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New Models for the New Healthcare

## Responsibility for Canada's Healthcare Quality Agenda: Interviews with Canadian Health Leaders

Terrence Sullivan, Fredrick D. Ashbury, Jason Pun,  
Barbara M. Pitt, Nina Stipich and Jasmine Neeson



**Commentary from** Jeffrey Turnbull, Owen Adams, Wendy Nicklin, Gail Williams, Janet Davidson, W. Ward Flemons, Thomas E. Feasby, Bruce Wright, Sharon Goodwin, Ariella Lang, Arlene S. Bierman, Hugh MacLeod, Rachel Bard, Mary-Anne Robinson and Dan Horvat

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Last January (2011) MacLean's announced that a recent survey of developed countries puts Canada at the bottom of the list in timeliness and quality of care. This issue of *HealthcarePapers* responds with an analysis of the challenge and thoughts on capacity building and responsibility for the healthcare quality agenda.

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# Notes from the Editor-in-Chief

A FEW YEARS ago, G. Ross Baker and five colleagues published a series of case studies under the title *High Performing Healthcare Systems: Delivering Quality by Design* (2008). Their goal was to investigate a handful of international and Canadian healthcare systems in order to learn about the leadership strategies, organizational processes and investments that had earned those systems the adjective “high performing.”

In their introduction to that collection, the researchers held out the Toyota Motor Corporation as an exemplar of the successful quest for quality. Alas, they mused, “there is no Toyota in healthcare: no one system clearly outdistances its competitors in virtually all its products and services” (23). Within a year, however, Baker et al. must have reflected a bit uneasily over their comparison: by late 2009, a series of quality-control lapses had forced Toyota into a series of embarrassing and costly product recalls involving mechanical, electrical and software failures.

From this little narrative I take away a lesson not only of time’s mostly inscrutable (and unavoidable) ironic power, but also about the difficulty both of defining and engineering quality with absolute certainty and long-term stability. And yet, it is into this complicated wilderness that our lead authors – Terence Sullivan, Frederick D. Ashbury, Jason Pun, Barbara Pitts, Nina Stipich and Jasmine Neeson – bravely stride and, in so doing, offer many valuable angles from which to view the subject.

As guides on their journey, Sullivan and his co-authors relied on extensive information gathered through interviews with 53 health leaders from across Canada. These interviews

were aimed at gaining “critical issues and perspectives” about three broad topics:

- Performance improvement and quality activities
- Challenges in the adoption and implementation of quality improvement
- Opportunities to strengthen the quality agenda at the individual, institutional, provincial and national levels.

Most readers will not be surprised to encounter the challenges about which Sullivan et al. heard. These include leadership that lacks a defined focus on quality, absence of a standardized approach across quality improvement initiatives, limited physician engagement, few physician champions and scarcity of human and financial capacity/resources. More optimistically, the researchers discovered “the existence of pockets of leadership” at the individual, organizational and agency levels.

While I wish that Sullivan et al. had spent more time describing the actual fabric, threads, and patterns of those pockets, I take their point that Canada’s healthcare system must develop ways to transfer knowledge from those successes “into measured behavioural and practice change.” At base, the authors learned, such knowledge transfer will require “consistent and strategic approaches” predicated on “the need to adopt a culture of quality” (a requirement cited by all their interviewees). Such a culture, the authors observe, entails continuous learning and improvement; it can, they claim, be achieved through investments that improve operational capacity, by aligning program and institution quality goals and through measuring and reporting.

Sullivan et al. conclude by advocating for a “performance agenda” and a “national agenda.” The latter, they say, must be “based on a coalition of the willing.” Perhaps it is too much to ask in a single essay, but the authors do not clarify who – individuals or organizations – would comprise such a coalition. It is all very good to call for new agendas and coalitions, but I am left feeling a bit dazed by the prospect of who or what body would take “responsibility” (a key word in their title) for contriving and managing such an entity in a country where the healthcare mosaic is so politically diverse.

At least part of my hesitation seems to be shared by Owen Adams who, in his commentary on the lead paper, observes that developing, agreeing on and using common indicators and reporting frameworks is a gigantic undertaking. Despite endorsement at various levels of government, the enterprise (other than with wait times) has never really gotten off the ground. As Adams notes, the last 15 or so years have seen lots of initiatives – for example, provincial quality councils and patient charters – that are likely steps in the right direction. But setting and sustaining a truly pan-Canadian “culture of quality” is on a wholly other order of magnitude.

In an effort to diagnose (partially) the lack of coordination in the national quality agenda, Wendy Nicklin and Gail Williams add the salient point that movement towards the creation of such an agenda will be supported by acknowledging “the interwoven relationship between quality and efficiency”; in their view, “an unrelenting focus on quality and efficiency ultimately results in positive change.” I was most struck by their observation that one of the strongest inhibiting factors afflicting the quality agenda is the proliferation of bodies to which healthcare organizations must submit data. Reporting is essential, but when does it become inefficient

through rampant duplication?

Our third commentary is by a leader of the calibre Sullivan et al. interviewed. Janet Davidson, the president and chief executive officer (CEO) of Trillium Health Centre, begins by stating that quality must be made “everyone’s business,” not just the purview of “evangelical leaders.” Largely addressing organizational-level quality, Davidson takes a sceptical view of large-scale “structures” such as provincial or national quality councils, a point that seems to be at odds with many of her peers across the country and several of her fellow commentators in this issue.

The next two commentaries add further dimensions unexplored by Sullivan et al. First, taking a more theoretical approach, W. Ward Flemons, Thomas Feasby and Bruce Wright suggest that the critical shortcoming in Canada is the lack of recognition that quality and safety are “system” properties and not confined to the competencies of individual care providers. The “disruptive change” for which they argue entails educating future physicians, other providers and managers about how to navigate the complex health systems in which they will one day work. Sullivan et al. are stuck, they say, at the “macrosystem level”; for real cultural change to occur, however, educators must also address the “meso” and “micro” levels in undergraduate and postgraduate healthcare education, including a strong leadership-training component.

Sharon Goodwin and Ariella Lang, meanwhile, view quality through the lens of the home and community-care sector, a practice-setting lacking amongst the leaders Sullivan et al. canvassed. How, for instance, do we deal with the quality issues attendant on the stress, fatigue, financial burdens and lack of training among informal caregivers who perform complex medical tasks in the home? Eighty percent of care in the home is delivered by family members: where do account-

ability and responsibility figure in those scenarios? I see great promise in Goodwin and Lang's contention that "exceptional client experience" might be the necessary "link" among quality, safety and efficiency and not, I would add, just in the home-care setting. In this regard, I detect a partial overlap with Arlene Bierman's contention that the leaders interviewed by Sullivan et al. missed the "perspective of front line providers, patients and the communities that they serve"; engaging these people and groups is, she says, critical. As well, Bierman was concerned that a number of leaders felt the lack of a clear definition of quality inhibited progress; this, she contends, is "a massive failure of knowledge translation." I was heartened, finally, by Bierman's contention that "upstream" public policy focused on health promotion ought to be part of the quality mix.

Hugh MacLeod – another major Canadian leader – devotes a good part of his commentary to exploring the implications of his striking contention that Canada does not actually have a healthcare "system" in the sense of "services that have been designed to work together to create an intentional outcome." As a result, how can the leaders interviewed by Sullivan et al. rationally expect to reform, transform, redesign and, in particular, align something that is more rhetoric than reality? MacLeod concludes by describing four "leverage" points for system redesign: front-line service providers, leadership and management, governance and government context (i.e., public servants and elected officials).

The last two commentaries in this issue address the lead paper from two distinct professional vantage points. Offering perspectives derived from the nursing profession, Rachel Bard and Mary-Anne Robinson echo the sentiments of a number of other commentators in wondering how the leaders Sullivan et al. interviewed seem rather out of touch with

quality-improvement developments occurring over the last 10-20 years. In addition, just as Goodwin and Lang were disturbed by the absence of home-care leaders from Sullivan et al.'s interviews, Bard and Robinson lament the lead authors' erasure of regulators from professional bodies, a group they believe is vital, in particular, to priority-setting and education. I would enjoy one day listening to a conversation on the matter of "efficiency" among Nicklin/Williams, Davidson and Bard/Robinson. I do not think it would lead to fisticuffs; rather, such a debate by these leaders who occupy such varied roles would, I believe, lead to intriguing nuances on how align, measure and balance quality and cost.

From views arising from the nursing profession, we move on to the concerns of a physician. Like nearly every other commentator, Dan Horvat wonders how, given the immense investments and efforts already made, so many quality-related problems still persist. One of Horvat's main points is that the "disconnect" between medical practitioners and healthcare administrators is a fundamental barrier to progress. Drawing on his own experiences, Horvat laments the difficulty physicians (and other distinct groups who comprise a "patchwork of cultures") have of sharing on-the-ground information with decision-makers. Looking beyond Canada for examples of quality-improvement success, Horvat concludes that Canada requires a "bigger tent." Under the canvas he envisions diverse professionals collaborating on plans and decisions, an approach that is superior to conventional performance management because it "promotes shared responsibility and accountability."

As I consider all the views presented in this issue of *Healthcare Papers*, I return to an observation made by Adalsteinn Brown when he was an assistant deputy minister in Ontario's Ministry of Health and Long-Term Care: "high quality is more the result of a

culture that pursues quality than of any single investment or policy” (Baker et al. 2008: 10). The sagacity of Brown’s words echoes in the findings presented by Sullivan and his fellow researchers, and in the commentaries that joust with the aspirations and complexities that surround the (possibly eternal) quality quest.

*Peggy Leatt*, PhD  
Editor-in-Chief

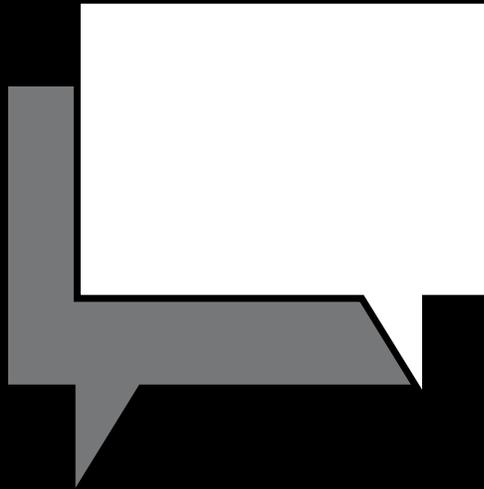
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INVITED ESSAY

# Healthcare*Papers*

# Responsibility for Canada's Healthcare Quality Agenda: Interviews with Canadian Health Leaders



INVITED ESSAY

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ABSTRACT

*Canadian healthcare is under increased scrutiny to improve quality and performance, and for good reason. The proliferation of provincial-level quality councils underscores the urgency to establish an aligned national quality agenda. Patient safety has long been held as a critical element of a high-quality healthcare system; with the inexorable growth in spending, efficiency has more recently been introduced. Efficiency and quality are both factors in Ontario's Excellent Care for All legislation introduced in June of 2010, and Quebec's l'Institut national d'excellence en santé et en services sociaux (INESSS) arising from the Castonguay report. These associations of quality and efficiency are also echoed in the US, Australian and UK public debates. The development of a quality agenda has concurrently precipitated discussion regarding responsibility for quality, particularly but not exclusively with the emergence of quality issues in the technical and interpretive pathology arena. The discussion and debate on responsibility have become preoccupations at the national, provincial, institutional and individual profession levels.*

*With this in mind, we conducted in-depth, one-on-one interviews with 53 health leaders from across Canada, representing hospitals, regional health authorities, quality councils and government. These interviews yielded several important insights and recommendations into the current status of and opportunities for Canada's quality agenda, including (1) the existence of pockets of leadership and the need for a better alignment on dimensions of quality; (2) the need to adopt a "culture of quality" at the individual, institutional, provincial and national levels; (3) a deepened commitment to measure and report on performance and quality outcomes; (4) and the need to identify external enablers and capacity building to facilitate the quality agenda.*

*Notwithstanding Ontario's commitment to hold institutional leaders to account for quality plans and progress, healthcare leaders were mixed in their support for personal-level incentives, and opinions varied regarding the appropriateness of a national organization or consortium of organizations to guide, oversee and support healthcare quality improvement. Some leaders mused that a barrier to healthcare improvement is the absence of a common definition of quality, which seems particularly puzzling. It suggests that until such a definition exists, we must continue with the status quo. However, we clearly have a fairly consistent set of thematic dimensions on quality across Canada, notwithstanding differences in provincial context and policy imperatives. This paper concludes with an elaboration of these findings, selected examples and some thoughts on capacity building and responsibility for a Canadian healthcare quality agenda.*

CANADIAN HEALTHCARE IS under increased scrutiny to improve quality and performance. Despite our national pride, Canada's overall quality performance remains middling at best (Canadian Health Services Research Foundation [CHSRF] 2010; Commonwealth

Fund Foundation 2010). This increased pressure for quality appears to be driven by three factors: (1) a move to person-centred models of care delivery in which individual needs and expectations for participation in health are given primacy; (2) the need to contain and

reduce costs in healthcare delivery, duplication of services and process inefficiencies; and (3) the need to improve quality and patient safety. The welcome evolution of provincial-level quality councils creates a necessary accountability mechanism for reporting on quality; however, the system-level responsibility to advance quality and delivery of high reliability

*“Locally, with so many competing priorities, quality improvement initiatives were said to be managed “off the side of the desk.*

and higher-quality health services in Canada remains fragmented and murky (Dobrow et al. 2006). While patient safety has long been held as a critical element of a high-quality healthcare system, efficiency has more recently been re-introduced as an integral component of quality, demonstrated in Ontario’s Excellent Care for All Act (Ministry of Health and Long-Term Care 2010) and Quebec’s l’Institut national d’excellence en santé et en services sociaux (INESSS 2008). These associations of quality and efficiency are also echoed in public debates in the United States (Randolph et al. 2009), Australia and the United Kingdom (Care Quality Commission 2011). The Institute for Healthcare Improvement Triple Aim framework also focuses on optimizing improvements in population health, the patient experience of care (quality, access and reliability) and cost containment (McCarthy and Klein 2010).

The development of a quality agenda has concurrently precipitated discussion concerning who is responsible for quality, particularly but not exclusively with the emergence of quality issues in the technical and interpretive

pathology arena and medical errors resulting in unnecessary and preventable patient morbidity and mortality (Baker et al. 2004; Doucette et al. 2010; Kohn et al. 2000). The discussion and debate has become a preoccupation at the national, provincial, institutional and individual profession levels.

The purpose of this paper is to describe critical issues and perspectives concerning Canada’s healthcare agenda, as reported by health leaders canvassed from across the country. In addition, the paper identifies possible institutional opportunities to contribute to and strengthen the quality agenda, based on the results of a survey launched by CHSRF.

### **Methodology**

CHSRF has relationships with healthcare leaders from across Canada in government, hospitals, quality councils and academic institutions. Based on these relationships, CHSRF developed a sample of 77 health leaders representing each province to participate in telephone interviews designed to understand performance improvement and quality activities, challenges in the adoption and implementation of quality improvement, and opportunities to strengthen the quality agenda at the individual, institutional, provincial and national levels.

The study design and draft interview guide were submitted to and received ethics approval from IRB Services. Invitations to participate in the interviews were sent by CHSRF, and the study team contacted candidates to confirm participation. Up to five callbacks were done to arrange an interview if no response was received, before abandoning the candidate. Interviews were conducted in English and French during the period July 26 through October 27, 2010.

To collect the data, an inductive, qualitative interview design was implemented in three phases. The inductive design enabled the study team to identify potential themes and to refine

and validate the lines of inquiry and themes through a buildup of data collected from study participants over time (Glaser and Strauss 1967). In phase one, nine interviews were completed and themes were identified. These themes were subsequently “tested” during interviews with an additional 11 health leaders in phase two. The final phase involved further elaboration and validation of the themes. Study team members independently reviewed the completed interviews, coded the data to identify potential themes and convened to discuss and achieve consensus on interpretations.

### Findings

Table 1 illustrates the provincial distribution of Canadian health leaders who partici-

pated in the interviews. As the table shows, interviews were conducted with 53 of the 77 interview candidates to whom invitations were sent to participate, for a response rate of 69%. The response rates by province are also presented and ranged from a low of 33% (Prince Edward Island) to a high of 93% (Ontario). Overall, responses from Ontario comprised approximately one quarter of the completed interviews (26%), followed by Quebec responses (17%).

Table 2 displays the distribution of interview participants by agency representation. Twenty-five representatives from regional health authorities (47.2%) comprised the largest group, followed by 15 hospital representatives (28.3%).

**Table 1. Canadian health leaders who were interview participants, by province**

Province	No. Invited	No. of Interviews Completed	Percentage of Invited Participants Who Responded	Percentage of Total Interviews That Were Completed
Ontario	15	14	93	26
Quebec	13	9	69	17
British Columbia	7	5	71	9
Alberta	8	3	38	6
Manitoba	6	5	83	9
Saskatchewan	5	3	60	6
Nova Scotia	7	4	57	8
New Brunswick	3	2	67	4
Newfoundland	4	3	75	6
Prince Edward Island	3	1	33	2
Territories	5	3	60	6
National	1	1	100	2
Total	77	53	69	

**Table 2. Canadian health leaders who were interview participants, by agency representation**

Regional Health Authority	Hospital	Quality Council	Government	Independent Agency	Professional Association
25	15	5	4	2	2

### **The Existence of Pockets of Leadership**

Interviews with health leaders from across Canada suggest that a key challenge to implementing quality improvement is consistent leadership with a defined focus on quality. The role and limited involvement of boards of directors were questioned by some interviewees, as they perceived their boards to be disengaged in providing a vision and setting expectations for quality and performance. Locally, with so many competing priorities, quality improvement initiatives were said to be managed “off the side of the desk.” As demands are continuing to increase on healthcare institutions, leadership needs to devote time and effort to quality improvement initiatives in order to implement sustainable change.

