, process, or outcome of care.

Structure Indicators:
"Structure refers to health system characteristics that affect the system's ability to meet the health care needs of individual patients or a community. Structural indicators describe the type and amount of resources used by a health system or organization to deliver programs and services, and they relate to the presence or number of staff, clients, money, beds, supplies and buildings“ (Mainz, 2003, p. 525).

Examples of structure indicators include:
• access to specific technologies (e.g. MRI scan);
• access of specific units (e.g. stroke units)

Process Indicators:
"Process indicators assess what the provider did for the patient and how well it was done. Processes are a series of inter-related activities undertaken to achieve objectives. Process indicators measure the activities and tasks in patient episodes of care.” (Mainz, 2003, p. 525)

Examples of process indicators include:
• proportion of patients with diabetes given regular foot care;
• proportion of patients with myocardial infarction who received thrombolyses

Outcome Indicators:
"Outcomes are states of health or events that follow care; and that may be affected by health care. An ideal outcome indicator would capture the effect of care processes on the health and well-being of patients and populations.” (Mainz, 2003, p.525) Outcomes can be expressed as 'The Five Ds' [5]:
(i) death: a bad outcome if untimely;
(ii) disease: symptoms, physical signs, and laboratory abnormalities;
(iii) discomfort: symptoms such as pain, nausea, or dyspnea;
(iv) disability: impaired ability connected to usual activities at home, work, on in recreation; and
(v) dissatisfaction: emotional reactions to disease and its care, such as sadness and anger.

Examples of outcome indicators include:
• infection rates
• mortality
• patient satisfaction

Balancing Measures:
Balancing measures are measures that look at other parts of the system or the organization to ensure that something does not change for the worse when an improvement is made in another area (Martin et al., 2007).

An example of a balancing measure includes:
• Verify that there is no increase in readmission rates when trying to reduce length of stay
Different stakeholders have different focal points for monitoring quality and accordingly, indicators need to be measured at different levels. A common framework is to classify indicators as Big Dots or Little Dots (Martin et al., 2007):

Big Dots are the key focal point for the Board and the Senior Executive Team. They are:
- whole-system measures used to evaluate overall organizational performance and the effectiveness of strategies;
- institution-wide;
- outcome driven;
- a reflection of the organization’s strategic priorities and quality definition;
- multi-faceted connections to the “Little Dots” or processes.

Little Dots are the focal point of the Quality Committee, Senior Executive Team responsible for quality and staff and are:
- the operationalization of Big Dots
- specific and targeted to measure activity progress, including:
  - Measures of outcomes;
  - Process measures;
  - Structure indicators (measuring people, space or money).

It is important to include structure, process and outcome measures in a Quality Plan in order to measure the success of improvements made across the spectrum. By reviewing specific and targeted activities, it is easier to get an idea of where weaknesses may exist and to target them as part of a concentrated approach.

Following on with the example in the previous section, the table below (Figure 2.0) illustrates possible performance measures for the sample objectives.

**Figure 2.0 – Example of Performance Measures**

<table>
<thead>
<tr>
<th>Quality Dimensions</th>
<th>Objectives</th>
<th>Performance Measure</th>
<th>Outcome indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCESS</strong></td>
<td>Reduce wait times in the ED by 15% for admitted patients by March 31, 2012</td>
<td><strong>ED wait times</strong>: 90th percentile ED length of stay for admitted patients (National Ambulatory Care Reporting System – NACRS, Canadian Institute for Health Information - CIHI)</td>
<td></td>
</tr>
<tr>
<td><strong>EFFECTIVENESS</strong></td>
<td>Reduce unnecessary hospital readmission from 10.80% to 10.70% for General Medicine patients by March 31, 2012</td>
<td><strong>Readmission rate</strong>: Readmission within 30 days for all patients readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions (CIHI)</td>
<td></td>
</tr>
<tr>
<td><strong>SAFETY</strong></td>
<td>Reduce Clostridium difficile associated diseases (CDI) from 0.62 to less than 0.42 per 1,000 patient days by March 31, 2012</td>
<td><strong>CDI rate per 1,000 patient days</strong>: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 (Canadian Nosocomial Infection Surveillance Program - NISP)</td>
<td></td>
</tr>
</tbody>
</table>
6.2.6 Targets

Once measures have been identified, setting the targets becomes the next step. Targets can be related to interim or final end points as appropriate.

**QUICK FACTS**

As general guidelines, optimum targets:

- are based on an accurately measured starting point or baseline
- are achievable within the specified timeframe
- allow for incremental improvement over time (vs. a ‘yes/no’ target)
- are able to be benchmarked for comparison against other similar organizations

Determining appropriate targets requires consideration of many factors, such as:

- Previous achievements - if applicable
- Benchmarks that are available - they may be clinical guidelines, best practices, or peer group performance
- Any changes in circumstance that might make it easier or more difficult to attain or sustain a target than in previous years
- The amount of resources required or available to focus on the target
- The number of indicators in the Plan - a focused effort on a smaller number of indicators might enable more difficult targets to be achieved

In this example the performance targets are set as follows (Figure 3.0):