Although many organizations endeavour to conduct quality improvement initiatives, perhaps not surprisingly these programs often lack a standardized and consistent approach. Many organizations are perceived to be “doing their own thing.” Additionally, limited physician engagement and few physician champions for quality improvement were cited as challenges. Many interviewees suggested that physicians have to be integrated and involved in the quality conversations in order to further the quality agenda. Several interviewees noted that a lack of capacity in terms of both human and financial resources and skills is an important barrier to the success of quality improvement initiatives. For example, some suggested that an absence of knowledge translation of best managerial practices and limited training in process improvement (e.g., Lean techniques) are inhibitors to quality improvement.

Nevertheless, the interviews yielded evidence of the existence of pockets of leadership in healthcare quality improvement throughout Canada. This includes examples of individuals and agencies and organizations whose efforts were recognized to

contribute positively to the quality agenda, including provincial health quality councils, the Canadian Patient Safety Institute, Accreditation Canada, the Canadian Institute for Health Information, INESSS, selected regional health authorities and examples of individual hospitals and agencies where quality improvement initiatives have taken a prominent role. While acknowledging that these pockets of leadership exist, the challenge facing the healthcare system is transferring and translating the knowledge from these sources into measurable behavioural and practice change that can be adapted at the individual, institutional, provincial and national levels.

### **The Need to Adopt a “Culture of Quality” at the Individual, Institutional, Provincial and National Levels**

Health leaders indicated that existing embedded cultures in healthcare organizations have failed to fully (or even partially) embrace quality. Resistance to change among clinicians and healthcare providers was noted as a key barrier. Some interviewees noted that a quality culture needs to start at the top of an organization. If the leadership (boards of directors, chief executive officers) makes the promotion of performance and quality improvement a high priority and aligns it with staff goals and objectives, then the institutionalization of the quality agenda can gain greater traction. Interviewees also discussed the need for change management to facilitate the transition to a culture of quality. In addition, if leadership sets the tone, then others in the management hierarchy down to the front-line staff can be expected to mirror this tone if an effectively implemented change management strategy is in place. Furthermore, many argued that the public should be included in the quality improvement discussion as they are the receivers/purchasers of care. Public engage-

ment is an integral component of the person-centred care mandate.

The interviewed health leaders felt strongly that quality cannot be the “flavour of the month”; rather, it must be integrated into the day-to-day business of the healthcare setting in order to shift the organizational culture to one of safety, efficiency and quality improvement. Additionally, they perceived that attracting and recruiting staff with the knowledge and skills needed for change initiation and management, and subsequently

*Health leaders felt strongly that quality has to be integrated into the day-to-day business of a healthcare setting to shift the organizational culture to one of safety, efficiency and quality improvement.*

linking quality to position descriptions are important steps to creating a culture of quality.

Interestingly, some interviewees felt that a clear definition of *quality* does not exist but is needed. Some believed that the ambiguity that exists around quality interferes with the implementation of a pan-Canadian quality improvement program that can be embraced by all. Others believed that, while it is certainly true that one common definition or thematic bundling of quality does not exist in Canada, there are many elements and metrics already common across different provincial frameworks and models of quality improvement, as was noted last year at the Canadian Health Services Research Foundation's CEO Forum (CHSRF 2010). To avoid paralysis, the leadership can certainly work with provincial quality

councils to address their provincially unique components of quality improvement to define and advance an institution's quality agenda.

### **The Need to Measure and Report on Performance and Quality Outcomes**

The leaders suggested that perceived barriers to quality improvement include access to data collection and clear, evidence-informed approaches to measurement strategies and tools. Among interviewees, there seemed to be a lack of consensus and difficulty in determining which indicators are most beneficial for tracking and reporting. Indicators, targets and benchmarks were felt to be inconsistent from one organization to the next, making comparisons difficult. At the systems level, measurement and reporting frameworks such as the Ontario Wait Times Strategy, which was referenced with respect to a successful access measure, can only be used to compare hospital performance in the province, not with hospitals from across the country. Some of the leaders interviewed had little confidence in the data that are available from existing systems, and some also expressed concern that data had been inappropriately analyzed and interpreted. However, as we know, “purification through utilization” is probably the best remedy for this concern (Sullivan et al. 2005). This concern was especially evident when interviewees discussed the need for a “level playing field,” where organizations are compared with one another and the metrics reported are standardized across organizations.

In order to mitigate these challenges, interviewees stressed the importance of aligning indicators across organizations and systems. Some argued that there is a need to increase internal and public reporting and evaluation and to include quality and cost data in accountability frameworks. Public accountability enables different players to understand

their relative rankings and facilitates decisions about where gaps can be addressed. In addition, public accountability, some argued, enables patients to make informed choices about what levels of health services they can expect from their local healthcare institutions.

### **The Need to Identify External Enablers to Facilitate the Quality Agenda**

Many of the health leaders interviewed felt there is insufficient enabling human and technical infrastructure in Canada to facilitate a quality agenda, while stating that existing organizations contributing to this enabling infrastructure lack a national focus. In the absence of this infrastructure, organizations supporting quality and performance improvement have significant opportunities to work in a more coordinated manner and to look at strategies to shore up jurisdictions within Canada that are struggling to embed quality improvement programs. It was argued by several that some type of national body is required to coordinate provincial resources and provide the necessary leadership to create policies that support an efficient, evidence-informed, pan-Canadian quality agenda. Some people interviewed believed that a national initiative that includes oversight, provincial participation in governance and mechanisms to identify innovation and assess the evidence to facilitate quality improvement is required.

Those interviewed indicated that the provincial quality councils present different perspectives on quality. These differences may be interpreted as inconsistent interpretations of quality improvement policies and strategies, and thereby contribute to confusion about how to address quality control and improvement.

There was some but certainly not universal support for a national strategy or a federated consortium of organizations to lead the quality agenda in Canada. If a consortium were formed, it would need to be one that is

led with provincial and territorial representation and national alignment and infrastructure support to the provinces. Others believed that rather than investing resources in the creation of a national entity, perhaps building on existing infrastructure to incorporate modules from proven initiatives in other jurisdictions would be more beneficial.

Many health leaders and their organizations were expending resources to receive consulting support from external agencies (an annualized range of \$12,500 to almost \$3,400,000, with an average of approximately \$600,000, was reported in the survey) such as the Institute for Health Improvement in the United States. Clearly, however, there is considerable information-seeking activity to obtain training and consulting support to bolster quality improvement program planning, policy, implementation and evaluation from Canadian and non-Canadian organizations and agencies. Very few of the external resources were drawing on Canadian capacity for quality improvement.

### **Use of Incentives**

Incentives (both positive and negative) have long been discussed as a strategy to drive change toward a desired outcome. Incentives to achieve performance and quality improvement have been directed at individuals, groups and institutions. Positive incentives can include financial reimbursement, awards for quality achievement, peer-recognition initiatives, career development opportunities (i.e., additional training and education) and increased resources. Negative incentives can include the publication of poor performance compared with peers and the withdrawal of funding if targets are not met.

The views among interviewees on the role of incentives to shape the uptake of a quality agenda were mixed, as was support for whether incentives should be “carrots,

sticks or both.” For example, there was strong support from interviewees for public reporting and peer comparisons. It was felt that these reports stimulate practice change because they publicize performance, thereby motivating organizations and staff to improve. However, some felt that public reporting can create challenges, such as the manipulation of data to show positive outcomes, or a failure to disclose data, thereby burying problems to avoid blame or other negative reinforcements.

*Everyone has a responsibility in ensuring an efficient and safe Canadian healthcare system.*

Interviewees were also asked to comment on proposed incentives to senior executives and their perception of the efficacy of these to change culture. Again, responses were mixed. Some felt that this can help bring about change and the adoption of quality at a faster pace. Others felt that incentives to senior executives to meet quality standards miss the point, as illustrated by the theme, “personal incentives are like paying people extra for doing their job.” The accuracy and precision of data collection (and the previously mentioned manipulation of data) were also voiced as barriers to the acceptance of personal incentives for senior executives. Another concern expressed was the potential misalignment of incentives in which institutions or individuals are reimbursed for volume (quantity) rather than quality of care.

## **Discussion**

The findings suggest a need for consistent and strategic approaches to support any national quality agenda in Canadian healthcare. Everyone has a responsibility in ensuring an

efficient and safe Canadian healthcare system. At the institutional level, the responsibility for quality requires board members, senior leadership, managers, front-line staff and the public to participate in determining and reinforcing quality healthcare. If boards and senior executives are not engaged, quality improvement cannot become a fundamental element of the culture of the institution. Baker et al. (2010) offer some reasons for the disengagement of boards from quality and performance, such as the traditional focus on finances and strategy, limited experience or knowledge about healthcare quality initiatives, a lack of the appropriate level of indicators and maintaining the role of oversight and governance. Hence, senior leadership must be given support in these areas that enable them to make quality the priority. Leonard and Frankel (2010) have argued that senior leadership must be actively seen to support and reinforce the quality agenda; the quality imperative must be clearly and routinely articulated throughout all levels of the healthcare setting, including front-line staff, and communicated to external stakeholders, particularly the public, to transmit that quality is a key value of the institution. They argue that an “environment of continuous learning and improvement” is essential and is characteristic of high-performing healthcare organizations that “constantly work to learn” (see also Jeffs et al. 2007).

Baker and Norton (2004) note that few healthcare organizations have made investments in building knowledge and skills to improve safety, as well as in implementing skills to identify issues and analyze events. Brien et al. (2009) offered that knowledge exchange initiatives, such as the exchange of reports within and across institutional settings, could be done to “catalyze the collaborative development of quality improvement initiatives.” Furthermore, they argued that knowledge transfer should be directed at appropriate

individuals who have an ability and determination to change practice and improve care.

While the absence of a common definition of quality was cited by some as a barrier to the adoption and implementation of performance and quality improvement programs, this seems to be a misplaced concern. There are certainly different models and frameworks for quality improvement (Brien et al. 2009), but most have common principles and attributes, including evidence-informed practice, patient safety, placing the individual at the centre of care, stakeholder engagement, data collection systems, performance indicators and monitoring and reporting functions.

The need to adopt a culture of quality was uniformly expressed by those interviewed. Culture change strategies, however, will be required in most institutions if quality improvement is expected to take place. Leonard and Frankel (2010) have noted that culture affects both practice behaviour and the ability to deliver safe care (see also Frankel et al. 2003). According to Leonard and Frankel, the institution must avoid a culture in which “blame” predominates as this may result in mistakes being buried (see also Jeffs et al. 2007). The focus instead needs to be on how and why issues arose, rather than who is to blame; this will allow for the identification of processes to prevent the problem from happening again. In addition, Shine and colleagues (2002) suggest that we need to move from a culture of autonomy (particularly among physicians) to one in which multidisciplinary teams and patients collaborate to identify and resolve problems. The quality culture is therefore focused not only on continuous learning but also on continuous improvement. A quality culture can be achieved in a sustainable way if investments are made to improve operational capacity; the goals and objectives of each program throughout an institution can be aligned with the overall goals and

objectives for quality of the institution; and a commitment to continuous improvement is not only articulated but measured, reported and built upon to improve care.

While those interviewed had different perspectives on (1) what quality metrics should be used to measure performance, (2) the quality of data currently being collected and (3) reporting, there was consensus that there is a need to measure and report on performance and quality outcomes. Similar to the discussion above, the absence of a quality definition that is shared by everyone should not be used as means to paralyze the movement to improve healthcare quality. Growth in the elderly population, increased prevalence of chronic illnesses, health human resource shortages, increasing public expectations and rising costs have placed demands on health systems to improve care and become more efficient (Kelley et al. 2006; McLoughlin et al. 2001). According to the literature, although quality is on the agenda in many nations and health systems, data collection to measure and improve the quality of care have recently started to increase in frequency (De Vos et al. 2009; Gibberd et al. 2004; Mainz 2003; Mainz et al. 2004). Mainz and colleagues (2004) point out that individuals, providers, regulators and payers are all demanding access to system performance to inform choices. Despite the delay in uptake, indicators lead to continuous quality improvement through monitoring of performance, benchmarking, making judgments, prioritizing and informing patient choice (Mainz 2003). Cheng and colleagues (2010) note that indicators are useful to assess structure, process and quality outcomes.

Recently, challenges with measuring data have changed from the availability of information to the management and proper use of data (Baker et al. 1999). Additional challenges with data measurement include creating

patient-friendly reports, improving the quality of the data and ensuring that data are easily accessible among providers (Baker et al. 1999). Collecting indicator data implies an administrative burden for physicians and hospitals (De Vos et al. 2009); thus, these activities should be optimized so that only data that will be used to drive decision-making are collected. Although our capacity to assess performance has increased, the resulting alignment of policies and strategies, which would result in high-quality care, “remains a work in progress” (Clancy 2006).

Public reporting results in transparency, a key element of the Institute of Medicine's recommendations to transform healthcare delivery to higher quality (Institute of Medicine 2000). Shine and colleagues (2002) argue that the public needs to have access to information on system performance to participate in determining the quality agenda. There is, however, a need to differentiate performance reporting on a national scale for accountability from the kind of performance assessment that is needed at the institutional level to improve efficiency, safety and patient outcomes (McLoughlin et al. 2001).

The comments from those interviewed underscore the need for external enablers to facilitate Canada's quality agenda. The increase in the provincial quality councils is a demonstration of rising commitment to establish quality improvement. Quality councils can play an important role in driving and sustaining quality improvement in provinces. They can be empowered, trusted and independent (Plumb and Cowell 2006).

Quality councils have been important institutional innovations on the Canadian landscape; however, they cannot be seen as the complete answer. Merely knowing how we are doing does drive some “herd behaviour” in a virtuous cycle to do better. Public reporting also serves to “shame and blame” the

laggards. The results of the review by Mainz and colleagues in 2003 that most countries lack mandatory systems to track and report on quality of care and lack evaluation and outcome assessments of health services – appear no less true today and certainly apply in Canada. Participation at all levels of the healthcare system is essential to contribute to a quality improvement agenda (Shine et al. 2002). Quality councils can do many things to shine a light on performance, and some can provide some instrumental support to ground-level change. At this stage, they cannot yet field an army of process engineers to transform delivery or build a leadership cadre at the executive and board levels for quality. Indeed, given the level of investment by existing institutions that we noted in the survey, it seems a far larger fraction of quality improvement investment for quality lies embedded through our large and some small institutions than a quality council can hope to deploy in the field.

A performance agenda driving quality will demand a redesign of care processes; better use of existing information systems and technologies (and the identification of new technologies); the alignment of incentives to increase quality; performance measurement; culture change; institutional and leadership alignment; clinical and regional engagement and collaboration; and knowledge exchange/transfer (Sullivan et al. 2008; Wang et al. 2006).

The Canadian Institute for Health Information has published a range of comparative indicators including quality and safety metrics over the past few years, and more are needed. The most recent report card by the Canadian Partnership Against Cancer serves as one of the few relatively good comparative pictures of quality performance in existence between jurisdictions in Canada in the narrow field of cancer services (CPAC 2010). The absolute fear of comparative performance assessment by many provincial governments

underscores our drive to get to the middle of the pack on quality performance.

In our view, informed by this national survey, we need a national agenda, based on a coalition of the willing, to drive greater quality and performance in our health system. How we might get there will involve an interesting mix of national and regional efforts, informed by the costs, quality and performance of our health services and moderated by a changing federal-provincial fiscal landscape in which quality will be wrapped with bending the cost curve and improving overall performance. In short, perhaps it is time we get over our giant inferiority complex and seize the nettle of building a national agenda and capacity for quality leadership in Canada.

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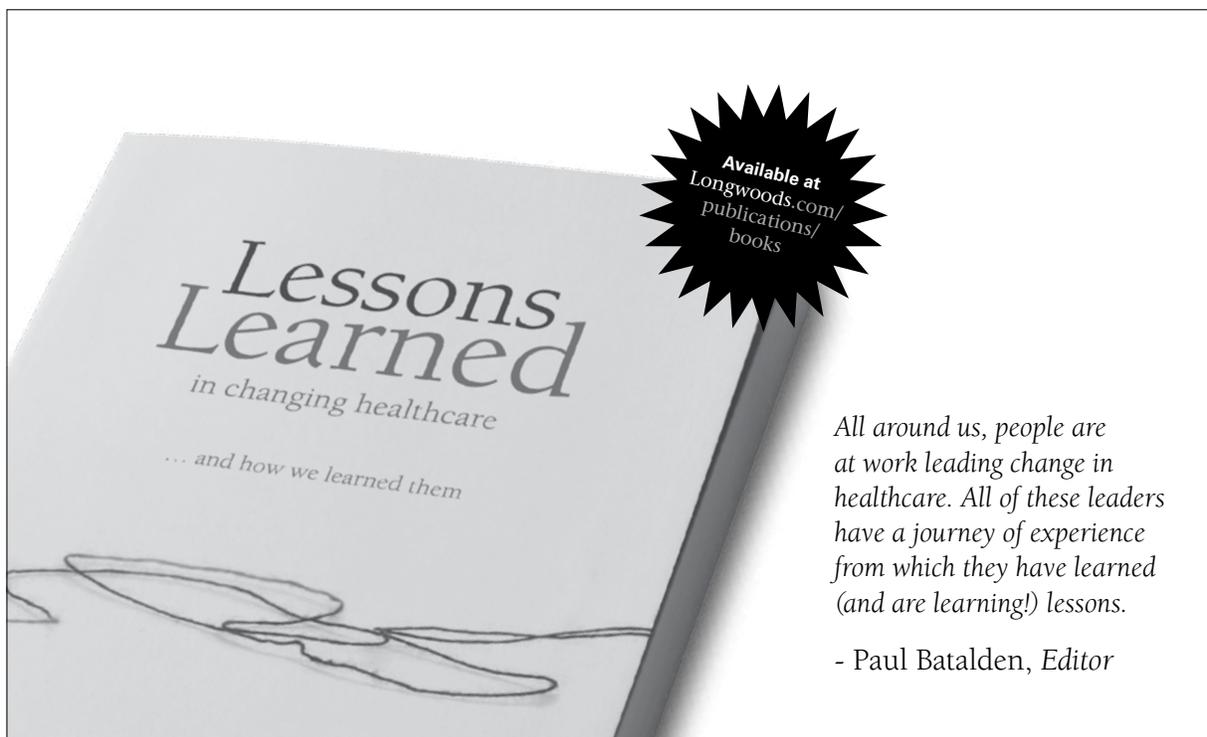
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The image shows the cover of a book titled "Lessons Learned in changing healthcare" with the subtitle "... and how we learned them". The cover features a stylized line drawing of a person's profile. A black starburst graphic is overlaid on the cover, containing the text "Available at Longwoods.com/publications/books". To the right of the book cover, there is a quote: "All around us, people are at work leading change in healthcare. All of these leaders have a journey of experience from which they have learned (and are learning!) lessons." followed by the attribution "- Paul Batalden, Editor".