**Figure 3.0 – Example of Performance Targets**

<table>
<thead>
<tr>
<th>Quality Dimensions</th>
<th>Objectives</th>
<th>Performance Measure Outcome Indicator</th>
<th>Current Performance</th>
<th>Performance Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCESS</strong></td>
<td>Reduce wait times in the ED by 15% for admitted patients by March 31, 2012.</td>
<td>ED wait times 90th percentile ED length of stay for admitted patients (National Ambulatory Care Reporting System – NACRS, Canadian Institute for Health Information - CIHI)</td>
<td>32.5 hours</td>
<td>&lt;15%</td>
</tr>
<tr>
<td><strong>EFFECTIVENESS</strong></td>
<td>Reduce unnecessary hospital readmission from 10.89% to 10.70% for General Medicine patients by March 31, 2012.</td>
<td>Readmission rate: Readmission within 30 days for all patients readmitted to any facility for non-effective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions (CIHI)</td>
<td>10.80%</td>
<td>10.70%</td>
</tr>
<tr>
<td><strong>SAFETY</strong></td>
<td>Reduce <em>Clostridium difficile</em> associated diseases (CDI) from 0.62 to less than 0.42 per 1,000 patient days by March 31, 2012.</td>
<td>CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 (Canadian Nosocomial Infection Surveillance Program - NISIP)</td>
<td>0.62 per 1,000 patient days</td>
<td>&lt;0.42 per 1,000 patient days</td>
</tr>
</tbody>
</table>
QUICK FACTS

It is necessary to consider the possible ‘reverse effect’ of measurement which has been observed in many organizations when they introduce or refine quality metrics. When focus is put on an area and measurement is formalized, it can result in performance appearing to trend negatively. For example, when there is an initiative to improve incident reporting, it is likely that the number of incidents will increase, giving the false appearance that patient safety has declined when in actual fact, more cases are being reported due to increased awareness. Another example of where this can occur is when the measurement approach becomes more sensitive or sophisticated. For example, rates for a hospital acquired infection may appear to increase after the introduction of more sensitive tests for the infections. When setting targets, the possibility of this reverse effect needs to be considered so that the performance goals are not inadvertently set at unattainable levels.

6.2.7 Activities

This section outlines the “How” for the Plan, including the specific actions that should be taken to carry out the Plan.

Determining the actions that are needed to attain the goals and targets is another key example of where front line staff, both clinical and non-clinical, can provide significant insight. If a desired outcome can be impacted by their day-to-day activities, they will know the opportunities to leverage, the barriers that have to be overcome, the effort involved and the best way to lead and motivate the change.

QUICK FACTS

In determining the activities, some guidelines to consider are:

- each activity should be tied directly to both an objective and a measure
- each activity should be either achievable within a one year or less timeframe or be broken out into sub-steps that have a one year or less horizon
- each activity needs to have an ‘owner’ who is responsible for driving the work effort
- activities should be designed to involve and engage staff at all levels wherever possible

Many actions that will be identified may be projects that will require much more detailed project plans. It is not necessary to include this level of detail in the Quality Plan.
The following are examples of activities, related process measures and targets related to the specific objectives (Figure 4.0):

**Figure 4.0 – Example of Activities, Process Measures and Targets**

<table>
<thead>
<tr>
<th>Quality Dimensions</th>
<th>Objectives</th>
<th>Performance Measure</th>
<th>Current Performance</th>
<th>Performance Target</th>
<th>Activities</th>
<th>Process Measure</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESS</td>
<td>Reduce wait times in the ED by 15% for admitted patients by March 31, 2012</td>
<td>ED wait times: 95th percentile ED length of stay for admitted patients (National Ambulatory Care Reporting System – NACRS, Canadian Institute for Health Information – CIHI)</td>
<td>32.5 hours</td>
<td>&lt;15%</td>
<td>1. Develop and implement the ED process</td>
<td>Physician consult to decision time</td>
<td>&gt;90% within 3 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15% improvement</td>
</tr>
<tr>
<td>EFFECTIVENESS</td>
<td>Reduce unnecessary hospital readmission from 10.80% to 10.70% for General Medicine patients by March 31, 2012</td>
<td>Readmission rates: Readmission within 30 days for all patients readmitted to any facility (non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions (CIHI)</td>
<td>10.80%</td>
<td>10.70%</td>
<td>1. Reduce readmissions for General Medicine patients</td>
<td>Completed for all patients</td>
<td>&gt;90% at discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&gt;60%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&gt;90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAFETY</td>
<td>Reduce Clostridium difficile associated disease (CDI) from 0.42 per 1,000 patient days by March 31, 2012</td>
<td>CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 (Canadian Nosocomial Infection Surveillance Program – CNISP)</td>
<td>0.62 per 1,000 patient days</td>
<td>&lt;0.42 per 1,000 patient days</td>
<td>1. Improve environmental cleaning in particular high touch areas</td>
<td>Audit</td>
<td>60% implemented</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60% of the recommendations are implemented</td>
</tr>
</tbody>
</table>

**6.2.8 Timeframe and Resources**

In developing the Quality Plan, it is important to note that the steps are not sequential, but rather, must be considered in tandem. For example, when setting the objectives and identifying the activities that will be undertaken to achieve these objectives, the organization must simultaneously be determining the resources needed to implement the Plan so that the final Plan is realistic.

This process may be iterative as many organizations may find they need to adjust the initial draft of objectives and activities or the timing of them, in light of the resource requirements and their ability to meet them. Most organizations will also have other major initiatives competing for resources and the optimum balance may take many refinements of the draft Quality Plan before it can be finalized.

Planners need to work with the Senior Executive Team to ensure the appropriate resources including people, capital, operating budget or space have been estimated as accurately as possible and factored into the Plan.
QUICK FACTS

In estimating resource needs, many organizations inadvertently underestimate or overlook:

- Training time for both the staff who may need added skills to execute the project as well as those staff who may need to be trained in new processes/procedures
- Backfill resources who may need to be brought in and trained to take over roles of individuals seconded to a project
- Adequate support time after the project implementation so that the organization's staff have sufficient follow-up assistance after a change has been implemented
- Procurement cycles that can impact both resource needs as well as timing if contracts have to be tendered as part of the initiative

Other considerations to keep in mind while planning the timing and execution of objectives include:

- It may be motivational to have some early ‘wins’ in the year with easier initiatives rather than to front load all the difficult activities at the start of the year;
- Activities that have long timeframes need to have interim targets set to keep the team focused and enable the organization to celebrate tangible progress even if a project is not finished;
- Some projects will flow across more than one fiscal year, either because they need to start late in the year or because they are big initiatives with long lead times. These require special care in planning to ensure the resource commitment can be met in the later year as well as the current year.
Continuing the examples presented earlier, the relevant timeframe and resources are identified in Figure 5.0:

**Figure 5.0 – Example of Timeframe and Resources**

<table>
<thead>
<tr>
<th>Quality Dimensions</th>
<th>Objectives</th>
<th>Performance Measure Outcome Indicator</th>
<th>Current Performance</th>
<th>Performance Target</th>
<th>Activities</th>
<th>Process Measure</th>
<th>Target</th>
<th>Timeframe &amp; Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESS</td>
<td>Reduce wait times in the ED by 15% for admitted patients by March 31, 2012.</td>
<td>ED wait times: 90th percentile ED length of stay for admitted patients (National Ambulatory Care Reporting System – NACRS). Canadian Institute for Health Information - CIHI.</td>
<td>32.5 hours</td>
<td>&lt;15%</td>
<td>1. Develop and implement the ED process</td>
<td>Physician consult decision time</td>
<td>&gt;90% within 3 hours</td>
<td>13% improvement</td>
</tr>
<tr>
<td>EFFECTIVENESS</td>
<td>Reduce unnecessary hospital readmission from 10.80% to 10.70% for General Medicine patients by March 31, 2012.</td>
<td>Readmission rate: Readmission within 30 days for all patients readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions (CIHI).</td>
<td>10.80%</td>
<td>10.70%</td>
<td>1. Reduce readmissions for General Medicine patients</td>
<td>Number of patients discharged from inpatient unit by 1200 hours</td>
<td>&gt;90% at discharge</td>
<td>90%</td>
</tr>
<tr>
<td>SAFETY</td>
<td>Reduce Clostridium difficile-associated disease (CDI) from 0.62 per 1,000 patient days by March 31, 2012.</td>
<td>CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 (Canadian Nosocomial Infection Surveillance Program – CNISP).</td>
<td>0.62 per 1,000 patient days</td>
<td>&lt;0.42 per 1,000 patient days</td>
<td>1. Improve environmental cleaning in particular high-touch areas</td>
<td>Implement recommendations from Infection Control</td>
<td>80% implemented</td>
<td>80% of the recommendations are implemented</td>
</tr>
</tbody>
</table>

Further examples of Quality Plans are available in Section 10.

### 6.2.9 Assigning Responsibilities

The final component of the Quality Plan is the identification of individuals or groups accountable for achieving the intended results. Assigning responsibilities may be identified either as a named individual or as a position title.

Note that the assignment of responsibility may exist at multiple levels. Accountability for an objective may be assigned to a member of the Senior Executive Team but the accountability will likely cascade down through the organization at the specific performance measure and activity level.

Accountability is defined as the person ‘most responsible’ for achievement of a target or completion of an action or task. It is preferable that the accountability be assigned to a specific person but there may be instances where it is assigned to a group.
When considering assignment of accountability within the Quality Plan some factors should be taken into consideration. In order to be held accountable, an individual must have:

- The skills and experience necessary to be successful;
- The authority necessary to execute the assigned responsibilities;
- Access to the necessary resources; and
- The visible support of management.

When assigning accountability it is also important to consider the other responsibilities the individual has and whether the Quality Plan execution can reasonably be accomplished in parallel. In particular, accountabilities that cascade to staff or middle management may require some effort to adjust workloads so that it is possible for the individual to accomplish the expected tasks or achieve the objective.
7.0 COMMUNICATIONS

Any major undertaking in an organization can be greatly helped or greatly hindered by effective communication or the lack of it. Quality improvement is no different. When, how and to whom the Quality Plan will be communicated is an integral part of building the Plan itself.