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COMMENTARY  
Healthcare*Papers*

# The Healthcare Quality Agenda in Canada



COMMENTARY

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Vice President, Health Policy and Research, Canadian Medical Association



## ABSTRACT

*Sullivan et al. have captured several important themes. One of the reasons that healthcare has been slow to adopt a culture of quality has been that it has taken a long time to recognize that quality is a continuous journey along several dimensions. Following advances in the early 1990s on appropriateness and effectiveness, there has been a decade-long preoccupation with accessibility that still remains an issue. Patient-centredness is one of the most recent dimensions to receive attention, and the overall goal of quality – improved patient outcomes – needs considerable work. Measurement and reporting are fundamental to quality improvement, but the provincial and territorial governments have not lived up to their Health Accord commitments to regular reporting on common indicators. At least six provinces have established health quality councils, but it remains to be seen if this bottom-up approach will lead to a common reporting framework that will support benchmarking. Canada would likely benefit from a pan-Canadian approach to innovation in healthcare quality.*

THE INTERVIEWS BY Sullivan et al. (2011) have captured several important themes. I would like to comment on three of them:

1. The need to adopt a culture of quality
2. Measurement and reporting on performance and quality outcomes
3. The issue of a national agenda for quality

## **Journey to Quality**

One of the impediments to adopting a culture of quality has been the length of time it has taken in healthcare to recognize that quality is a continuous journey along several dimensions that have been advancing at different rates over the past two decades. While the six-dimensional framework (safe, effective,

patient centred, timely, efficient, equitable) set out by the Institute of Medicine (IOM 2001) in its landmark 2001 report *Crossing the Quality Chasm* is probably the best known, it was preceded by almost a decade by a framework set out in 1992 by MacIntosh and McCutcheon in the *Canadian Journal of Quality in Health Care* (Figure 1).

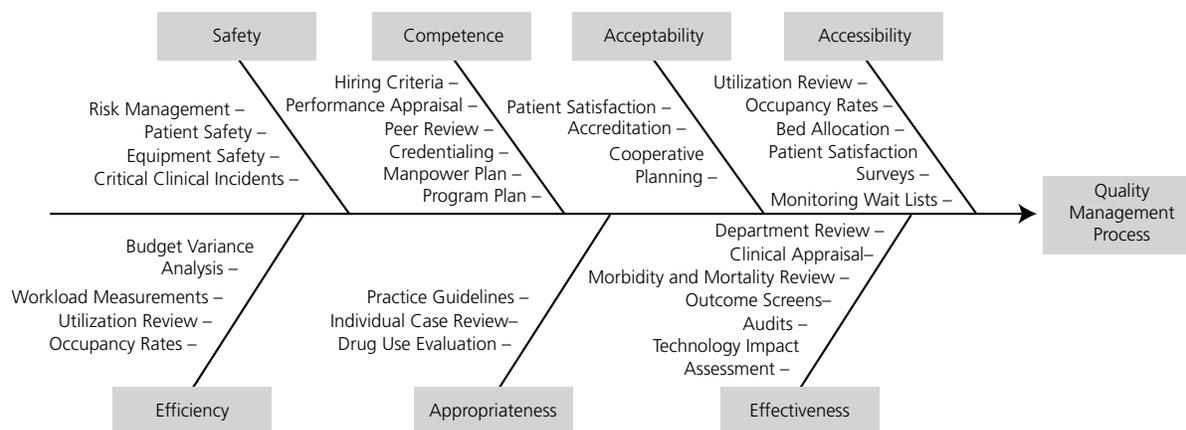
While some of the terminology is a little dated, there is much similarity between this and the IOM framework. Over the past two decades, there has been significant progress on several of these dimensions. The first dimensions to be addressed were those of *appropriateness* and *effectiveness*. The Canadian Coordinating Office for Health Technology Assessment was established in 1990; it has flourished and continues today as the Canadian Agency for Drugs and Technologies in Health (CADTH; www.cadth.ca). It has also taken on the Common Drug Review, which reviews the cost- and clinical effectiveness of new drugs and makes formulary recommendations to provincial drug plans.

In November 1992, the first paper with *evidence-based medicine* in the title was published by the group with that name from McMaster University (Evidence-Based Medicine Working Group 1992). This widely

popularized approach considers the strength of the evidence that bears on each treatment decision, the benefits and risks of alternative management strategies and the role of patients' values and preferences. In 1993, the Cochrane Collaboration (www.cochrane.org) was established to produce systematic reviews of evidence from randomized clinical trials. This has become an international network that has produced more than 4,000 reviews to date. These developments are the foundation of the numerous efforts that are under way to package evidence-based reviews into point-of-care tools. Since the early 1990s, the Canadian Medical Association (CMA n.d.) has developed and updated the CMA Infobase, which contains some 1,200 clinical practice guidelines.

Over the past decade, we have come a long way from "risk management" to "patient safety." The *safety* and *competence* dimensions of quality have received considerable attention. During the 1990s, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada enhanced their programs of lifelong learning as a prerequisite to maintaining fellowship status. A one-day forum on the topic of patient safety was held at the 2001 annual meeting of the Royal College. This meet-

**Figure 1. The dimensions of quality**



Source: Reproduced with permission from MacIntosh and McCutcheon (1992: 21).

ing resulted in the formation of a national Steering Committee that gave rise to the establishment of the Canadian Patient Safety Institute (CPSI) in 2003 (<http://www.patient-safetyinstitute.ca>), which pursues a range of research and educational initiatives across the spectrum of healthcare. More recently, regulatory bodies in Canada and internationally have begun mandating lifelong learning through what they call “revalidation.”

The journey to quality hit a bump in the road in the mid-1990s after the severe recession earlier in the decade, compounded by the \$6 billion cut in the federal cash transfer that was implemented over two years beginning in April 1, 1996. At around that time, growing waiting lists led to a major preoccupation with the *accessibility* dimension.

In 2004, the First Ministers acknowledged this problem, and the federal government established the Wait Times Reduction Fund to address five procedural areas. While there has been progress, especially in the targeted areas, the access problem is by no means solved. There remain significant access challenges in the areas of primary care and long-term facility-based care. By the most recent estimates, some five million Canadians do not have access to a family physician. The shortage of appropriate long-term care is a major challenge for acute care hospitals where, at any given time, some 20% of the beds might be occupied by patients waiting for an alternative level of care.

Access is only one dimension of quality, but it has taken up a great share of concern over the past decade and continues to do so. The quality dimensions are also interlinked. For example, wait list priority scoring tools such as those of the Western Canada Waiting List Project (<http://www.wcwl.org>) project also address appropriateness.

More recently, attention has turned to what MacIntosh and McCutcheon labelled the

*acceptability* dimension but is more commonly called today *patient-centred care*. CMA has defined patient-centred care as “seamless access, with no financial barriers, to the continuum of care in a timely fashion, in a matter that takes into consideration the individual needs and preferences of patients and their families and treats them with respect and dignity.” (CMA 2010: 6) How will we know when we have achieved it? CMA has proposed that one way of advancing patient-centred care is through the adoption of a patient charter. After a national consultation with patients, physicians and representatives of patient advocacy groups in 2010, CMA adopted a Charter for Patient-Centred Care that contains 25 elements in seven dimensions (CMA 2011; Table 1). While several provinces have either stated an intention of or proposed private members’ bills to introduce a patient charter in the past, in its 2010 Alberta Health Act, Alberta was the first to pass legislation that provides for a Health Charter and a Health Advocate to oversee it (Government of Alberta 2010).

**Table 1. Charter for patient-centred care**

Dignity and respect  
 Access to care (timeliness, continuity, comprehensiveness)  
 Safety and appropriateness  
 Privacy and security of information  
 Decision-making  
 Insurability and planning of health services  
 Concerns and complaints

Source: Data from Canadian Medical Association (2011: 8–9).

The late Avedis Donabedian made a fundamental contribution to quality with his classification of structure, process and outcome for the evaluation of quality. The elements of the MacIntosh-McCutcheon framework address structure and process, but they do not develop the concept of outcomes,

which Donabedian defined as “the effects of care on the health status of patients and populations” (1988: 1745). To date, the quality field has focused mainly on intermediate outcomes of the *processes* of care. One of the first large

*Clearly, there is much work ahead to make systematic use of outcome measures in Canadian healthcare.*

outcome studies in Canada was conducted by the Case Mix Research Group of Queen’s University for the Canadian Council on Health Facilities Accreditation in 1990–1992. The study was based on the abstraction of data from a sample of 4,000 hospital charts. Researchers captured data including adverse in-patient and intra-operative occurrences, unscheduled return to the operating room, trauma suffered in the hospital and nosocomial infections (MacKenzie et al. 1992). Chart abstraction of intermediate outcomes was also the basis for the study by Baker et al. of adverse events conducted a decade later (Baker et al. 2004). The Canadian Institute for Health Information (2011) has developed indicators related to processes of care such as the Hospital Standardized Mortality Ratio, which compares hospitals across Canada.

Over the past few decades, the health services research field, the health economics area in particular, has made advances in the development of patient- and population-based measures of both general health status and condition-specific measures (e.g., vision, joints). Since April 2009, the UK National Health Service (NHS) has mandated the administration of pre- and post-operative patient-reported outcome measures (PROMs) for NHS-funded hip and knee replacements, groin hernia surgery and varicose vein surgery. The PROMs include both generic measures

of health status and condition-specific measures (UK Department of Health 2009–2010). The data are being published on a monthly basis. For example, during the period from April 2009 to December 2010, of respondents who had undergone hip replacement surgery 95.8% recorded joint-related improvements following their operation (Oxford Hip Score) and 87.3% recorded an increase in their general health (generic EQ-5D; NHS Information Centre 2011). Clearly, there is much work ahead to make systematic use of outcome measures in Canadian healthcare.

### **Measuring and Reporting on Performance and Quality Outcomes**

The authors of the lead paper cite the interviewees’ observations about a lack of consistency in the choice and measurement of performance indicators. This is not surprising. Over the past decade, the provinces and territories seem to have developed an allergic reaction to any attempts to benchmark their performance against each other, despite commitments made by first ministers in 2000 and 2003. As part of their 2000 Health Accord, first ministers agreed to provide regular public reporting on health programs and services and to collaborate on a framework of *jointly agreed comparable indicators* including health status, health outcomes and quality of service (Canadian Intergovernmental Conference Secretariat 2000). An initial series of reports was published in 2002, and in their 2003 Accord first ministers agreed to annual reporting with common indicators in 2004 (Canadian Intergovernmental Conference Secretariat 2003). An annex to the 2003 Accord listed 41 indicators. A second series of reports was issued in 2004, and since that time only the federal government has continued to live up to its reporting commitments. *The Statutory Parliamentary Review of the 10-Year Plan to Strengthen Health Care* (House

of Commons Canada 2008) called for a set of comparable data and indicators, without result.

The Conference Board of Canada published a provincial benchmarking report in 2006 that compared the provinces on the basis of health status, healthcare outcomes and healthcare utilization and performance. This has not been repeated since.

*Looking ahead, it seems unlikely that the federal and provincial and territorial governments will lead the way on performance measurement and reporting.*

One area where the provinces have developed indicators is in the area of wait times, particularly for the procedures specified in the 2004 accord. However, it has taken significant efforts on the part of the Wait Time Alliance (see reports at <http://www.waittimealliance.ca/>) to establish comparability for benchmarking and grading purposes.

Looking ahead, it seems unlikely that the federal and provincial and territorial governments will lead the way on performance measurement and reporting. A number of provinces have established health quality councils that are reporting on a wide range of quality indicators, but it remains to be seen if this bottom-up approach will evolve to a common reporting framework and indicators that can be used for benchmarking purposes.

### **A National Agenda for Quality?**

As noted previously, there are several bodies in Canada such as CADTH and CPSI that concentrate on specific elements of quality. Accreditation Canada comes closest in terms of using a comprehensive quality framework to underpin its work in assessing health

facilities and services against its accreditation standards to enable facilities to improve. However, there is no national body in Canada that is charged with driving the adoption of quality improvement techniques. As Sullivan et al. note, many of the survey respondents reported spending significant sums to receive training and consulting support from agencies such as the US Institute for Healthcare Improvement (IHI), which is dedicated to bettering and promulgating methods and processes for improving the delivery of healthcare throughout the world. Saskatchewan's Health Quality Council, for example, has adopted IHI's collaborative method. Aside from the quality councils, there are provincial efforts, such as Alberta's Access Improvement Measures Program (see <http://www.albertaaim.ca>) and British Columbia's Impact Health Improvement Action Society (<http://www.impactbc.ca/>), that promote practice redesign and quality improvement, but they are by no means pan-Canadian.

In conclusion, I think that Canada could benefit from a national approach to innovation in healthcare quality that would be expected to achieve the following:

- Develop and disseminate the means of engaging front-line clinicians in quality improvement processes
- Promote a pan-Canadian sharing of innovative practices
- Establish international partnerships for the exchange of innovative practices
- Promote a comprehensive approach to quality improvement in healthcare

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# What's on the Quality Agenda? Acknowledging Progress, Respecting the Challenges



COMMENTARY

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## ABSTRACT

*While many quality improvement and performance measurement initiatives are under way in Canada and beyond, there are challenges to be met around effectively coordinating the national quality agenda, sharing expertise and reducing duplication. An important first step has been recognizing the vital connection between quality and efficiency.*

*While many provinces and territories have embraced the quality challenge, the national quality agenda remains less than coordinated. Reaching agreement on goals must be done in full collaboration with the provinces and territories, respecting their unique priorities while also providing the benefits of a national measurement and performance system and broader-level strategies.*

*Workplace culture affects the ability to deliver safe care. Creating an integrated culture of quality results in measurable improvements in staff satisfaction and patient outcomes. However, this process requires long-term commitments from governments, boards, chief executive officers (CEOs) and staff, and involvement at all levels in design, initiation and implementation.*

*There is frustration with the extensive and growing number of bodies to whom health organizations must submit data. This duplication could be reduced through consistent definitions, measurement priorities and reporting mechanisms, as well as national agreement on core performance measures. Ongoing collaboration at many levels is increasing the sharing of information and aligning of definitions in this regard.*

THE AUTHORS OF the lead paper, titled “Responsibility for Canada’s Healthcare Quality Agenda: Interviews with Canadian Health Leaders,” present important views about the increasing focus on a pan-Canadian quality agenda (Sullivan et al. 2011). This commentary speaks to some of the issues raised and provides additional perspectives.

### **Factors Contributing to the Focus on Quality**

In the lead paper, the authors identify a number of factors that are giving rise to the increased focus on quality in healthcare. It is suggested that one factor is the move to person-centred models of care delivery. However, many healthcare leaders and providers are aware that this move is not recent; rather, it started several decades ago, with organizational structures and programming being adjusted to organize care around the patient. University and college health educational programs began to increasingly use this concept to plan their curricula. In 1995, Accreditation Canada (then the Canadian Council on Health Services Accreditation) released the Client-Centred Accreditation Program, also based on a patient-centred model of care. There are many other examples of where this focus has been embraced.

That being said, the struggle continues to find the best model around which to provide care and service while improving quality, outcomes and efficiency. Despite several decades of a sincere belief in and expressed commitment to patient-centred models of care, progress has been slow. Canada and other countries continue to have a provider-centred model of care within which patients are expected to be “compliant.” While there are pockets of success where the patient is truly at the centre, it is possible that pressure from the public and other stakeholders will be the catalyst to finally achieving a patient-

driven model, thus truly improving quality. The better educated and informed consumers become, the greater may be the impetus to address inadequacies that have been perpetuated for too long.

*When quality is no longer seen as the antithesis of efficiency, it becomes possible to address quality and efficiency challenges in an integrated way.*

A second contributing factor noted in the paper is that of the need to reduce costs, duplication and inefficiencies. A very positive step is the critical recognition across Canada (in fact, internationally) of the interwoven relationship between quality and efficiency. From the policy levels within government through to the direct care providers, and across the continuum of care within all sectors, acknowledging this link is instrumental and essential to true innovation and improved outcomes while saving dollars. When quality is no longer seen as the antithesis of efficiency, it becomes possible to address quality and efficiency challenges in an integrated way.

The need to improve patient safety as a third contributing factor has had a significant impact on catapulting the focus on quality to the top of the agenda. Patient safety, adverse events and other such terms can be disconcerting for the media, public and others. Adverse events-related research has been and continues to be a wake-up call to those who have been complacent about quality of care, and it is an important and essential component of the quality journey. Implementation of proven patient safety initiatives will be effective only if communication, teamwork,

collaboration, transparency and respect for and involvement of patients and families are included in the equation. Otherwise, patients and families will not be satisfied with their care, and quality and outcomes may be less than adequate.

Sullivan et al. note that the inception of health quality councils in a number of provinces underscores the need to establish an aligned national quality agenda. While this may be the perception of several interviewees, there is an alternative explanation. Credit must be given to those provinces that identified the need to focus on the quality of healthcare in a structured and organized manner and in alignment with provincial priorities. This is not necessarily reflective of the need for an aligned national quality agenda.

The contributions and achievements of the quality councils are impressive and measurable. Establishing a national quality agenda is important; yet this process must complement the work of existing quality councils and provincial priorities. The authors indicate that the councils create an accountability mechanism for reporting on quality. While this is true, it is important to note that the councils exercise this accountability in different ways and to varying degrees. Each has taken a different yet complementary route on the quality journey. Their mutual commitments to share expertise and collaborate with other provincial and national health organizations increasingly demonstrate the important role they play in improving the quality of healthcare.

### **Knowledge Transfer**

The authors acknowledge that pockets of leadership exist, but a key challenge is “transferring and translating the knowledge from these sources into measurable behavior and practice change that can be adapted at the individual, institutional, provincial and national levels.”

At the International Forum on Quality and Safety in Healthcare held in Amsterdam in April 2011, Sir John Oldham stated that we suffer from “pilotism.” There are many pilot projects and initiatives under way. At some point, definitive steps must be taken to act on available knowledge and implement effective practices, flexing with the context, across the system(s). Some systems and provinces have initiatives that are well on their way, while other jurisdictions are moving at a slower pace. Accreditation Canada has been contributing to the knowledge transfer arena for many years. Its strategic plan identifies knowledge transfer as a strategic direction, demonstrated in the following ways:

- **Standards** – a knowledge transfer mechanism
- **Required organizational practices** – introduced in 2005; play a strong role in transferring knowledge and influencing behaviour and practice
- ***Qmentum Quarterly*** – a publication Accreditation Canada developed specifically as a means of sharing leading and innovative healthcare practices
- **Leading practices** – published on the website

It is important to note that clinical practices guidelines and other specialty-focused initiatives remain the domain of the specialists and professionals in their respective areas. However, for those standards and practices that fall within Accreditation Canada’s mission, significant progress in knowledge transfer has occurred and our contribution will continue to increase. Concurrently, there is ongoing collaboration between Accreditation Canada and health organizations such as the Canadian Patient Safety Institute, the Community and Hospital Infection Control Association, the Canadian Institute for

Health Information and others to identify areas where information might be shared, definitions aligned and duplication reduced.

### **Culture of Quality**

The paper's finding that "health leaders indicated that existing embedded cultures in healthcare organizations have failed to fully (or even partially) embrace quality" is interesting. While progress has been slow, there are many encouraging examples of health leaders who have strongly embraced quality and implemented quality improvement initiatives,

*Quality improvement initiatives are not a criticism of the past or present way of doing things but, rather, a recognition that the healthcare environment and its immense complexity continue to evolve and change.*

and have evidence to support their success. These leaders and their achievements should be acknowledged and applauded. The quest for quality is a long-term commitment rather than a short-term undertaking, and recognizing the investment of time and energy up front is fundamental. An unrelenting focus on quality and efficiency ultimately results in positive change.

No one goes to work in healthcare intending to provide poor quality care or service. The statement that "resistance to change among clinicians and healthcare providers was noted as a key barrier" does not acknowledge that physicians and other healthcare providers participate in the quality agenda in the same way that any other group participates and adapts to change. The approach is key. Any

successful change process must involve all stakeholders in design, initiation and implementation. It requires early acknowledgement that quality improvement initiatives are not a criticism of the past or present way of doing things but rather a recognition that the healthcare environment and its immense complexity continue to evolve and change. Thus, our approaches must change. If we continue to do things the way we always have, we will continue to get what we have always gotten.

"A quality culture needs to start at the top." *The top* includes the government, board, CEO and the entire leadership team. Their support must be visible, sincere and valued – month after month after month. As the quality culture plan is developed, quality and change champions, including those providing direct care, must be identified throughout the organization. There are many questions to be answered: What is the goal of developing or strengthening the culture of quality? What is the strategy? Is everyone involved? While the quality culture starts at the top, success is achieved when it is palpable and measurable throughout the entire healthcare organization.

Those interviewed for the lead paper noted that quality must be integrated into the day-to-day business of the healthcare setting. This is crucial. Of interest, it is also the fundamental principle underlying the development and format of Accreditation Canada's Qmentum accreditation program, released in 2008. Previously, organizations tended to ramp up their accreditation focus and activities six to 12 months prior to the on-site survey. In other words, accreditation was not integrated into the quality improvement program of the organization but considered an add-on. It was evident to Accreditation Canada that accreditation tools and processes had to be redesigned to effectively support ongoing quality improvement. This was a major shift in the traditional view of accredi-

tation, and health organizations are finding that as Qmentum is applied in this integrative way, the resource impacts are declining.

Creating a culture of quality in healthcare organizations, regardless of size or sector, is essential and fundamental to providing quality care. The elements of a culture of quality, a culture of work-life quality and a culture of patient safety are one and the same, having a positive impact and showing measurable improvements in staff satisfaction and patient outcomes. Culture affects practice, behaviour and the ability to deliver safe care. The quality of the work life influences and is influenced by the culture within which staff work and practice. This has a major effect on the ability to deliver quality care. Cultivating a quality culture includes creating safe, secure and transparent working environments. This means “safe to talk, safe to work (the right tools and equipment), safe to ask” and so on (Squires et al. 2010). If staff, clinicians and administrators are respected and supported, the quality of care that is expected and required will be realized, and efficiencies will be achieved.

### **Definition of Quality**

Some of those interviewed noted that definitions of *quality* can be ambiguous and that this is a barrier to developing an integrated quality plan for Canada. When Accreditation Canada, the provincial health quality councils and the Health Council of Canada began biannual meetings in 2007, one of the first activities was to compare definitions and dimensions of quality. While there was variation in the dimensions, the components of quality were the same, the fundamentals were aligned and the definitions were compatible. The provinces and territories have their own priorities and perspectives, and the framework and definitions vary given this reality. In the same way, there is variance in quality improvement policies and strategies. This is necessary to take

into account the different contexts and realities of the various systems across the country.

### **Measuring and Reporting on Performance**

It would be of great benefit to have consistent definitions, measurement priorities and collection and reporting mechanisms across the country. Over the past several years, a number of groups have been working to determine whether there might be national agreement on some core performance measures, and whether these could be aligned so as to compare apples with apples. At the same time, it was recognized that this process needs to respect that regions, provinces and territories will always require performance measures that meet their own unique issues.

Sullivan et al. suggest that a greater proportion of quality improvement investments come through institutions than through quality councils. While the resources of healthcare organizations are comparatively substantial, they can be effectively complemented by the resources of health quality councils and other quality organizations. Each partner organization must action the appropriate strategy within the region or jurisdiction in its control, while collaborating with the quality councils to identify, implement and evaluate strategies at a broader level to enable greater impact and consistency.

The provinces and territories have embraced the quality challenge. However, the national quality agenda remains less than coordinated. Why? Focusing this agenda requires us to identify the burning platform. What are the issues? What needs to be fixed? What would be the measurable benefit of a national agenda? These discussions are under way, and many synergies and collaborations are emerging. Coordinating the discussion and agreeing on the platform, goals and imperatives are vital.

A key reality and major frustration is the extensive and growing number of bodies to which healthcare organizations must submit data. The proliferation of quality organizations over the past five years and the corresponding rapid increase in reporting requirements by government and others have led to a busy and often-confusing playing field, making it difficult to determine “who’s on first?” Alignment and consistency with the goal of reducing duplication are essential because the current reality is not sustainable. Reporting requirements must be tightened and streamlined. In 2004, the Interagency Collaboration Group, a collaboration of national organizations contributing to the quality agenda, began to meet. In addition, as mentioned previously, four years ago the quality health councils, the Health Council of Canada and Accreditation Canada also began meeting regularly. The synergies that have evolved and the degree of collaboration are immense. Discussions related to aligning quality definitions continue to be positive and this group is now discussing the steps necessary to identify core national healthcare quality indicators.

### **Governance Competencies**

For a governing body to provide effective oversight of quality of care, board members must possess the appropriate knowledge, skills and understanding. Board members from many industries are taking this role more seriously. Quality committees are becoming integral components of most healthcare boards. The knowledge base of board members around the quality and safety agenda is being increased both through internal education and external governance courses. The seriousness and commitment by which boards are assuming accountability for quality and safety are far greater than ever before.

### **Conclusion**

Many commendable quality improvement and performance measurement initiatives are under way throughout Canada and beyond. The challenge lies in effectively sharing learnings and expertise, minimizing the constant “reinvent the wheel” syndrome that is part of the pilotism trend and reducing duplication. Discussions about the benefits of alignment and the risks of status quo must become part of the national quality discussions – and everyone will reap the rewards.

We must give credit where credit is due – there are great initiatives taking place across Canada to improve the quality of healthcare. We must celebrate what has been achieved. We must also make the leap forward to effectively coordinate and focus the national quality agenda and move it to the next level.

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# You Just Need to Get Started



COMMENTARY

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## ABSTRACT

*An organization can drive quality only through its people. Too often, we relegate quality to a single department or a small group of evangelical leaders but fail to make it everyone's business. Accountability has become a buzzword, and we have translated it into huge agreements with myriads of measures and indicators, all purporting to have something to do with quality.*

*Institutions need to focus on a few things to improve quality. How do you build a culture? You plan, you pick certain goals to which you aspire, you set targets and you measure against those targets. You provide the skills, knowledge, expertise and infrastructure necessary to enable people to meet those targets, and then you drive for them. And you are transparent about it.*

*I often think that we overcomplicate quality. As I have said repeatedly, it is as simple as choosing a measure, planning to implement some changes and re-measuring to see if your changes have had any impact. You don't need a national council, or even a provincial one, to make quality happen in the day-to-day operations of every healthcare organization in the country. Rather, you just need to get started.*

IN REVIEWING THE article “Responsibility for Canada’s Healthcare Quality Agenda: Interviews with Canadian Health Leaders” (Sullivan et al. 2011), I found myself wondering why Canadian health leaders know so much about quality and, yet, have such a difficult time making quality job one, to borrow a phrase from Ford. I thought I would provide

my comments based on what has worked at Trillium Health Centre, where, I believe, we have truly built a quality culture.

## **Building a Quality Culture**

The first, and perhaps most obvious, point is that an organization can drive quality only through its people. Too often we relegate

quality to a single department or a small group of evangelical leaders but fail to make it everyone's business. But you can't have quality patient care if you are not concerned about the people you have and the quality of their working lives. People who are not satisfied in their work and do not feel valued are not likely to provide a high-quality product. We know, ourselves, that when we are not happy we are not able to do our best work. I believe passionately that measures of staff and physician satisfaction and engagement are absolutely critical to the safety and quality you can offer patients. If your staff are unhappy, you cannot possibly build a quality culture.

Further, if we think we can drive quality by setting up measures and then getting out the whip or, worse yet, the paycheque, we will not achieve the goal of building a quality culture. At best, we will see modest improvements for the wrong reasons – which are not sustainable over the long term.

### **The Board**

But let's start back at the beginning – getting the board and senior leadership team involved. At Trillium, the quality journey took a fast forward a few years ago when the board did a governance renewal. It realized that it had a fiduciary responsibility not just to make sure that the organization operated within the resources that it is given but also to ensure that we are providing value to our communities. How do you assess value? Our board decided that value in healthcare has to be the quality of the services we provide.

The board reviewed the literature, particularly the work by Don Berwick, former head of the Institute for Healthcare Improvement (IHI), in the United States. He famously issued a request for proposal (RFP) to all hospitals at an IHI meeting in New Orleans where he spoke about looking for someone to do his knee replacement surgery. From

Berwick's work, the board extracted four broad themes that have served as our touchstones ever since: no needless death, no needless pain, no needless waits and no needless harm.

So we translated those themes into four measures – what we call our big dot indicators. The first, aligned with no needless death, is hospital standardized mortality ratios – HSMRs. No needless pain is measured by a question in our patient satisfaction survey on the organization's success in controlling a

*Four broad themes have served as our touchstones ever since: no needless death, no needless pain, no needless waits and no needless harm.*

patient's pain. No needless wait is measured by emergency wait times, although surgical wait times or any number of other indicators could also be used. For no needless harm, we felt a good measure was the incidence of hospital-acquired pressure ulcers. This measure is a good surrogate for quality care at the front lines, and that's what a quality culture is all about.

### **The Physicians**

I have worked with physicians for many years and know that they, along with other members of the healthcare team, absolutely want to do the right thing. They advocate for their patients. They stand for their patients. So they are our natural allies when it comes to building a quality culture. At Trillium, we have a co-management model with physician chiefs and operational directors working closely together to manage our organization. Physicians are experts on the clinical elements, so they know what it takes to build in quality.

You keep physicians interested by involving them in a meaningful way. Don't make

them do useless paper work. Physicians are smart people – they will see through “make work” projects or window dressing quickly. Our Medical Advisory Committee has developed its own big dot indicators that it uses to track its own successes. This is certainly the result of the board’s work and our relentless scrutiny of the four big dots at each board meeting.

### **Change Management**

Quality is not negotiable – it is not something that can wait until you get around to it or have enough resources. Of course, institutions should be expected to provide quality service.



*The culture of quality has to be living and breathing in the organization.*

I think one of the reasons quality has become a burden is because we look at it as an add-on rather than saying it is part of what everyone does. And when I look at what Trillium is about, I see the culture of quality has to be living and breathing in the organization. It is not about putting it in the strategic plan and saying quality is important. You have to translate that into meaningful goals for individuals.

You have to be a quality institution in everything you do. You can’t say, for instance, that you want to provide a high-quality, patient care program but that you don’t care how clean your patient rooms are or if your parking services are quality driven.

You need to have the whole organization rallied around quality. And in order to do so, all organization members have to own it – whether they be the accounts payable clerks who talk to patients about bills or nurses and therapists who offer treatment.

I believe in that adage “what gets meas-

ured gets managed.” If everything is important, then nothing is important. *Accountability* has become a buzzword, and we have translated it into huge agreements with myriads of measures and indicators, all purporting to have something to do with quality. My own view is that institutions need to focus on a few things to improve quality. How do you build a culture? You plan, you pick certain goals to which you aspire, you set targets and you measure against those targets. You provide the skills, knowledge, expertise and infrastructure necessary to enable people to meet those targets, and then you drive for them. And you are transparent about it.

### **Sustaining Momentum**

Right now, in Ontario, legislation is trying to sustain quality. The new Excellent Care for All Act (2010) is one example. But, unfortunately, legislation often makes quality more about the quality plan you have to file, by this date and with these indicators. And some of the indicators have to be tied to pay-for-performance.

I agree that you should tie quality to individual performance. But we translate that into our whole performance management system. Individuals have goals and objectives related to quality, and their performance is assessed on those. And we don’t stop there. We say, “What do people need to do their job?”

We have devoted resources to training people and, I think, wisely so as it pays off. We have invested more in our people. We provide all kinds of training and development support. You cannot expect people to carry out a task if you don’t provide the knowledge, tools and techniques for them to do the job.

So, you put in place your strategy, build your goals and objectives, establish the policies and procedures and do the training and skills development. It’s all aligned. That’s the important thing, and over time that builds a quality culture and sustains it.

## Big Dots

As I mentioned, as part of the board's governance review big dots were created on four key proxies for no needless death, no needless pain, no needless waits and no needless harm. From that point, we widely communicated the dots to members of our programs and services so that they know the big dots are important and everyone understands how he or she fits into those big dots.

Individual programs and services have their own indicators as well. Each area chooses what is important to it. On some units, they have a "no falls" measure because that is important. In obstetrics, they might measure repeat Caesarean sections. In surgery, the measure might involve post-operative infections.

The point is that you pick a few measures. You know why you picked them; there is some evidence saying these are important measures of quality. Then you measure, and based upon those measures you start to develop improvement plans. You implement the plans, and you measure again. Then you continue the cycle.

## Use of Incentives

At Trillium, we have spent a fair amount of time aligning our incentives around the right aspects. We have an annual award process to which people throughout the organization submit their quality initiatives. I am always one of the judges and, each year, I am impressed by both the number of submissions and the amazing levels of innovation that the front-line staff initiate. Many of the ideas that are presented from one unit are ultimately implemented across the organization.

Some of what is going on in the province now is not about incentives. That, quite honestly, is my big worry about a lot of the quality systems that are rolling out. For example, pay-for-performance as part of executive compensation is not pay-for-performance right now. Rather, because of the public sector

wage freeze in Ontario, we are taking money away from senior leaders. I believe we have to be able to incent the behaviour we want, not terrorize people or penalize them.

Consider some of the experiences in the United Kingdom when they implemented some of their measures. For example, the UK hospitals were only "allowed" a couple of outbreaks of methicillin-resistant *Staphylococcus aureus* (MRSA). What happened if you had more? The chief executive officer was fired. What does that do? Or a patient could only stay in the emergency department for so long. What happened after that? You got a black star. Too many of those and you were gone. People are smart, and they learn how to game the system. What the United Kingdom inadvertently did was incent the wrong behaviour.

## Reflective Learning

If you are going to encourage reflection and learning, you have to do it in an environment that supports people. This isn't to say that things don't go wrong; but when they do you have to critically appraise what happened, rather than establish blame, to make sure it doesn't happen again. And you have to learn from it. In the four years I have been at Trillium, I have never seen a case in which someone asked who was responsible for a mistake.

This attitude is exemplified by the fact that we call our process to investigate adverse events *reflective learning*. When a near miss happens, we review the incident with a mindset to learn. As the terminology suggests, the investigation is an opportunity to reflect on what happened.

People who go into healthcare want to make a positive difference in the lives of others. They are there to help people. And it doesn't matter where in the hospital they work – whether in accounts payable or on a ward. People want to do the right thing, and they

want to help people. If you start from that premise, then reflective learning is clearly the right approach. Mistakes very rarely are the result of malice; far more often they are the result of systems that do not support people in doing their jobs effectively.

### Efficiency and Quality

I often hear the argument that you need more money to provide quality care. What that implies is that you can do substandard work within your financial resources but that to

*It is a typical Canadian approach to jump to structural solutions – but I don't think structures are going to solve the perceived lack of a quality agenda*

provide quality care you need more. Of course, institutions should be expected to provide quality service within their existing resources. I don't buy the argument that quality costs money. (It may cost money to begin with if you are referring to specific training for people.)

There is ample evidence that if you do not provide good bedside care, bad things can happen. The result? Patients stay in hospital longer. And they are sicker. They may require special medications and perhaps surgical intervention. These are not cheap. So, by providing poor-quality care, you are adding to your costs.

I think it is too easy to say that quality costs money. Quality is part of our strategy. We have said that *how* we do our work is as important as *what* we do. And *the how* is all about quality, so that is an overarching theme. Quality is translated into specific objectives; we measure against those, we plan improvements and we report on them. And then, we start all over again

### Knowledge Exchange and National Structures

I am not opposed to national structures that encourage knowledge exchange, but I am somewhat skeptical about their effectiveness. Certainly, information sharing is an excellent outcome, but national councils cost money and they become big forums. It is a typical Canadian approach to jump to structural solutions – but I don't think structures are going to solve the perceived lack of a quality agenda.