Since the Board has ultimate accountability for quality, it is imperative that communication of the Plan starts at that level. The Board or the Quality Committee would normally be responsible for approving the Plan so an effective means to ensure that all members understand the Plan is the first priority.

Since the Quality Plan aims to inspire, motivate and attain sustained cultural change, it is readily apparent that it needs to have visibility with staff and management at all levels. Communication with internal stakeholders serves to:

- Make them aware of the Plan and set the expectation of change;
- Highlight coming initiatives and possible opportunities for involvement;
- Demonstrate Board and Senior Executive Team support for quality as a priority;
- Be transparent about goals, targets and metrics;
- Garner understanding and alleviate any insecurities about how the Plan will impact staff or the achievability of targets; and
- Motivate a positive attitude and receptiveness to participating in the journey the organization is undertaking.

It is equally important that the Plan is communicated to external stakeholders. These might include patients, families, funders, suppliers, affiliated organizations, philanthropic donors, the media and others depending on the breadth of the organization. The form and content of the communication to these entities will vary according to their specific interest and needs but in all cases, the communication strategy around a Quality Plan should aim to:

- Demonstrate that the organization takes its responsibility and accountability for quality seriously;
- Highlight impending changes that may impact the stakeholder;
- Inform the external stakeholder of their role in the quality initiatives (e.g. suppliers may be required to alter labeling or hospital visitors may be required to wash hands upon entering);
- Demonstrate transparency and good stewardship of public funding; and
- Create a positive attitude around the Quality Plan and initiatives.

There are many approaches to how the communication strategy for the Quality Plan can be developed and implemented. If the organization has a Public Relations or Communications department, they would normally play a key role in devising the strategy and materials for the roll-out. Some organizations may have a broader communication plan that encompasses all aspects of communication for the year. In this instance, the communication around the Quality Plan may be addressed as a sub-component of the broader plan. Others may charge the team that develops the Quality Plan with the task of also devising the communication strategy to go with it. Irrespective of which of these approaches is taken, common tactics of a Quality Plan communication strategy may include the use of:
• CEO presentations or speeches;
• Town Hall or small group meetings;
• Posters, bulletin boards and websites;
• Internal and external newsletters; and
• Training and education forums or seminars.

Finally, while this section is focused on communication of the initial roll-out of the Plan, there is an equally important and on-going need for the communication strategy to include an approach to communicate progress of the Plan. The section on Reporting addresses this aspect in greater detail.
8.0 REPORTING

The purpose of developing a Quality Plan is to bring about change and improvement in the organization. The metrics identified in the Plan allow the measurement of progress. However, just as important as the measurement itself is the reporting of that progress against the Plan to each of the stakeholders.

On-going monitoring of quality and patient safety is a Board responsibility, often delegated to the Quality Committee of the Board. Accordingly, regular reports of progress, designed to meet the specific objective of Board accountability are a key requirement. Frequency, level of detail and format of these reports will vary from Board to Board depending on how they elect to execute their quality and patient safety responsibilities however emerging standards (e.g. from Accreditation Canada) make the expectation of Board oversight very clear.

In addition to supporting the important oversight role, effective reporting on progress against the Quality Plan serves many purposes. It:

• Provides management with feedback about the effectiveness of the initiatives underway and directs attention to areas where adjustments in activities or targets may be required;
• Aids in the early identification of possible problems or gaps (e.g. resource commitment)
• Reminds stakeholders of the quality priorities of the Board and the Senior Executive Team;
• Informs stakeholders about the activities underway;
• Inspires and motivates staff by showcasing the results of their efforts;
• Demonstrates value for money; and
• Keeps the organization focused on the desired activities and outcomes.
The Working Group identified some key characteristics of effective reporting mechanisms.

**KEY CONCEPTS**

An effective reporting mechanism should:

- Be designed with input from multiple stakeholders
- Include goals and objectives:
  - Directly tied to the Quality Plan
  - Reflecting the organization's definition of quality
- Include performance measures in a format that displays trends and/or problem areas
- Identify domains or attributes of quality outlined in the Quality Plan
- Be reviewed on a regular basis
- Be displayed in a format that is clear and easily understood
- Differentiate between two types of questions:
  - How do we compare to others like us?
  - Are we getting better? Are we on track to achieve our aims?

Formats to present reports may include Dashboards, Scorecards, Stop Light Reports, Fact Sheets, PowerPoint and Electronic Business Intelligence Tools. Many organizations will employ multiple formats, tailored to the needs of individual stakeholders. Table 2 provides some guidelines on which formats to consider for different types of stakeholders.
Table 2: Reporting Format by Stakeholder