I often think that we overcomplicate quality. As I have said repeatedly, it is as simple as choosing a measure, planning to implement some changes and re-measuring to see if your changes have had any impact. You don't need a national council, or even a provincial one, to make quality happen in the day-to-day operations of every healthcare organization in the country. Rather, you just need to get started.

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# Building a Safety and Quality Culture in Healthcare: Where It Starts



COMMENTARY

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ABSTRACT

*Healthcare in Canada underachieves stakeholders' expectations for safe, high-quality care. The authors maintain that a common understanding of, and vision for, what is required to achieve improved outcomes for patients is missing. Educating tomorrow's healthcare professionals is paramount to address this critical shortfall. However, healthcare educational institutions must themselves break out of a 20th-century paradigm of viewing healthcare safety and quality as functions of individual healthcare providers rather than as properties of the clinical micro- and meso-systems within which they function and are a part. Canadian healthcare systems are ailing; like treating a sick patient, interventions should be grounded on a solid understanding of anatomy (structure) and physiology (function). The Healthcare Encounter Safety and Quality Model (HESQM) highlights the structures underlying healthcare delivery and the key system functions required to achieve safe, high-quality care. The model has been used to frame the University of Calgary Faculty of Medicine's educational strategy for achieving safer, higher-quality care. The HESQM is based on leadership – leaders whose decisions and actions are guided by core safety and quality principles. Today's and especially tomorrow's healthcare leaders require a common understanding of how to achieve higher-performing healthcare systems; it is the responsibility of Canada's post-secondary institutions to deliver it.*

HEALTHCARE IN CANADA and elsewhere in the world is not as safe as it could or should be (Baker et al. 2004). Data supporting this opinion are largely irrefutable, but Canadian healthcare organizations and their funders/regulators (provincial and federal governments) have made only variable and inconsistent investments in the quality and safety of care. Why is that? What is lacking is a common understanding and vision of what a

*A fundamental tenet of the system paradigm of quality and safety is that improvement must take place at the level of the micro-system.*

high-quality, safe healthcare delivery system looks like and how to achieve it. Further, it is uncertain what the optimal approach is for teaching medical students, the future providers of healthcare, how to understand and navigate complex systems. The opinions of Canadian healthcare leaders, as described by Sullivan and colleagues (2011), highlight two of the fundamental problems. First, Canada only has “pockets of leadership,” suggesting a lack of motivation and understanding of how to implement an effective safety and quality management system that engages all of its levels. Second, Canadian healthcare systems lack an appropriate quality and safety culture. The leaders interviewed by Sullivan and co-workers shared some important aspects that they feel are needed to move the quality agenda ahead: the “adoption of a quality culture,” the measurement of performance and outcomes, human and technical infrastructure and the use of incentives. However, we maintain that before anything else, there needs to be a disruptive change in how we all view healthcare quality and safety.

Healthcare management and education are stuck in a 20th-century quality and safety paradigm – if individual healthcare providers are trained to a very high standard, then it follows that the care they deliver will be safe and of high quality. In this paradigm, quality and safety are viewed as properties of the individual. Healthcare is far behind many other industries that long ago came to understand that quality and safety are actually properties of systems and that people, although important, are only one component of those systems. Safer, higher-quality healthcare requires much more than further investment in skill training and knowledge acquisition of individual providers; it will only be achieved through an understanding of a system approach and sowing the seeds of a safety and quality culture. Donabedian’s view of structures underlying the processes that produce outcomes for patients (Donabedian 1966) can serve as the basis for gaining a system perspective. As healthcare educators, we believe that this disruptive change will only come about when there is a common understanding of how healthcare is structured, delivered and improved. Although our focus is physician training, we believe these issues are relevant for the education of all healthcare providers and managers.

So where do we start with teaching medical students about this “new” system paradigm of safe, high-quality healthcare? Perhaps the initial step is to model such a system, first in the classroom and then through clinical experience. If we accept that the current healthcare system is ailing – not delivering what we believe it is capable of – we can draw an analogy to a sick patient. Our approach to such a patient would be to use our understanding of anatomy (structure) and physiology (function) to diagnose and treat. What is the structure of a healthcare system, and what functions does it need to accomplish for optimal health?

### **Common Understanding of the Structure of Healthcare Systems**

Most discussions of healthcare systems default to the definition of financial and regulatory accountabilities; thus we speak of the Canadian healthcare system or a provincial healthcare system. However, a functional definition would be based on the collection of elements required to deliver care to a patient or population of patients. This has been called a clinical micro-system and is defined as a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients; it produces performance outcomes (Nelson et al. 2002). Patients with a particular health issue invariably receive care from numerous micro-systems – this collection of interrelated micro-systems is referred to as a meso-system (Nelson et al. 2008). The extent to which the meso-system functions in a coordinated, reliable and effective manner determines the experience that patients have, as well as the quality and safety of the care they receive. Macro-systems are the larger organizational units that provide the infrastructure and the resources for clinical micro-systems to function (Nelson et al. 2008) and whose goal it is to make patients' journeys as seamless as possible by properly coordinating the functions and workflow of its meso- and micro-systems. Using this healthcare system definition, it is possible to have productive discussions of how to make improvements and where to focus efforts.

A healthcare system's "anatomy" can be described that identifies its important components and their potential interactions. The well-known organizational accident model proposed by Reason (1997), commonly referred to as the "Swiss cheese model," has limitations when applied to healthcare. Davies's modification of Reason's model, developed for healthcare, describes five components, or layers, of the system that

contribute to patient outcomes: (1) patient, (2) personnel, (3) environment and equipment, (4) organization and (5) regulatory agencies (Davies 2000). This is a very useful model for structuring an analysis of the system components and contributing factors when a patient is harmed or nearly harmed. The Healthcare Encounter Safety and Quality Model (HESQM), used as the foundation of the Health Quality Council of Alberta's (HQCA) Blueprint Project, is an extension of the work by Davies that incorporates Reason's visual of a sharp end and a blunt end of care (Flemons et al. 2010). (The HQCA Blueprint Project is a collaborative effort between many of Alberta's post-secondary healthcare institutions, Alberta Health Services and other western provincial quality/patient safety councils with a mandate to transform healthcare safety and quality education [for current and future healthcare workers].) The HESQM is centred around the interaction between providers and patients where care is provided within clinical micro-systems. This part of the model is shown in Figure 1.

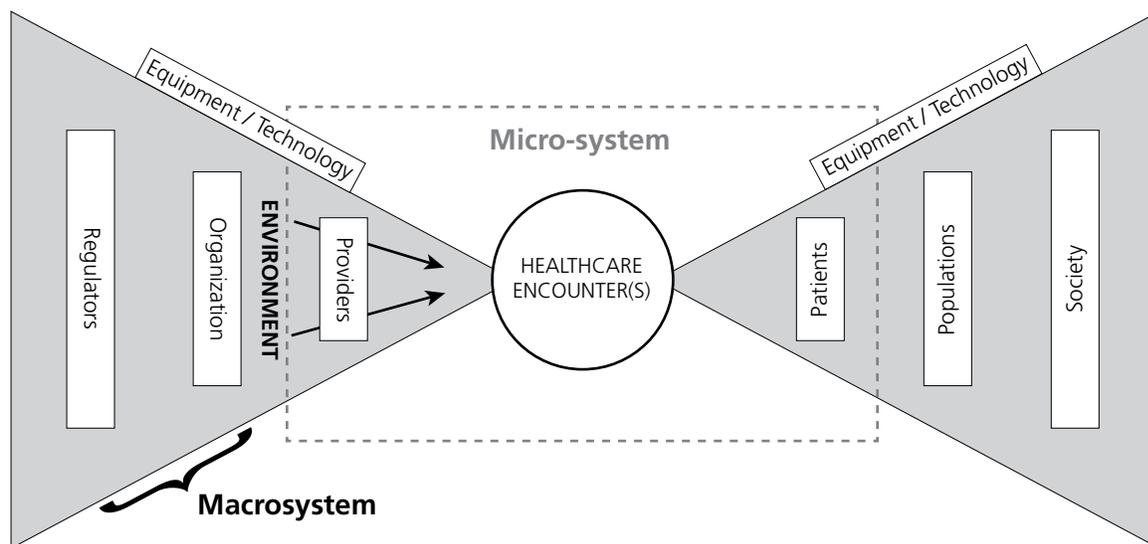
The healthcare quality agenda, as discussed by Sullivan and colleagues, is focused at the macro-system level. Most current healthcare leaders do not understand the concept of micro-systems and, by extension, that a fundamental tenet of the system paradigm of quality and safety is that improvement must take place at the level of the micro-system. Performance measurement and improvement efforts that exist only at the macro-system (organizational or provincial) level will not result in sustained, measurable improvement.

### **Functions of a Safe and High-Quality Healthcare System**

Healthcare systems need to focus on three broad functions if they are to attain their objective of safer, higher-quality care:

(1) design healthcare delivery for optimal care,

**Figure 1. Clinical micro-systems and factors that influence the outcomes of healthcare encounters**

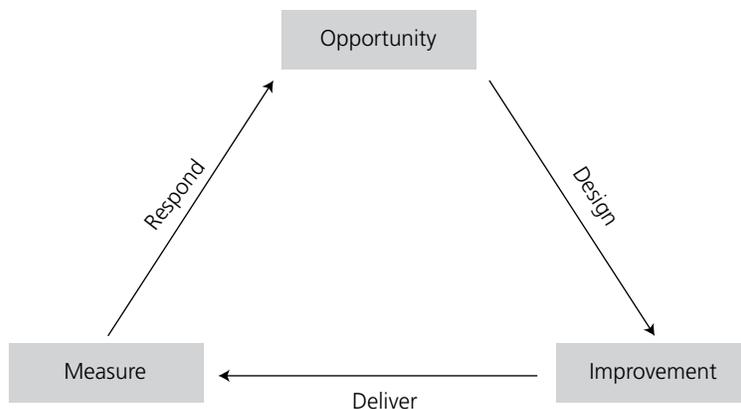


(2) deliver optimal care and (3) respond appropriately when the outcomes and delivery of care are not optimal. Comprehending this “physiology” will assist post-secondary institutions and existing healthcare organizations to understand the necessary components of a patient safety and quality curriculum. Topics that fall within the framework of these three functional categories (Table 1) are referred to as providing a solution to the patient safety conundrum (Flemons 2011). Collectively these three categories underlie quality and safety management (Figure 2).

Although the teaching of evidence-based medicine in medical schools has evolved over the past 15 years, teaching students *how to translate best evidence into reliable delivery of care* has not. Reliable care delivery requires an understanding of key processes that affect important patient outcomes, the skill to design standardized care protocols that make it easier for providers to complete

these processes reliably and the ability to create performance measures (of processes and outcomes); measurement at the clinical micro-system level provides the foundation for continuous improvement. Achieving optimal outcomes for patient populations requires an understanding of how best to identify improvement opportunities (including hazards and hazardous situations), prioritize those opportunities and use quality improvement methods to test and implement redesigned

**Figure 2. Quality management model**



A safety management model might replace *Opportunity* with *Hazard/hazardous situation* and replace *Improvement* with *Risk mitigation*.

**Table 1. Framework and learning themes and topics for healthcare safety and quality**

Theme	Topic
<b>Design</b> healthcare delivery for optimal outcomes	Identification (and prioritization) of opportunities for improvement
	Identification of hazards and hazardous situations (and prioritization of strategies to minimize harm)
	Reliable delivery of optimal care
	Changing systems of care
	Measurement and evaluation
<b>Deliver</b> optimal care	Use of standardized care protocols
	Situational awareness
	Information and informed consent
	Shared decision-making
	Effective communication with patients
	Healthcare literacy and numeracy
	Teamwork (crew) resource management
<b>Respond</b> when healthcare delivery and outcomes are not optimal	Support of patients and healthcare providers
	Disclosure
	Reporting
	Informing
	Evaluation of systems
	Assessment of individuals

processes and structure. Training students to consider human factors will help both students and providers to design more robust improvements. Since most initiatives often fail at the implementation stage, exposing students to change management theory should be a core element of quality and safety education.

The delivery of optimal care depends on the ability of individual providers and teams of providers (clinical micro-systems)

to effectively use standardized care protocols and communicate with patients; the underestimated issues of patient’s healthcare literacy and numeracy need to be raised. Another core topic for undergraduate and postgraduate trainees is how to provide information effectively so that patients can make informed decisions about their care. Because so much patient care is delivered in a team-based setting, the theory and practice of effective teamwork and communication within teams are also essential topics, particularly given the complex nature of healthcare delivery.

Inevitably there are situations where healthcare is not delivered optimally and patients are harmed, not by their underlying disease but, rather, by the healthcare provided to them. It is imperative that all healthcare providers understand the basics of how to manage such a situation – if not done well, the patient harm will occur again. Accordingly, we believe that undergraduate and postgraduate students need instruction on how to provide support for patients (and providers) involved in an adverse event, disclose to the patient what happened and ensure there is system-level learning through a structured analysis process. Students require a working understanding of informing (communicating information to stakeholders not directly involved with the adverse event) and reporting (communicating with the organization about what happened to afford the opportunity for learning). Finally, students and providers should know what to expect when it becomes necessary to assess the actions and behaviours of an individual provider involved in an adverse event – this should be done in a fair way using the principles of a just and trusting culture.

**Patient Safety and Quality Principles and Culture**

Ultimately, the safety and quality of healthcare lie with the decisions and actions of

healthcare workers at all levels – from the governors and executive leaders who make policy decisions to the front-line workers and managers who execute the care patients receive. Decisions and actions that are principle based will better support quality and safety, especially in situations where there are competing demands. The principles defined by the HQCA Blueprint Project (Table 2) are intended to guide decision-making at *all levels of the healthcare system* (Flemons et al. 2010). In addition, we believe these principles form the basis for creating the safety and quality culture that was called for in the lead article by Canadian healthcare leaders.

**Table 2. Patient safety and quality principles**

Patient engagement
Respectful, transparent relationships
Complex systems
Just and trusting culture
Responsibility and accountability (with appropriate authority)
Continuous learning and improvement

If *culture* is defined as “the way things are done around here,” then these principles help to define that *way*. Culture can be affected by consistent, visionary and principle-based leadership that helps to define how things are done. We believe there is a role for exposing students to models of leadership that are required at individual, team and organizational levels. Healthcare will only begin to change when students begin to implement leadership skills to which they are exposed during their training, when they become the future leaders of clinical micro-systems and macro-systems.

## Challenge for Educational Institutions

At the University of Calgary, we have only just begun working with the Blueprint Project’s model and framework to structure patient safety and quality education; much

*Healthcare will only begin to change when students begin to implement leadership skills to which they are exposed during their training.*

work remains to be done. We do not believe it will be useful to cover all the topics in the framework exclusively in the undergraduate curriculum. Instead, we see our initial work including an evaluation of what topics to introduce to students at each level of training – either at the undergraduate or the postgraduate level. We have implemented introductory training to healthcare safety and quality problems in the first-year undergraduate curriculum. During the start of medical students’ clinical experience, we have initiated a program of teaching to introduce them to the principles of patient safety and quality using small-group, case-based instruction that highlights how each of the principles can affect the safety and quality of patient care. At this time, students are also introduced to the concepts of teamwork and communication through the use of simulation-based scenarios. Because the examination of an adverse event provides an opportunity to introduce students to a system-based view of healthcare during their final clerkship year, University of Calgary students are exposed to an approach for such an analysis.

In the future we plan, as a high priority, to conduct a comprehensive assessment of

the undergraduate curriculum to determine how other components of the patient safety and quality framework (see Table 1) can be integrated into existing courses, rather than attempting to create de novo curriculum additions or a stand-alone course. The challenge in the immediate future is to concurrently coordinate faculty development so that there are preceptors available to guide the students. Ultimately, the success of this approach will also rest on the ability of healthcare organizations, their leaders and their funders and regulators to align with a similar approach and philosophy. The new healthcare safety and quality paradigm, with a focus on the healthcare system, needs to be an “all in” proposition.

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# Responsibility for Canada's Healthcare Quality Agenda: The Home and Community Sector



COMMENTARY

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ABSTRACT

*In their study on the current state of the quality agenda in the Canadian healthcare system, Sullivan and colleagues interviewed healthcare leaders across Canada who predominantly represent the hospital care sector. The home and community sector is under-represented in research and discussions about quality and patient safety, despite the fact that it is the fastest-growing sector in healthcare. Patient safety research in home care has been spearheaded by VON Canada and the Canadian Patient Safety Institute since 2005. Quality and safety are not just parallel imperatives; rather, they are inextricably linked concepts that rely on each other to function effectively. Safety for clients or patients is complex when multiple organizations, regulated and unregulated paid providers and unpaid family caregivers make up the team providing care in an uncontrolled home environment. Add to this the pres-*

*sure of reducing costs while increasing home care admissions, and the equation seems impossible. Client or patient participation is increasingly recognized and advocated as a main component in the redesign of healthcare processes to improve patient safety and may provide a key organizing principle for better care and outcomes.*

THE HOME AND community sector is growing in importance as hospital stays grow shorter, as people live longer with chronic diseases and as the focus shifts from acute, episodic care to care across the lifespan. People live, get sick and get better in communities. Hospitals, physicians and health providers are part of a system that exists within communities. In community care, professionals quickly become aware that the client is the centre of care and that, as providers, they are simply passing through someone's life. In institutional care clients are the guests, whereas in the community the paid care providers are guests in the clients' life and home. The term *patient* is not used in the community; instead *client* is used, denoting a customer orientation.

In their study on the current state of the quality agenda in the Canadian healthcare system, Sullivan et al. (2011) interviewed healthcare leaders across Canada who predominantly represent the hospital care sector. The home and community sector is a smaller part of the Canadian healthcare system from a government-funding perspective. As a result, it receives less attention and notice from governments, quality councils and researchers. The purpose of this paper is to provide a response from the home and community care sector to the research on leadership viewpoints regarding the quality agenda, completed by Sullivan et al.

Sullivan et al. reported that provincial quality councils are a positive step, that patient safety is now viewed as a necessary part of a quality system and that efficiency improvements are being pursued in many provinces and institutions. Quality and efficiency emerged as the parallel imperatives in all

provinces and internationally. Who is responsible and accountable for quality is an area of concern for many at local, provincial and national levels. Increased pressure for quality is being driven by three factors, namely: "(1) a move to person-centred models of care delivery in which individual needs and expectations for participation in health are given primacy; (2) the need to contain and reduce costs in healthcare delivery, duplication of services and process inefficiencies; and (3) the need to improve patient safety."

### **Quality and Patient Safety in the Home and Community Sector**

Quality and safety are not parallel imperatives; rather, they are inextricably linked and rely on each other for success. National and international literature have identified patient safety as a healthcare issue requiring immediate attention. Home care is the most rapidly growing segment of the Canadian healthcare system; yet, overwhelmingly, research on patient safety has been conducted within institutional settings, resulting in a significant knowledge gap about safety in home care.

VON Canada recognized this gap and in collaboration with the Canadian Patient Safety Institute (CPSI) spearheaded a number of initiatives. Together, in 2005, these organizations commissioned the development of a background paper that initiated a national roundtable dialogue on systematically identifying the key issues in home care safety and developing a research program to fill in significant gaps in our understanding. The report, titled "Safety in Home Care: Broadening the Patient Safety Agenda to Include Home Care Services," highlighted the need to view

safety through a new lens in order to attend to the complexity, multi-dimensionality and distinctness of home care safety compared with institutional care safety, while addressing the importance of continuity across the continuum of care (Lang and Edwards 2006). This foundational portrait formed the basis for the work that CPSI is doing in home care safety. It prompted the establishment of a CPSI Core Safety in Home Care Team to investigate and increase understanding of home care safety. This core team conducted an environmental scan of the state of knowledge regarding safety in home care in Canada, and most recently secured an unprecedented number of partners to fund *Safety at Home: A Pan-Canadian Home Care Safety Study*.

### **Linking Safety with the Client, Family, Caregiver and Provider**

Caring for individuals with chronic illness in their home is inherently complex. There has been an augmentation in the medicalization of private homes, resulting not only from the escalating threshold for hospitalizations but the increasing acuity of patients at the time of discharge. This transition has been facilitated by an explosion in “hospital at home” services and the increasing availability of mobile technology (i.e., peritoneal dialysis and hemodialysis, long-term intravenous catheters and oxygen/inhalation therapy; Williams 2002). Furthermore, the physical environment, family dynamics and the cognitive and physical abilities of the client and caregivers are other essential factors to be considered when delivering services. Caregivers are often elderly and contending with their own health challenges. They often lack sufficient sleep as they provide around-the-clock care. This is in stark contrast to the institutional scenario, where two or three shifts of professionals provide care. Family and caregivers often make promises out of love and a sense of responsibility to

keep loved ones at home, without being aware that this objective may be beyond their capacity (Stajduhar 2003; Stajduhar and Davies 1998). Thus, the quality of care and safety of clients cannot be attended to without including the family members, unpaid caregivers and paid providers in the equation (Canada Health Council 2008; Harrison and Verhoef 2002; Lehoux 2004).

Healthcare providers vary greatly in their abilities. Lay people, who increasingly represent a growing proportion of caregivers, demonstrate even more variability. Their performance and the safety profile of the care they provide are often compromised by noise, poor lighting, heat, dirt, improper cleaning products and moisture. Stress and fatigue, in addition to their lack of preparation and education to manage an array of medications and treatments, can also degrade performance over time. Caregivers’ performance is directly influenced by the operating characteristics of the equipment or medication involved (Macdonald et al. 2011).

The unique nature of private homes and communities as well as the multiple interrelationships among clients, family, unpaid caregivers and home care staff constitute a complex socio-ecological phenomenon. Providers can engage clients and families in conversations and collaborate with them to mitigate risks; but the nature of the home setting requires clients and caregivers to regularly exercise autonomous decisions in the context of minimal professional supervision as well as frequently strained or absent home and community supports (Lang and Edwards 2006).

Family caregivers provide more than 80% of the care needed in the home, causing them physical, emotional, social and financial challenges. When the needs of caregivers are not clearly understood and supported, home care clients end up institutionalized at an earlier point in their illness trajectory (Canadian

Home Care Association 2008). Quality and safety in home and community care cannot be addressed or improved without recognizing and attending to the family and caregivers who provide the lion's share of the care. The issues of accountability and responsibility for healthcare outcomes become complex when much of the team is composed of unpaid family members.

### **People-Centred Care**

Consistent with the increased pressure for high-quality care is a growing desire for people-centred care (Sullivan et al. 2011), strongly driven by the delivery of care in people's homes. Client-centred care is an approach that actively involves the clients in decision-making about their care; this client empowerment is in contrast to the power imbalance seen in provider-centred models of care. Family-centred care is the purposeful inclusion of family members in decision-making related to client care (Kyler 2008).

Client participation is increasingly recognized and advocated as a key component in the redesign of healthcare processes to improve patient safety (Harrison and Verhoef 2002; Longtin et al. 2010). Entwistle (2007) noted that certain interventions to support patient involvement in patient safety are not only justified but ethically required. The meaningful engagement of patients and their families/caregivers in patient safety supports the development of respectful relationships, open communication and empowered patients and family members (Hovey and Paul 2007). To date, efforts have not focused much on the client experience, and certainly not on the family/caregiver experience, beyond asking what was good and what was not. Questions have not been asked to find out details of what their experience was or should be (*experience* being different from *attitudes*); this information could systematically be used to co-design

services with clients. Clients are the experts on the experience of being a client, on how it feels to be ill and on what they need. Family members and unpaid caregivers who provide the majority of care at home are the experts on caring for their patient as well as their own needs to remain healthy and productive.

*Quality and safety are not parallel imperatives; rather, they are inextricably linked and rely on each other for success.*

Many organizations would report that they are doing well in family- and client-centred care. In reality, however, clients are rarely consulted about program design, few organizations have client advisory committees and fewer still have client advisors for every change they make in care services. The concepts of client- and family-centred care are in sharp contrast to how healthcare organizations have traditionally operated and require a significant culture shift. The concepts are "soft" and are mistaken as easy to achieve. A growing body of evidence is linking improved patient- and client-centred care with better health outcomes. The Institute for Healthcare Improvement identifies five drivers of an exceptional client experience; leadership, engagement of staff hearts and minds, respectful partnership, reliable care and evidence-based care (Balik et al. 2011). Involving clients, family members and caregivers in the design of care processes and in the development of care plans, and listening to their feedback as a way to boost improvement in organizations takes strong leadership – in healthcare organizations accustomed to a paternalistic approaches to knowing best what the clients need.

Community care access centres (CCACs) in Ontario have embarked on measurement of the client experience as a key performance indicator for care organizations providing services. In future, these results will be available to the public. When the healthcare consumer can shop for the best healthcare organizations, not only for the best clinical results but also for how they treat patients and families, organizations will be motivated to change. The CCAC survey tool provides comparable data by using standard questions, and the results can be compared with international data and other healthcare services (CCAC 2010). The new survey tool has allowed VON Canada to identify areas for change and to target training and service delivery improvements to address the areas of greatest impact to the client experience. An emerging body of research and best practice about client and family experience improvement is available to help organizations such as VON Canada to pave the way to better care. VON Canada is leading the way in establishing exceptional client experience as a key performance indicator in its strategic plan.

Although measurement of client experience by CCACs is an encouraging direction, it falls short of clients, family members and caregivers being involved in the design of care processes and it does not deal with the complexity of multiple providers working with unpaid caregivers in the delivery of home care. “Nothing about me, without me’ as an underlying paradigm is still an emerging concept that is getting attention but is still far from being practiced routinely in home care” (Balik 2010: 2). Future directions should involve all partners in the delivery of care, including clients and caregivers, redesigning processes together with a focus on the care delivered to the clients.

### **Reducing Costs and Increasing Efficiency**

Ironically, while the healthcare system still has

an unacceptable error rate, this industry has rising costs. The study by Baker et al. (2004) put patient safety on the agenda when it found that 7.5% of patients admitted to acute care hospitals experience one or more adverse events. The error rate in healthcare is at  $10^{-2}$ , whereas the aviation and nuclear industries achieve rates as low as  $10^{-6}$ . The healthcare error rates are not consistent with a high-reliability industry, and such errors increase costs (Evans et al. 2006). Trends show that healthcare costs are increasing at an unsustainable rate. Ontario has been growing the healthcare budget at a rate of 7.7% per year, from \$21.2 billion in 1999 to \$45.2 billion in 2009, while the tax base in the province is being eroded (Ontario Association of Community Care Access Centres et al. 2009). The situation is similar in every province in Canada, with the cost of healthcare taking up 42% of provincial budgets. Costs continue to rise, with an aging population, chronic diseases and the increasing use of new treatments and drugs (McKenna 2011, February 27). With little understanding of healthcare except the rising costs, politicians of all stripes ultimately cut budgets and tinker with payment systems, with little lasting effect and no real solution to the problem.

Few who work in healthcare would describe the industry as efficient or effective. Healthcare is behind in terms of computerization of the clinical record, making it difficult to quantify and manage clinical care. Healthcare is an information industry, and without the necessary tools to manage that information there is little hope of efficiency. Healthcare has relied on the individual practitioners’ competence and knowledge as the major quality control mechanisms. With the information revolution, individual practitioners cannot keep abreast of all changes in treatments, and every practitioner has a slightly different knowledge base to work from. As a

result, care delivery is not consistent or reliable, and the error rate in healthcare remains unacceptably high compared with other industries (Evans et al. 2006).

An emerging trend of looking to other industries for guidance on approaches is occurring in the United States, Great Britain

*With little understanding of healthcare except the rising costs, politicians of all stripes ultimately cut budgets, with no real solution to the problem.*

and Canada. One organization in the United States, ThedaCare, has been on a remarkable journey using the knowledge of Lean methodology from Toyota. What it has discovered is that “a different kind of healthcare is possible – care that is patient focused, with less waste and cost and better medical outcomes” (Toussaint et al. 2010: 3). The outcomes ThedaCare has achieved speak for themselves: improved health outcomes and reduced costs. It has focused on the science of healthcare rather than the art, on the experience of care from the patients’ perspective and on the process of steps in healthcare delivery to reduce waste, increase ease of work and remove barriers. These changes require knowledge, leadership and a culture shift in order to succeed. VON Canada is taking initial steps to introduce Lean processes to the organization to address a specific challenge. Lean methodology is a new paradigm and tool set in healthcare. We believe learning can occur as people use the Lean methods to solve real problems and that capacity building can result.

## Conclusion

At the heart of patient safety and efficiency

in home care are the client and the family. What appears to link the concepts of quality, safety and efficiency is an exceptional client experience. Is it possible that by becoming truly client and family centred we can also achieve safer healthcare and lower costs for all involved? Leadership is critical for quality improvement and patient safety – leadership that truly engages and respects those who deliver and receive care. Leadership that puts the tools in their hands to solve the problems, address the challenges and create the efficiencies will head the organizations that lead the way in quality and patient safety. Mitigating the risks and reducing error and waste while streamlining care delivery and improving safety for all are possible by involving the patients and clients, families, caregivers and front-line staff directly in the design of healthcare delivery.

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# The PROMise of Quality Improvement in Healthcare: Will Canada Choose the Right Road?



COMMENTARY

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## ABSTRACT

*Canadians pride themselves in their healthcare system. Yet, multiple problems are the focus of ongoing debates. The adoption of effective clinical and organizational interventions to improve health outcomes has not kept pace with the science. Solutions lie in health system redesign to improve quality and efficiency, focusing on the goal of improving population health. This commentary addresses the original conception behind medicare – an unfinished task; the implementation of a quality agenda; and the use of patient-reported outcome measures (PROMs) to inform the development and evaluation of tailored interventions. Finally, it offers considerations for moving the health system forward toward the ultimate goal of keeping people well.*

*Let us not forget that the ultimate goal of Medicare must be to keep people well.*

*– Tommy Douglas*

THE CANADIAN HEALTH system, under enormous pressure, is at a crossroads. Canadians pride themselves in their healthcare system. Yet, multiple problems – uneven quality, access barriers, important gaps in coverage (e.g., prescription drugs, home care) and rising

*In 2010, 52% of Canadians surveyed felt that the system needed fundamental changes, and another 10% felt the system needed to be completely rebuilt.*

costs – are all the focus of ongoing debates. The Commonwealth Fund's 2010 international survey found that 52% of Canadians felt that the system needed fundamental changes, and another 10% felt the system needed to be completely rebuilt (Health Council of Canada 2010). Concerns about sustainability have led some to look to the private sector for solutions. However, a large body of evidence shows that privatization leads to lower quality, inefficiency, higher costs and greater inequities in health and health-care (Comondore et al. 2009; Devereaux et al. 2002, 2004; Himmelstein et al. 1999). Thus, this road is likely to exacerbate, not ameliorate, current problems.

It is important to consider current health system challenges in context, recognizing that the seemingly insurmountable problems confronting the Canadian health system are indeed not unique to Canada, and solutions abound. Healthcare delivery systems across the developed world are all struggling with these same pressing issues (Schoen et al. 2007, 2009). Health systems designed in the past century to primarily treat acute illness fall short in managing today's demands for

chronic disease prevention and management. They are particularly ill suited to meet the needs of aging populations, who have a high prevalence of chronic disease and comorbidity (Boult et al. 2009; Reuben 2009). The adoption of effective clinical and organizational interventions to improve health outcomes has not kept pace with the science. Solutions lie in health system redesign to improve quality and efficiency, focusing on the ultimate goal of improving population health. This triad of objectives is now an important focus of the Institute for Healthcare Improvement through its Triple Aim framework (Berwick 2011). A strategic focus on achieving these objectives through health system redesign and innovation can result in a sustainable health system better able to meet the needs of Canadians. Widespread implementation of an effective quality agenda, as discussed by Sullivan and colleagues (2011), is central to achieving this objective.

### **Canadian Medicare: A Task Unfinished**

Two major factors are responsible for the current situation. First, medicare as originally conceived by Tommy Douglas consisted, first, of the removal of financial barriers to care and, second, of the development of an integrated, coordinated, primary care-based system focused on maintaining and improving health; the second stage of medicare has yet to be implemented (Association of Ontario Health Centres 2007, Rachlis 2007). Thus, the creation of medicare is a task unfinished. Insurance coverage for physicians and hospitals is essential but not sufficient for the creation of a high-performing health system that meets population needs. Second, while there are many pockets of excellence and many first-rate reports to guide health system innovation and improvement (Health Council of Canada 2010; Mackenzie 2010), Canada has lagged behind other nations both in widespread

adoption of innovations and in the integration of the quality agenda into care delivery. As a result, Canada fares poorly in international comparisons of health system performance. (Schoen et al. 2007, 2009) In the 2010 Commonwealth Fund survey of 11 countries, Canada placed at the bottom of the group on many measures of access, with Canadians waiting the longest to see a doctor when sick and more likely to seek emergency department care (Health Council of Canada 2010). This need not be the case. There are areas where Canada does well, including some measures of primary care performance in the Commonwealth Survey. In an international comparison, cancer survival was highest in Canada, Australia and Sweden, intermediate in Norway, and lowest in Denmark, England, Northern Ireland and Wales (Coleman et al. 2011).

### **Implementing a National Quality Agenda**

Sullivan and colleagues interviewed healthcare leaders across Canada to assess their perspectives on the challenges currently confronting the Canadian health system and potential solutions, focusing on perspectives for an expanded quality agenda. They identified important themes, including facilitators as well as multiple barriers to moving the quality agenda forward. They found both pockets of excellence and innovation and multiple barriers to successful implementation, including fragmentation of efforts, competing demands and the need for requisite skills. Leaders interviewed highlighted the need for physician engagement in the quality agenda. Missing from the interviews is the perspective of front-line providers, patients and the communities that they serve, who were not the focus of the study. These are the voices that understand all too well the failures of the current health system and, if engaged and given support, are key to health system transformation.

It is concerning that a number of the senior leaders interviewed perceived the lack of a clear definition of quality as a barrier to moving forward. This represents a massive failure of knowledge translation. In 1990, the US Institute of Medicine (IOM) defined quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (IOM 1990: 21). This definition still resonates today.

In its landmark 2001 report, *Crossing the Quality Chasm*, the IOM identified and defined the key dimensions of quality (Institute of Medicine 2001). The Ontario Health Quality Council, building on these dimensions, identified nine attributes of a high-performing health system: safe, effective, patient-centred, accessible, efficient, equitable, integrated, adequately resourced and focused on population health. These nine attributes continue to form the framework for public reporting on the quality of the Ontario health system as the council has been transformed with an expanded mandate to Health Quality Ontario. The literature abounds with examples of successful implementation of quality improvement strategies in diverse settings including, most notably, the US Veterans Health Administration, the UK National Health Service through the Quality and Outcomes Framework and hospital systems such as Intermountain Healthcare in Utah (Greenfield and Kaplan 2004; Perlin 2005). Implementation science is providing new evidence about what works to accelerate the uptake of evidence into practice.

### **Performance Measurement and Reporting: The PROMise of PROMs**

One of the four major themes identified by Sullivan et al. is the need for a “deepened commitment to measure and report on performance and quality outcomes.” Indeed the

old adage “you can’t manage what you can’t measure” is true. Performance measurement played a central role in the examples of health system transformation cited in the preceding paragraph, resulting in improved quality and efficiency. While there are limitations to performance measurement, and when used inappropriately it can have negative unintended consequences, the science of performance measurement has advanced significantly (Bierman and Clark 2007). When used appropriately, quality indicators can stimulate, inform and guide urgently needed health system redesign and improvement.