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Reporting Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board</td>
<td>• Dashboards/Scorecards - focus on ‘Big Dot’ indicators or system level measures</td>
</tr>
<tr>
<td>Quality Committees</td>
<td>• Dashboards/Scorecards</td>
</tr>
<tr>
<td></td>
<td>• Performance Report s— detailed report based on organization’s Quality Plan</td>
</tr>
<tr>
<td>Senior Executive Team</td>
<td>• Dashboards/Scorecards</td>
</tr>
<tr>
<td></td>
<td>• PowerPoint Presentations</td>
</tr>
<tr>
<td></td>
<td>• Stop Light Reports</td>
</tr>
<tr>
<td>Physicians</td>
<td>• Dashboards/Scorecards</td>
</tr>
<tr>
<td></td>
<td>• Stop Light Reports</td>
</tr>
<tr>
<td>Middle Management</td>
<td>• Dashboards/Scorecards</td>
</tr>
<tr>
<td></td>
<td>• Written reports</td>
</tr>
<tr>
<td>Clinicians</td>
<td>• Quick Fact Sheets</td>
</tr>
<tr>
<td></td>
<td>• PowerPoint Presentations</td>
</tr>
<tr>
<td>Patients and Families</td>
<td>• Summary</td>
</tr>
</tbody>
</table>

Reporting frequency will similarly be driven by the differing needs of the various stakeholders. In some jurisdictions, there may be mandated reporting timelines for certain stakeholder reports (e.g. funding authorities may impose specific requirements). Most organizations will have different reporting timetables for different stakeholders. While internal staff may require more frequent updates in order to maintain motivation and enthusiasm, some external stakeholders may not require updates as often.

Examples of the some of the identified reporting mechanisms are included in Section 10.
9.0 ASSESSING THE EFFECTIVENESS OF THE QUALITY PLAN

Towards the end of each year the governing body should take time to assess the effectiveness of the year’s Quality Plan. If a Quality Committee is in place, this group should take sufficient time to reflect on the past year and what was accomplished. A report of this assessment should be presented to the Board of Directors. If the Board, as a whole, acts as the Quality Committee then this group should undertake the same task.

It is not likely that a Quality Plan will be successful in achieving all of its objectives and performance targets. Many things can happen during a year that can alter the desired outcomes (e.g. outbreaks) or divert major energies (e.g. assignment of additional funding for specific wait time procedures, budget cutbacks due to unforeseen developments, etc). It is important to assess the circumstances under which a Plan or parts of a Plan were either exceeded or not attained.

Two Level Review Process
It may prove helpful to undertake the assessment at two levels: the first being a top level overview and the second being a more in depth look at various components of the Plan.

Top Level Assessment
The intent of this top level assessment is to get a ‘30,000’ ft. view of the performance of the Plan for the previous year. Questions such as the following should be considered:

1. Did the planning process for the Quality Plan reflect the input that was needed to prepare an effective Plan? Were the major internal stakeholder groups consulted as part of the process as well as signing off on the Plan? What changes should be considered for the following year?

2. What were our main accomplishments for the past year? List here the notable successes of the past year and note any special circumstances that allowed these results to be attained. What were the main shortfalls in the past year? Why did these occur? What lessons did we learn from these shortfalls?

3. Are we comfortable with our definition of quality and safety as well as our quality framework (the main dimensions of quality (e.g. accessible, appropriateness, safety, etc)? Should we consider any modifications for the coming year?

Second Level Assessment
This second level assessment would involve a more detailed review of the various components of the Quality Plan. Questions that should be considered for this review can include:

1. Are we making progress in our desired improvements over time (and not just this year)? If not, why not? What might we do to make a significant improvement in performance?

2. Are we measuring the right things? Are there other measures that may be more appropriate?
3. Are we using the right performance indicators? What other measures could we use?

4. Are we motivating the right behaviours? Are we impacting the culture in the desired way?

This assessment has a number of uses. It can form a major part of the report of the Quality Committee to the Board. It can also serve as an important component for assessing the performance of the Chief Executive Officer, the Senior Executive Team and the clinical leaders.
10.0 HIGHLIGHTS OF QUALITY PLANS

Members of the Collaborative have volunteered to share their current Quality Plans. These Plans are at various stages of evolution. The examples below present some key elements of strengths.

For example, the Saskatoon Health Region’s Quality and Safety Plan clearly identifies the organization’s strategic direction, vision dimensions of quality and goals.

| Strategic Direction: Transform the Care and Service Experience |
| Vision for Quality and Safety: Saskatoon Health Region will provide the safest, highest quality care, delivered with pride, in collaboration with patients and families. |

**Dimensions of Quality**
- Client- and family-centered
- Safety
- Effectiveness
- Access
- Efficiency
- Equity

---

**Goal 1: Place Clients and Families First**

**Quality Dimension:** Client- and family-centered

**Definition:** Provide care that is respectful of and responsive to individual client preferences, values and needs, and ensures that client values guide all clinical decisions.

**Objective:** 1. Create a culture of exceptional service and care which exceeds client expectations and is consistent with best practices.

**Initiatives:**
- Create at least 3 additional, specific client- and family-centered advisory councils.
- Develop a customer service training tool kit.
- Provide customer service orientation and training to all new employees through WOW.
- Orient 50% of all new employees on customer service plan.

**Measurement:**
- % of staff trained in customer service orientation.
- % on client- and family advisory council.

---

**Goal 2: Eliminate Harm and Avoidable Death**

**Quality Dimension:** Safety and Effectiveness

**Definition:** Safety: Eliminate preventable harm to patients from care that is intended to help them.

**Effectiveness:** Do the right thing to achieve the best possible result.

**Objective:** 1. Develop and implement a comprehensive harm reduction strategy.

**Initiatives:**
- Design and implement a Region-wide notification and response plan for issues clients consistent with new process developed by the Ministry (MOH).

**Measurement:**
- Uptake of applicable clients (MOH).
Another example is the Quality Plan used by St Michael’s Hospital which identifies objectives, outcome measures, current performance, activities and targets based on their quality framework. Below you can see three objectives under the quality dimension of safety.

### PART B: Improvement Targets and Initiatives

#### St. Michael’s Hospital

**Inspired Care, Inspiring Science.**

<table>
<thead>
<tr>
<th>AIM</th>
<th>MEASURE</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Reduce incidence of ventilator associated pneumonia (VAP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VAP rate per 1,000 ventilator days: the total number of ventilator days excluding days with VAP events in the ICU divided by the number of ventilator days in the reporting period, multiplied by 1,000 - average for Jan-Dec, 2010, consistent with national recommended patient safety data.</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>Reduce incidence of ventilator associated pneumonia (VAP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VAP rate per 1,000 ventilator days: the total number of ventilator days excluding days with VAP events in the ICU divided by the number of ventilator days in the reporting period, multiplied by 1,000 - average for Jan-Dec, 2010, consistent with national recommended patient safety data.</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>Safety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduce incidence of ventilator associated pneumonia (VAP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VAP rate per 1,000 ventilator days: the total number of ventilator days excluding days with VAP events in the ICU divided by the number of ventilator days in the reporting period, multiplied by 1,000 - average for Jan-Dec, 2010, consistent with national recommended patient safety data.</td>
<td></td>
</tr>
</tbody>
</table>
The following example is The Ottawa Hospital’s 3-year Quality Plan which identifies goals, objectives, indicators, activities, dates, targets and accountabilities based on their chosen quality framework. Below you can see the start and end dates for the various activities.

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Goal</th>
<th>Objective</th>
<th>Board Indicators</th>
<th>Activities</th>
<th>Performance Indicators</th>
<th>Target</th>
<th>Start Date (for activities)</th>
<th>Finish Date</th>
<th>Goal Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve access to Emergency Care, Urgent OR, Surgery and Diagnostic Imaging</td>
<td>To improve access and management times for Emergency Department patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACCESS - Patients should be able to get the right care at the right time in the right setting by the right healthcare provider (Ontario Health Quality Council - OHQC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve</td>
<td>To improve access and management times for Emergency Department patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/10 to be reassessed; ED Offload 90th percentile Offload Times for CTAS 1; Target – Improvement over combined Q1-4 FY07-08 performance; ED Offload 90th percentile Offload Times for CTAS 2 - 5; Target – CH: 2.00 GH: 1.20</td>
<td>ED Process RNs dedicated to patient flow; ED Waiting Room RNs; Inpatient Flow Manager; Enhanced portering for patient movement; Aftercare RN for follow-up on reports and free up of RNs and MDs; Support Staff dedicated to ECOs in ED; Maximize utilization on Clinical Decision Unit at Civic (summit funded pilot project)</td>
<td>Average and median monthly ambulance off-load delay; Cumulative minutes of ambulance vehicles in off-load delay by TOH. % compliance for disposition decision time done within 3 hrs of being paged; ED Access Times (% admitted patients with ED LOS ≤ 8 hours; % of CTAS 1 and 2 non-admit patients in ER ≤ 8hrs; % of CTAS 3 non-admit patients in the ER ≤ 6 hrs; % of CTAS 4 and 5 non-admit patients in the ER ≤ 4 hrs)</td>
<td></td>
<td></td>
<td></td>
<td>Sept 2008</td>
<td>March 2009</td>
<td>Mike Tierney Dr. Adam Cwirn</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Under the performance measures section of this Guide, we discussed big dots indicators. As an example, Trillium Health Centre has identified ED Wait times, patient satisfaction, pressure ulcers and HSMR as their four big dots indicators.

**Trillium Health Centre’s Four Big Dots**
The following are some examples of reporting mechanisms. The use of the red, yellow and green is ideal because it is easily understood and immediately indicative of the current status of an organization. This easy to review style of presentation is great when you need a quick idea of where things stand within the organization, but there is also enough information if a more thorough understanding is required.