Quality of care is a multi-dimensional construct, and measures that capture these multiple facets are necessary (Clancy and Bierman 2000). By measuring individuals’ assessments of their health and functional status and experiences with healthcare, quality indicators based on patient-reported outcome measures (PROMs), we can capture unique dimensions of quality not regularly assessed in many performance measurement indicator sets. PROMs can be used to evaluate the quality of care received by adults with chronic disease and disability as well as to inform interventions to improve the quality of life of these individuals. Inequities in health status associated with socio-demographic factors can also be assessed with PROMs; they can thus be used to guide the development and evaluation of tailored interventions to reduce these inequities. PROMs may be derived from population health surveys such as the Canadian Community Health Survey to identify and evaluate interventions to improve population health. While PROMs hold much “promise,” much work remains to be done. Real-time routine collection of PROMs at the point of care is needed to realize their benefit in improving practice. Further development and validation of the use of PROMs as quality indicators are also needed. Should these

objectives be accomplished, PROMs can play a critical role in providing essential information to inform efforts to actively maximize health system value through improvements in quality of life and reduction of illness burden.

### **Moving Upstream**

It has been known for decades that the primary determinants of health, living and working conditions, lie outside the health system. Just as insurance coverage for doctors and hospitals is necessary but not sufficient to create a high-performing health system, improving the quality and efficiency of services is critical but also not enough to improve population health. It will be necessary to focus attention upstream on the social determinants of health, creating public policy to promote health, including access to healthy foods, assurance of safe communities and workplaces and the reduction of poverty. Health system leaders need to support and contribute to cross-sectoral partnerships aimed at improving population health. As a colleague remarked at a recent meeting, “Where were healthcare professionals when physical education was cut from the schools?” This move has contributed to the rising epidemic of childhood obesity, with staggering consequences for the health system.

In Ontario, the Project for an Ontario Women’s Health Evidence-Based Report (POWER study) reported on gender, socioeconomic and geographical inequities in performance on a comprehensive set of evidence-based indicators of the leading causes of morbidity and mortality in the province, including selected PROMs (Clark and Bierman 2009; Shiller and Bierman 2009). Disparities in health and functional status were much greater than inequities in access and quality of care, underscoring the need to focus upstream. The consequences for the health system of health inequities are

considerable. The POWER study estimated that if all Ontarians had the same health as Ontarians with higher incomes, an estimated 318,000 fewer people would be in fair

*There is cause for optimism. Canada has all of the elements needed to move from being a laggard to a leader in quality improvement.*

or poor health, an estimated 238,000 fewer people would be disabled and there would be an estimated 3,373 fewer deaths each year among Ontarians living in metropolitan areas (Bierman et al. 2009). Reducing the burden of population illness is important for health system sustainability and will require not only a focus on chronic disease prevention and management to improve health system performance in this area but also policies that address the social determinants of health.

### **Which Road Will Canada Choose?**

There is cause for optimism. Canada has all of the elements needed to move from being a laggard to a leader in quality improvement and to create a sustainable high-performing health system. First, looking back and returning to the original vision of medicare's creators can inform the development of health and public policy together to finally implement medicare's second stage. Second, there is much infrastructure to build upon including national, provincial and regional bodies committed to improvement and many local pockets of innovation. Third, national and provincial investments in primary care provide an important resource. Fourth, Canada has been a leader in understanding the role of the social determinants of health, providing the

knowledge needed to develop population-based strategies to improve the health of Canadians. Fifth, we can learn from successful innovations elsewhere and adapt these to the Canadian context. While there is a potential for Canada to leapfrog forward among nations in implementing a successful quality agenda, it is not clear whether this promise will be fulfilled. There are multiple barriers to change, a tendency toward inertia, considerable fragmentation across the system leading to a patchwork of uncoordinated responses and the false allure of market solutions.

Will Canada choose the right road?

The risk of a wrong turn is great. A national strategy, linked to provincial and local activities with a clearly developed road map for improvement, could most efficiently drive health system transformation. However, this is not on the immediate horizon. Nevertheless, there is no need to wait. Perhaps interested parties could form a "coalition of the willing," composed of agencies, organizations, providers and communities committed to moving the quality agenda forward. Central to supporting these efforts is the role of performance measurement to inform and guide change, monitor progress and evaluate specific approaches. It will be important to include PROMs along with more traditional quality measures of structure, process and outcomes for these purposes. The use of PROMs as an integral component of the quality agenda can keep the focus on patient-centred care that meets the needs of a diverse Canadian population and can serve as a reminder that the ultimate goal of medicare is to keep people well.

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# We Have a Perfect Storm – Let’s Use It



COMMENTARY

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## ABSTRACT

*The lead paper, “Responsibility for Canada’s Healthcare Quality Agenda: Interviews with Canadian Health Leaders,” is a valuable contribution to the quality and safety improvement conversations taking place across the country. My commentary suggests a dramatic convergence of social, economic, demographic and technological forces has brought healthcare to a threshold of a perfect storm. To brace ourselves against this storm, I have suggested that we need to understand the system not as a structure but as relationships. I argue that alignment is not a concept that is particularly well understood – and we tend to focus almost exclusively on the component of structure.*

THIS IS CERTAINLY an exciting time to be a healthcare executive in Canada as we listen to and observe the many storms that are gathering. Converging are the *financial storms* dashing against provincial government revenues; the *chronic disease management storm* that is overwhelming our healthcare delivery system – where the hub of the service delivery is still the acute care hospital; the *quality storm*, which has passed through the evidence-gathering

and the evangelizing stages and is now increasingly in the hands of healthcare consumers from the baby-boomer generation, who are beginning to practise medical consumerism and are demanding “patient-centred care”; and, finally, the *healthcare worker storm* gathering to take greater responsibility for finding the solutions to the problems created by a lack of system alignment.

The lead paper suggests that “we need a

national agenda, based on a coalition of the willing, to drive greater quality and performance in our health system” (Sullivan et al. 2011). I’m not going to suggest that CPSAI does not have an important role to play in promoting and advocating for safer healthcare. But while we and our provincial counterparts have a significant role, we are certainly *not* the solution. “Solutions” and the key “leverage points” lie elsewhere.

What I have come to understand is that our task is both more complex and simpler than you might imagine. Sometimes we’ve got to get completely emerged in complexity to fully appreciate just how paradoxically simple some things actually are – and how more complex some issues can in fact be.

The lead paper challenges us to meet and work together on the various landings and balconies, and build new, more efficient stairwells and realign our ladders to achieve higher quality goals. An interesting assumption at the core of the lead paper – and one held by many of the health leaders interviewed – is that somehow there is actually a “system” that can be reformed, transformed, re-designed and aligned to improve quality and safety. While we all use the term *healthcare system*, the truth is we do not have a system of services that have been designed to work together to create an intentional outcome. The component parts of an automobile have been designed and aligned together to produce an intentional outcome: you can drive somewhere. It is important to state the obvious: Canada is not the United Kingdom, with a single National Health Service (NHS) driver. In Canada, we have hundreds of stairs, halls and balconies called healthcare networks, regions, institutes, councils, agencies, think tanks, foundations etc. In addition, we have thousands of independent stairs called health service delivery agents – each doing their own thing as independent, rather than as interdependent, operators In

reality, rather than a “system,” what we have is a set of publicly financed federal, provincial and territorial insurance plans. Understanding our context is crucial.

A common thread throughout the lead paper is a call for an aligned quality agenda that links federal, provincial and local efforts. The fact is that for an organization, or a network/system of organizations, to be successful, each of its interdependent parts must be designed

*“Alignment” is not a concept that is particularly well understood in our healthcare delivery system.*

to operate in sync with one another – and with the overall strategy. A smooth operating system is not the product of a series of isolated actions but stems, rather, from orchestrating the right combination of interactions at the right time for the right person in the right places. However, “alignment” is not a concept that is particularly well understood in our healthcare delivery system in Canada. Rather than aligning the components of culture, skills, knowledge, structure and strategy – the actual requirements for system alignment – we tend to focus almost exclusively on the component of “structure.” This is what Peter Senge referred to as a “mental blinder.”

*Structure* is the DNA of the health system. Whatever we design into it will produce the outcome or results. In fact, every system is perfectly designed to produce the results that occur. If we don’t like the results that we are currently producing, we need to understand that the outcomes of the system are embedded in its design. *Alignment* refers to the degree of integration of a system’s or organization’s core systems, structures, processes and skills, as well as the degree of connectedness of the people to the organizational (or systemic) strategy. *Align*

represents a force, such as magnetism. It is what happens to scattered iron filings when you pass a magnet over them.

Unfortunately, the traditional response to poor performance has been to shuffle the internal organizational boxes rather than align all of the integrated components that could achieve the results required. If we are to stop repeating the mistakes of the past, our healthcare system leaders at the macro-level and our organizational leaders at the local and operational levels need to master the art and science of *system alignment* and *organizational design*.

It is time for an adult conversation and a mindset change. While Canadians are saying that they love our healthcare system, the fact is that today our current methods of organizing and delivering care are unable to meet the expectations of patients and their families. In part, this is because the science and technologies involved in healthcare – the knowledge, skills, care interventions, devices and drugs – have advanced more rapidly than our ability to deliver them safely, effectively and efficiently. For example, application software, or “apps,” are now available to provide patients who have undergone prostate surgery with day-to-day preoperative and discharge instructions – complete with checklists, warning signs, automated medication and follow-up appointment reminders.

Just as we are facing a federal/provincial funding crunch, it is interesting that these new disruptive technologies are starting to spread. Several of these technologies are expected to revolutionize “how healthcare is done.” While the lead paper has many valuable features, it does not anticipate the radically different future that technology will bring over the next three, five and 10 years. It expects the “same old, same old.” However, the revolution is already here. There are more than 18,000 medical applications available for downloading from major app stores for the iPhone and iPad

and for smart phones and mobile computers using any of the existing major systems: BlackBerry, Microsoft Mobile, Android etc.

But this is just the consumer market – which is currently dominated by mobile phone operators. Today, thousands of mobile apps are being developed by traditional healthcare providers, device manufacturers, drug companies and healthcare researchers around the world. They range from blood pressure cuffs to new applications that take advantage of the capabilities of the latest smart phones to detect and automatically report patient falls – and even elopements of patients with dementia.

My concern is this: we could be running out of runway. I think that the vote-rich baby boomers are going to drive health reform during the next five to 10 years. Remember, we had more social activism in the 60s than in any other period. Will the baby-boomer activists rise up again? And will healthcare become their burning platform? We are already beginning see a power shift by a new and informed consumer. Are we experiencing the “boiled frog syndrome,” where we don’t really notice how our environment is changing? Consider these numbers:

- 36% of people want to see what other customers say about medication and treatment
- 34% use social media
- 46% use online health portals
- 67% use search engines
- 60–80 million US consumers use social media to share their health experience
- 830 US hospitals are now using social networking channels, totalling over 3,300 social media sites ( TELUS 2011)

Every other major service and production organization in the world has had to refocus and question existing processes, decision trees, contractual arrangements, and their “value-

for-money” propositions etc. Are we actually waiting for a consumer revolt? Or could we still get ahead of the curve by designing a system with quality as its foundation?

So how do we advance a health quality agenda as advocated in the lead paper? We need a mindset shift by health system leaders at the governance and managerial levels from viewing themselves as “governors and managers” – to “system architects or system designers” focused on the public interest, as well as their organization’s interest.

The role of government would be that of an architect – through the creation of sound healthcare policy and aligned incentives, not as a “manager.” The delivery system, on the other hand, would be an accountable operator and innovator within the architecture set up by the government. This is a very different way of thinking about a service delivery system that has traditionally been designed by politics – not evidence about what works.

Imagine the health system to be a multi-story building. Often leaders have been far more concerned with the dramas taking place in the upper room balconies and halls of the building than the relationship flaws on stairs and ladders to achieve higher goals. These flaws are the true source of transitions of care and quality breakdown. Instead of thinking and acting as isolated silos under siege, governance and managerial leaders can choose to see themselves through another lens, a lens in which you can see yourself and your organization in a relationship with the health service delivery system and your community partners in the delivery of care. Robert Quinn writes: “Deep change requires more than the identification of the problem and a call to action. It requires looking beyond the scope of the problem and finding the actual source of trouble. The real problem is frequently located where we would least expect to find it – inside ourselves.”

So what should the quality agenda look like? First, the healthcare system would be organized around different patient groups, not providers or hospitals. In an environment characterized largely by chronic disease, this is the only reasonable way to coordinate and integrate care delivery. Second, politicians would not debate individual cases, they would get objective evidence based on transparent advice regarding what to do and leave the doing up to the managers. Third, often “fixes” fail because a final plan becomes a negotiated settlement – at the lowest common denominator. The operations focus would be on common areas of real value creation: transparency, reduction of variation, standardization, greater coordination across the continuum, accountability for results, use of evidence and obligations of the citizens themselves.

In an opinion piece titled “The Crisis No Leader Is Talking About,” Terence Corcoran (2011, April 6) in the *Financial Post* referred to a recently published C.D. Howe Institute paper on chronic healthcare spending (Dodge and Dion 2011). Corcoran was present at the press conference attended by healthcare leaders and had this to say about healthcare leadership: “The health-care players in the audience seemed powerfully resistant to radical options ... If some of the leading figures in health-care services don’t seem ready to tackle the funding reforms ... that means the leadership role on health care will have to be taken up by others” (Corcoran 2011, April 6).

I think he is wrong. I think that the health system must step up to the plate and redesign our delivery system. The knowledge and wisdom about how to do that is in the front lines of our healthcare delivery system – in the hearts and minds of all our health professionals. We could use this “perfect storm” to have an open and honest conversation about our current realities – and about how we

can leverage the focus on *quality* and *patient safety* agendas as an unprecedented leadership opportunity to redesign our healthcare services delivery systems.

As I considered the issues surfaced by Sullivan et al., I visualized four key leverage points: *front-line service providers, leadership and management, governance and government*. Below are my reflections.

### **Front-Line Service Providers**

Quality is ultimately in the hands of those who actually deliver care. Their quality performance is dependent on their knowledge, skills, and attitudes, their beliefs about current levels of quality, their sense of the roles they play in delivering quality and their perception of the status quo. It also depends on how they define themselves as professionals – their values, aspirations, organizational ethos, information-seeking behaviours, sense of stewardship over resources and comfort level with inter-professional teamwork. These questions apply to all professionals and all occupations. What is the hierarchy of values among professionals and occupations? Does quality trump other values such as autonomy and group loyalty?

Those organizations and jurisdictions that invest in the skills development of their people perform best. It is really that simple. Yet in tough economic times in the past, the health sector has always cut staff development budgets first – as if investing in our people is just “nice to do” rather than “essential to our success.”

### **Leadership and Management**

The day-to-day work of the healthcare system is transitions of care and transactional processes. Whether care is of high quality depends significantly on whether and how front-line healthcare delivery is managed. The role of governance is to establish quality as a core organizational value – and hold execu-

tives accountable for performance. CEOs and managers carry out the quality-related mandate by designing for quality and by motivating, prioritizing, measuring, coaching, supporting and celebrating excellence. We need CEOs who see the next five to 10 years as an opportunity to “leave a legacy” – a once-in-a-life-time chance to create something of real value for their community and for Canadians. In five years from now, a critical mass of our existing health system leadership will retire. What qualities should we be looking for in the next generation of healthcare leaders?

### **Governance**

How organizations behave is also significantly influenced by how they are governed. By their priorities, the information they receive and the decisions they make, governors signal how seriously they perceive quality issues – and what they are prepared to do to ensure that quality is a core value and entrenched in practices in their organization. Do boards make it clear that the adoption of quality improvement practices is a core expectation? Do they drive improvement beyond the requirements of government and external accreditation, regulatory and licensing bodies?

Governance boards exist to represent the interests of the “owners” of the organization. Wherever boards are active and involved in quality, the quality is measurably higher.

### **Government**

The allocation of resources and economic incentives created by provincial governments is how we created the delivery system that is now in place. Behaviours are also driven by the regulatory framework and by how accountability is designed in the system. So, how government defines and plays these roles profoundly affects quality. We need our public servants and political leaders to be really

passionate about quality. Quality requires both ground-up commitment and activity and top-down policy direction and accountability.

Indeed, the most leveraged action that provincial governments could take would be to “celebrate quality.” This wisdom comes from the field of appreciative inquiry, which teaches this: *in whatever you celebrate, pay attention to and reward, you will get movement.*

## Conclusion

The authors of the lead paper have sent out a call to action based on a coalition of the willing to drive the quality agenda. Count me in.

In closing, a dramatic convergence of social, economic, demographic and technological forces has brought healthcare to a threshold of a perfect storm. To brace ourselves against this storm, I have suggested that we



*We need our public servants  
and political leaders to be  
really passionate about quality  
improvement.*

begin with self-reflection to understand how we are connected with our local and larger community. We need to understand the system is not structure, but as relationships – and we need to play our roles as architects, aligning and designing better connectivity. We need to make sure we create sustainability – where our collective productive energy does not go to waste. A strategic coming together for a new adult conversation on system alignment using the dimension of quality as a focus and leverage point could be a humanistic unifying theme in an otherwise-divisive health system environment. Let’s begin by asking, “What do healthcare consumers need, and how can the system respond?”

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# National Quality Framework – Yes We Can!



## COMMENTARY

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## ABSTRACT

*This commentary provides perspectives from the nursing profession on the lead article that address professional and regulatory issues and shares insights derived from many years of leading quality enhancement initiatives at policy and clinical levels. The commentary calls attention to a number of successful national and provincial approaches founded on strong leadership, collaboration and consensus building. It also underscores the idea that professional organizations and individual health professionals are important drivers of quality initiatives at the point of care and when overseeing adherence to standards and successful program implementation.*

*Although we agree with the authors' call for a national quality framework, this commentary stresses the importance of achieving consensus among all healthcare actors on what are valid and relevant metrics and indicators. It also points out the potential risks of linking performance to financial and some non-financial incentives and offers ideas for fostering convergence of the financial and the quality agendas in healthcare.*

“RESPONSIBILITY FOR CANADA’S Healthcare Quality Agenda: Interviews with Canadian Health Leaders” (Sullivan et al. 2011) sounds out the observations of key figures

in Canadian healthcare on how we can best move the quality agenda forward. This snapshot of the healthcare quality landscape reveals several of the strong assets that

can be leveraged for the benefit of the health system, as well as significant gaps that need to be addressed if we are to meet the evolving needs of the Canadian population.