Saskatoon Health Region Performance Dashboard
### Vancouver Coastal Health

**Our health care report card**

#### Provide the best quality of care

<table>
<thead>
<tr>
<th>Category</th>
<th>Frame Period</th>
<th>Target</th>
<th>Year to Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCESS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ER Wait Time</td>
<td>Apr 2011 to Nov 2011</td>
<td>&lt;= 54.0</td>
<td>51.4</td>
<td></td>
</tr>
<tr>
<td>Surgery Wait Time</td>
<td>Apr 2011 to Oct 2011</td>
<td>&gt;= 80.0%</td>
<td>75.3%</td>
<td></td>
</tr>
<tr>
<td>Mental Health and Addictions Community Follow-up</td>
<td>Apr 2013 to Mar 2011</td>
<td>&gt;= 80.0%</td>
<td>82.1%</td>
<td></td>
</tr>
<tr>
<td>Residential Care Wait Time</td>
<td>Apr 2011 to Oct 2011</td>
<td>&gt;= 80.0%</td>
<td>70.6%</td>
<td></td>
</tr>
<tr>
<td><strong>SAFETY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA Rate (PHC not included)</td>
<td>Apr 2011 to Sep 2011</td>
<td>&lt;= 5.8</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile Infection Rate</td>
<td>Apr 2011 to Sep 2011</td>
<td>&lt;= 7.4</td>
<td>8.5</td>
<td></td>
</tr>
<tr>
<td>Hand Hygiene Compliance</td>
<td>Apr 2011 to Sep 2011</td>
<td>100.0%</td>
<td>86.6%</td>
<td></td>
</tr>
<tr>
<td><strong>CLIENT CENTERED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Patient Experience</td>
<td>Apr 2011 to Jun 2011</td>
<td>&gt;= 90.0%</td>
<td>87.0%</td>
<td></td>
</tr>
<tr>
<td><strong>EFFECTIVENESS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Standardized Mortality Ratio</td>
<td>Apr 2011 to Jun 2011</td>
<td>&lt;= 190.0</td>
<td>198.0</td>
<td></td>
</tr>
<tr>
<td><strong>Promote better health for our communities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EFFICIENCY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternate Level of Care Days</td>
<td>Apr 2011 to Nov 2011</td>
<td>&lt;= 7.2%</td>
<td>0.2%</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Care Sensitive Condition Rate per 100,000 population</td>
<td>Apr 2010 to Mar 2011</td>
<td>&lt;= 17.1%</td>
<td>190.0</td>
<td></td>
</tr>
<tr>
<td><strong>EFFECTIVENESS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps and Rubella (MMR) Immunization Coverage Rates</td>
<td>Sep 2010 to Jun 2011</td>
<td>&gt;= 90.0%</td>
<td>87.5%</td>
<td></td>
</tr>
<tr>
<td>Early Childhood Development Index</td>
<td>2009-2011</td>
<td>&lt;= 15.0%</td>
<td>32.8%</td>
<td></td>
</tr>
<tr>
<td><strong>EQUITY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disparity Ratio for Life Expectancy</td>
<td>2006-2013</td>
<td>1.0</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td><strong>Optimize utilization of our current workforce and prepare for the future</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PEOPLE DIMENSION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Productive Hours per Patient Day (PHC not included)</td>
<td>Apr 2011 to Nov 2011</td>
<td>&lt;= 7.1</td>
<td>7.0</td>
<td></td>
</tr>
<tr>
<td>Staff Safety Scores (PHC not included)</td>
<td>Apr 2011 to Mar 2012</td>
<td>Not yet available</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>Total Absence Rate</td>
<td>Apr 2011 to Jul 2011</td>
<td>&lt;= 13.0%</td>
<td>13.2%</td>
<td></td>
</tr>
<tr>
<td><strong>LEARNING AND GROWTH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research Productivity (in millions of dollars)</td>
<td>Apr 2010 to Mar 2011</td>
<td>Not yet available</td>
<td>120.3</td>
<td></td>
</tr>
</tbody>
</table>
Winnipeg Regional Health Authority Performance Dashboard

The Winnipeg Regional Health Authority has used a combination of actual stoplights and graphs to illustrate their progress and areas for improvement. Note the way that the dashboard presents the strategic direction of the organization along with the dimensions of quality.

<table>
<thead>
<tr>
<th>VAMH Strategic Directions</th>
<th>Indicator</th>
<th>Year over Year</th>
<th>2011 / 2012 Current Performance</th>
<th>Comment</th>
<th>Dimensions of Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance Patient Experience</td>
<td>Week Time for Magnetic Resonance Imaging (days)</td>
<td>9.0 X 07</td>
<td>8.4 X 07</td>
<td>7.2 X 07</td>
<td>6.0 X 07</td>
</tr>
<tr>
<td>Enhance Patient Experience</td>
<td>Week Time for Ultrasound Procedures (in weeks)</td>
<td>11.0 X 08</td>
<td>10.0 X 08</td>
<td>9.0 X 08</td>
<td>8.0 X 08</td>
</tr>
<tr>
<td>Enhance Patient Experience</td>
<td>Admissions for Ambulatory Care Sensitive Conditions (ACSC)</td>
<td>2.00 X 08</td>
<td>1.90 X 08</td>
<td>1.80 X 08</td>
<td>1.70 X 08</td>
</tr>
<tr>
<td>Enhance Patient Experience</td>
<td>Week Time for Hip Fracture Surgery</td>
<td>2.00 X 08</td>
<td>1.90 X 08</td>
<td>1.80 X 08</td>
<td>1.70 X 08</td>
</tr>
</tbody>
</table>
11.0 CONCLUSION

Developing a Quality Plan and improving it over time is a critically important and challenging task for any healthcare organization, regardless of size, complexity or focus. Even though the overall objective of quality planning and reporting is a shared desire to improve patient care, each organization has different needs, experiences and culture and accordingly their Quality Plans and reporting templates will be uniquely reflective of their circumstances. This Guide has attempted to provide a structured approach to building an effective, actionable and measureable Quality Plan. Users of this Guide are encouraged to build upon the recommendations and examples provided and to share their experiences with their colleagues in the broader health sector so that we assist one another to collectively raise the bar in quality and patient safety.
12.0 REFERENCES


Steering Committee Responsible Care. Quality Framework Responsible Care: Nursing, Care and Home Care (Long-term and/or complex care. The Netherlands. 2007; 71 p. (Available at http://www.biomedcentral.com/content/supplementary/1472-6963-10-95-S1.PDF)

APPENDIX 1: EXAMPLES OF QUALITY FRAMEWORKS

Institute of Medicine

The quality dimensions are:

- **Safe**: avoiding injuries to patients from the care that is intended to help them.

- **Effective**: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.

- **Patient-centered**: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.

- **Timely**: reducing waits and sometimes harmful delays for both those who receive and those who give care.

- **Efficient**: avoiding waste, including waste of equipment, supplies, ideas, and energy.

- **Equitable**: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
Accreditation Canada’s Quality Framework

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>TAG LINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>POPULATION FOCUS</td>
<td>Working with communities to anticipate and meet needs</td>
</tr>
<tr>
<td>ACCESSIBILITY</td>
<td>Providing timely and equitable services</td>
</tr>
<tr>
<td>SAFETY</td>
<td>Keeping people safe</td>
</tr>
<tr>
<td>WORKLIFE</td>
<td>Supporting wellness in the work environment</td>
</tr>
<tr>
<td>CLIENT-CENTRED SERVICES</td>
<td>Putting clients and families first</td>
</tr>
<tr>
<td>CONTINUITY OF SERVICES</td>
<td>Experiencing coordinated and seamless services</td>
</tr>
<tr>
<td>EFFECTIVENESS</td>
<td>Doing the right thing to achieve the best possible results</td>
</tr>
<tr>
<td>EFFICIENCY</td>
<td>Making the best use of resources</td>
</tr>
</tbody>
</table>

- 8 dimensions that guide focus of standards
- Tag lines give a clear sense of each dimension
**QUALITY DIMENSIONS**

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Tag line</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility</td>
<td>Providing timely services</td>
<td>The ability of patients/clients to obtain care/service at the right place and the right time, based on respective needs, in the official language of their choice.</td>
</tr>
<tr>
<td>Appropriateness</td>
<td>Relevant and evidence based</td>
<td>Care/service provided is relevant to the patients/clients’ needs and based on established standards.</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Doing what is required to achieve the best possible results</td>
<td>The care/service, intervention or action achieves the desired results.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Making the best use of resources</td>
<td>Achieving the desired results with the most cost-effective use of resources.</td>
</tr>
<tr>
<td>Equity</td>
<td>Aiming for equitable care and services for all</td>
<td>Providing quality care to all, regardless of individual characteristics and circumstances, such as race, color, creed, national origin, ancestry, place of origin, language, age, physical disability, mental disability, marital status, family status, sexual orientation, sex, social status or belief or political activity.</td>
</tr>
<tr>
<td>Safety</td>
<td>Keeping people safe</td>
<td>Potential risks of an intervention or the environment are avoided or minimized.</td>
</tr>
</tbody>
</table>
Reporting Framework:
The Attributes of a High-Performing Health System

Ontarians want their health system to be —

**ACCESSIBLE** — People should be able to get the right care at the right time in the right setting by the right healthcare provider.

For example, when a special test is needed, you should receive it when needed and without causing you extra strain and upset. If you have a chronic illness such as diabetes and asthma, you should be able to find help to manage your disease and avoid more serious problems.

**EQUITABLE** — People should get the same quality of care regardless of who they are and where they live.

For example, if you don’t speak English or French it can be hard to find out about the health services you need and to get to those services. The same can be true for people who are poor or less-educated, or for those who live in small or far-off communities. Extra help is sometimes needed to make sure everyone gets the care they need.

**EFFECTIVE** — People should receive care that works and is based on the best available scientific information.

For example, your doctor (or healthcare provider) should know what the proven treatments are for your particular needs including best ways of coordinating care, preventing disease or using technology.

**SAFE** — People should not be harmed by an accident or mistakes when they receive care.

For example, steps should be taken so that elderly people are less likely to fall in nursing homes. There should be systems in place so you are not given the wrong drug, or the wrong dose of a drug.

**PATIENT-CENTRED** — Healthcare providers should offer services in a way that is sensitive to an individual’s needs and preferences.

For example, you should receive care that respects your dignity and privacy. You should be able to find care that respects your religious, cultural and language needs and your life’s circumstances.

**APPROPRIATELY RESourced** — The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people’s health needs.

For example, as people age they develop more health problems. This means there will be more need for specialized machines, doctors, nurses and others to provide good care. A high quality health system will plan and prepare for this.

**INTEGRATED** — All parts of the health system should be organized, connected and work with one another to provide high quality care.

For example, if you need major surgery, your care should be managed so that you move smoothly from hospital to rehabilitation and into the care you need after you go home.

**FOCUSED on POPULATION HEALTH** — The health system should work to prevent sickness and improve the health of the people of Ontario.
The BC Health Quality Matrix was developed in collaboration with the members of the BC Health Quality Network which includes health authorities, the Ministry of Health Services, the Ministry of Healthy Living and Sport, academic institutions and provincial quality improvement groups and organizations.