This commentary provides perspectives of the nursing profession on the article that address professional and regulatory issues and share insights derived from many years

*One of the most striking characteristics of the lead article is the familiarity of its terrain.*

of leading quality enhancement initiatives at policy and clinical levels. It also calls attention to a number of successful national and provincial approaches founded on strong leadership, collaboration and consensus building.

One of the most striking characteristics of the lead article is the familiarity of its terrain. For example, the healthcare leaders interviewed were in strong agreement of the “need to adopt a ‘culture of quality.’” How many readers are unaware of the total quality management and continuous quality improvement movements that gripped the agendas of national conferences for many years and engendered programs in healthcare organizations? Some readers may find themselves asking whether the quality agenda has truly shifted or whether we are simply seeing the same ideas resurface.

Other themes emerging from the interview data were familiar in a different way. Take, for instance, the concepts of avoiding a culture of blame and of moving from a “culture of autonomy ... to one in which multidisciplinary teams and patients collaborate to identify and resolve problems.” These concepts, which are critical for improving healthcare, were part of the discourse

of 2003 when healthcare leaders, including the Canadian Nurses Association, lobbied effectively for the establishment of a national institute to promote patient safety. Are we repeating those same discussions? If so, why?

### **Measuring Success**

Another familiar theme was the inconsistency of data that could otherwise drive evidence-informed decisions and enable reliable performance tracking as well as cross-jurisdictional benchmark comparisons. Such benchmarks would, of course, need to rely on accepted indicators and shared definitions for common measurement. National goals, uniform data collection, standardized metrics: these should not imply the imposition of formulaic, one-size-fits-all measures that resist adaptation to changing circumstances. Rather, they facilitate the quicker and more efficient identification, optimization, implementation and transfer of successful approaches. They also allow for earlier detection and remediation of gaps in quality, and they support continuous improvement cycles.

Consensus on what constitutes valid and relevant metrics is essential, however. Whatever you measure is eventually perceived as important, even if it is of little practical significance to practitioners. We may be tracking certain data simply because they are readily available (data collected under fee-for-service billing systems, for example). It is therefore vital that all parties agree on what constitutes a measure of quality and how measurement will affect clinical and organizational behaviours.

We need measurements that actually guide clinicians and managers in delivering patient-centred care. And we need measurements that help us address the significant challenges that our health system is facing, such as chronic disease management. The Academy of Canadian Executive Nurses and the Canadian Nurses Association have, for instance, been

collaborating to identify national quality indicators that are relevant to nursing but are part of, or easily integrated into, existing quality indicator initiatives. This begs such questions as, why are we not collecting data across the country on self-care abilities when Canadian nurse researchers have developed a valid and reliable measure to do so? The results of this data collection would be key to identifying where healthcare is effective and would prepare us for demographic challenges ahead. Setting national quality indicators will take strong, patient-centred leadership.

The interviews in the lead article remind us that we have, on other occasions, tried to tackle the complex goal of quality healthcare. This historical perspective helps us to remember where we have been and what has been gained at each iteration – and to ask ourselves why sound theories fail to be fully applied in practice. Indeed, the authors make the excellent point that “the challenge facing the healthcare system is transferring and translating the knowledge from these sources into measurable behavioural and practice change.”

### **Coordinating Organizations and Initiatives**

The article reveals progress being made across the country in what the authors refer to as “pockets of leadership.” The growth and success of provincial quality councils are exciting responses to the rising demands being placed on our increasingly complex healthcare system. The Canadian Patient Safety Institute (CPSI) and its action campaign for front-line health professionals – Safer Healthcare Now! – has received broad inter-professional buy-in and is hard at work filling current research gaps. For the board members and chief executive officers who believe that the buck stops with them, CPSI has also created a wonderful array of resources that focus on board governance and patient safety. As well, Accreditation

Canada and the Canadian Institute for Health Information each play important roles in creating information and providing benchmarking opportunities that have a high degree of relevance across the country.

The Quality Worklife–Quality Healthcare Collaborative (QWQHC) has also served as a national catalyst for positive change. Because the quality of practice environments has a marked effect on the ability of health professionals to meet their standards of practice, health professions and key players such as Accreditation Canada and CPSI joined forces to systematically remove barriers to quality care by promoting practice environments that foster the much sought-after culture of learning and improvement. QWQHC has been able to showcase striking successes.

All of these groups are leading important innovations to improve quality care; however, we wondered why the interviews with 53 leaders did not include a mention of members from the Health Council of Canada (2009), which, according to its mission statement, “fosters accountability and transparency by assessing progress in improving the quality, effectiveness and sustainability of the health-care system.” The Health Council of Canada’s excellent publications provide information that can be extremely useful in feeding our continuous improvement cycles.

We were also struck by the absence of regulators from the pool of interviewees. Regulatory bodies such as the professional colleges are important actors in the quality continuum, setting standards for professional practice and conduct, offering practice advice and promoting continuing competence. The Health Quality Council of Alberta, for example, has established a health quality network that is founded on the active participation of the three main colleges (pharmacists, nurses and physicians and surgeons) and the Alberta Federation of Regulated Health Professionals,

Alberta Health and Wellness, Alberta Medical Association and Alberta Health Services. All of these bodies are involved in the quality conversation, providing valuable advice on priorities and collaborating on education strategies.

Although opinions differ on how quality efforts can be coordinated across the country, we have seen several successful initiatives to create national frameworks on specific health issues. For example, the Canadian Stroke Strategy took between two and three years to set up, but it leveraged the work of several jurisdictions to establish common measures. Questions arise: How can we best leverage the considerable resources available in Canada to arrive at the goal of quality that is shared by so many organizations? Is there a role for CPSI and the Health Council of Canada to support the coordination of frameworks being developed across the country?

### **Disseminating the Quality Agenda**

The article speaks of “transferring and translating” knowledge from existing contributors to the quality agenda at various levels, including individual care providers. It is vital that all individuals within an organization internalize values that are consistent with the provision of quality care. Professional organizations are bringing expertise to the table in many of the forums mentioned here to advocate for quality, both at the system level and among their members. The health professions are made up of individuals, each of whom is educated to provide safe, competent, ethical and compassionate care, and each of whom adheres to high standards of education and practice through profession-led regulation – which is an essential part of the quality chain in Canada. The regulatory bodies (through transparent processes that involve representatives of the public) establish standards that include responsibilities toward continuing competence

and a duty to speak out in situations where safety and quality could be compromised.

The title of the lead article implies that health leaders are ultimately responsible for Canada’s healthcare quality agenda. We congratulate the authors on bringing forward the views of health leaders to move this program forward, and we see that the professions are an important element of that leadership, both at the point of care and in the

*As well, although we agree with the authors that the quality agenda must have the explicit backing of top echelons for it to filter down within an organization, mechanisms are necessary for the effects of personal and local leadership to trickle up as well.*

overall architecture. The professions themselves, of course, hold pockets of leadership that are essential to achieving quality care. Physician leadership is mentioned a number of times in the article, but this concept should be broadened to promote an inter-professional approach to quality. As well, although we agree with the authors that the quality agenda must have the explicit backing of top echelons for it to filter down within an organization, mechanisms are necessary for the effects of personal and local leadership to trickle up as well. Cultural shifts require buy-in at the ground level in order to achieve maximum success, and we need goals that show respect for clinicians delivering care and give meaningful guidance to health professionals.

While leadership sets the tone of organi-

zational change, creating the right incentives sets the pace. Unfortunately, incentivizing can also lead to distortions, with significant resources being directed at specific targets while other considerations are neglected. Political motivations can also result in priority being given to some targets at the expense of other, less popular but perhaps more necessary goals. Public incentives can lead providers to “game” the system in an attempt to mask poor performance. Confidential benchmarking against aggregate data may prove more useful in promoting quality within an organization, while offering no disincentive to the accurate public reporting of adverse events or medical errors.

Legislated incentives (as in some pay-for-performance contracts and recent legislations in Ontario and Quebec) offer us the opportunity to see if this is a worthwhile approach. It will be important to closely monitor the impacts, both intended and unintended, of these relatively new initiatives. There is a real danger of what the authors call “potential misalignment of incentives in which institutions or individuals are reimbursed for volume (quantity) rather than quality of care.” Although it is tempting to track outputs that are simple to measure at the institutional level (e.g., number of diagnostic tests), we must also capture, with quantitative and qualitative measures, the benefits of positive outcomes for the broader health system (e.g., the impact of successfully supporting self-care ability).

Attempts to link quality and patient safety improvements to efficiency gains also warrant close scrutiny. Such strategies may help underwrite costs related to the implementation of changes in processes, systems and organizational cultures. They may also ameliorate prospects for long-term health system sustainability. Although it stands to reason that better outcomes should spell reduced long-term costs overall, it may be useful to systematically explore linkages and synergies among quality

improvements, enhanced patient experiences and long-term cost containment. Where multiple motivators underpin quality initiatives, it may be easier to achieve the necessary buy-in by all stakeholders.

### **Quality Impact Assessments**

The financial agenda and the quality agenda have been running parallel but not meeting. Quality should, of course, be where the conversation starts. Perhaps “quality impact assessments” need to become a standard tool to inform board decision-making. These could resemble the environmental impact assessments that regularly accompany proposals for large construction projects. If we manage to more effectively marry quality programs and cost-containment imperatives, we may be able to avoid financial decisions that diminish quality. We can also more systematically evaluate the return on investment of various quality initiatives. Looking forward, we see the merits of the proposed national framework of clearly defined indicators based on shared principles and common attributes. Pan-Canadian adoption of standardized electronic health records, for example, would be an excellent first step in generating consistent and reliable data nationally. This is where leadership at all levels plays an important role: it can enable champions to work to their full potential and demonstrate tangible results on multiple fronts that have a proven positive impact on quality. Perceiving the potential disconnect between research and practice, the Canadian Stroke Strategy (2008) recognized that best practices are not consistently applied, leaving a significant gap in the quality of stroke care between what should be done and what is being done. The primary goal of the Canadian Stroke Strategy is to help close this gap. Many organizations dedicated to health system optimization could benefit from such a systematic approach (CMAJ 2008).

As negotiations ramp up in the lead-up to the 2014 renewal of the health accord, the findings of this article lead us to focus, appropriately, on the quality agenda. National goals need real leadership as well as the political will to align reforms with what is in patients' interests and to avoid getting caught up in politics, optics and opinion polls. We commend the authors for demonstrating how far we have all advanced in achieving quality care and for shedding light on some of the hurdles that remain. Much of the heavy lifting involves integrating quality measures "into the day-to-day business of the healthcare setting in order to shift the organizational culture to one of safety, efficiency and quality improvement."

We believe that through a continued focus on consensus building, information sharing and timely strategic investments, healthcare leaders can catalyze a marked improvement

in quality and patient safety while fostering exciting interdisciplinary approaches to provide the very best in patient- and family-centred care.

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# Healing Healthcare in Canada: A Shared Agenda for Healthcare Quality and Sustainability



COMMENTARY

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## ABSTRACT

*Sullivan et al. make a compelling argument that a “coalition of the willing” must seize the nettle and create a national agenda and the capacity for quality leadership in Canadian healthcare. While there is reason to believe that Canada could benefit from such an agenda, there is also evidence that, if done incorrectly, such an agenda could be expensive and counterproductive. To increase the likelihood that a national quality agenda will contribute to the creation of a sustainable and effective health-care system, it will be important to understand potential pitfalls and to incorporate approaches that have enabled leading organizations to achieve success. It will be key to create a shared vision of healthcare that focuses on the health needs of our population and engages stakeholders broadly.*

SULLIVAN ET AL. (2011) have sought input from a selection of healthcare leaders across the country to assist with clarifying current thinking regarding the quality agenda in Canada and how a national strategy might

be of benefit. They conclude by challenging us to form a “coalition of the willing” to “get over our giant inferiority complex and seize the nettle of building a national agenda and the capacity for quality leadership in Canada.”

As a physician with a long-standing interest in improving the quality and sustainability of healthcare, I am supportive of a quality agenda at all levels and agree with the assertions made in the article that it will take many working together to make this happen. Not addressing this issue effectively will both impact the quality of health services that Canadians receive and the funding available for other priorities and also threaten to make Canadians feel like people of a can't-do nation.

The lead article covers a wide range of issues related to such an agenda, including three drivers of change: “(1) a move to person-centred models of care delivery in which individual needs and expectations for participation in health are given primacy; (2) the need to contain and reduce costs in healthcare delivery, duplication of services and process inefficiencies; and (3) the need to improve patient safety.” Also included are impediments such as an embedded culture, a lack of definition of quality, insufficient engagement of boards and physicians and concerns regarding measurement. The importance of leadership is identified. In order for a national agenda to be successful, exploring these issues further and considering potential pitfalls will be beneficial.

### **Potential Pitfalls**

Concerns regarding the quality and sustainability of health services persist, despite many investments and efforts over the years. Further, many jurisdictions have struggled with similar concerns and have also been disappointed with their attempts at change. As efforts internationally in recent years have had a similar focus to that supported by the lead article's authors, considering such experiences is instructive. A jurisdiction mentioned in the article that invested heavily in a bold national strategy to become more patient centred and achieve measurable targets through a variety of means is England's National Health Service

(NHS). Between 1999 and 2000, that centrally run health service was able to achieve many improvement targets, especially those related to wait times. Unfortunately, the NHS also more than doubled its budget (Jim Easton, presentation June, 2009). Its strategy contributed significantly to the current need for an austerity budget. Targets that had been reached have been scrapped due to a lack of sustainability. NHS has now embraced a radically different policy approach, the results of which will not be known for years. The UK example is dramatic but serves to point out that a bold national agenda focused on quality does not necessarily result in the desired outcomes. Such experiments suggest that a more nuanced quality agenda will be required for success.

*“The UK example is dramatic but serves to point out that a bold national agenda focused on quality does not necessarily result in the desired outcomes.”*

### **Engaging a Broader Stakeholder Group**

It is interesting to note that the immense policy shift occurring in England's NHS is being driven from the political level and involves putting the vast majority of resources under the direction of general practitioners. The logic, as I understand it, is that empowering those more directly engaged with addressing the needs of patients is more likely to lead to the population's needs being met. Further, by tying budgetary accountability to the same people, it is more likely this will be achieved in a fiscally responsible manner.

I can certainly relate to this logic. Early in my career as family physician, I noted clear

trends that were negatively impacting the quality and sustainability of health services. There were some primary care initiatives in the province (British Columbia) at the time, but they were so proscriptive and the government of the day was so clearly anti-physician that few physicians, me included, were interested in engaging. The anti-physician sentiment carried into negotiations and, due to lack of trust and relationship, there was little scope for negotiation beyond dollars and cents. The resulting physician master agreement provided a substantial increase in physician income and a concomitant decrease in physician morale and system functionality. This is an example of the increased cost and decreased function that plays out in many ways across our country. I suspect that there are numerous stories that can be told by clinicians, users of the system and others regarding their perception of system waste and dysfunction. Obtaining such insights and empowering change are critical to sustainable improvement.

### **The “Culture” of Healthcare in Canada**

The lead paper contends that the culture of healthcare in Canada needs to shift and embrace a focus on quality and sustainability. Understanding the current cultural issues ingrained in our healthcare system should assist with increasing the clarity regarding what will be required to make this shift.

My early experiences in healthcare caused me to become concerned about having a long career within a system that was becoming increasingly dysfunctional. In an effort to contribute to solutions, I became involved in a variety of activities, initially in the governance of a regional health authority. Through this role, I came into contact with board members from across British Columbia, senior administrators and ministry staff as well as a physician and academic leaders. I came to realize that issues and trends that

seemed obvious were not understood by many in healthcare. Further, there was no clear path for sharing this information in ways that were constructive. I am not alone in this observation. Most physicians experience such a disconnection. As is evidenced by the membership survey published in the fall 2009 newsletter of the Canadian Society of Physician Executives, even physicians who are committed to substantive leadership roles within our system share this experience. The survey reveals that the top three challenges for their membership are (1) being effective in the leadership role, (2) making an impact on decision-makers and (3) being included in key organizational decisions.

Canada is not alone with such disconnections. Brent James of Utah-based Intermountain Healthcare, a well-recognized leader of health system improvement, describes the medical and healthcare administrative communities as “fundamentally joined structures with fundamentally separate objectives” (Personal communication, June 2009). Significant disconnections between such major components of the healthcare system are, in my estimation, at the root of the structural and cultural issues that impede progress. Sullivan et al.’s paper also references disconnections in healthcare when it mentions such things as physician autonomy and when it describes boards as being too focused on finances and strategy. My diverse activities in healthcare, including medical administration and academia, have helped me to see that disconnections do extend beyond the administrative and medical communities. Healthcare is made up of many groups, each with its own culture, that do not connect with each other as well as they need to. Doug Eby, of Southcentral Foundation, who consults widely internationally, describes healthcare as a “non system” (Personal communication, June 2009). Perhaps the best way to consider the

culture of healthcare in Canada is a patchwork of cultures that are only loosely related.

Those of us who are, or have been, immersed in the culture of healthcare have experienced the atmosphere of mistrust and the lack of shared vision present in many settings. It is reminiscent of what the late BC author Peter Frost (2003) described as a “toxic” work environment.

### **A Quality Culture**

The quality agenda has the potential to create a bigger tent under which the many cultures that exist within healthcare in Canada can come together to co-create a more effective and sustainable healthcare system. My academic focus has been on understanding how the organizations viewed by the international community as being the most effective, from quality and sustainability perspectives, have used a quality agenda to achieve success. It is clear that, despite significant contextual differences, such organizations share many traits (Horvat 2011). For such organizations, quality improvement provides an approach that brings people with different roles together in a respectful and supported fashion to consider how resources can be used most effectively to address the health needs of the population being served. Clinicians and those responsible for significant infrastructure work together to identify priority areas. With the support of those with expertise in such areas as quality improvement, data analysis and finances and with input from patients, relevant best practices in clinical and non-clinical realms, appropriate measures and suitable Plan-Do-Study-Act (PDSA) cycles to trial changes are identified. Trials are made, results measured and, if effective and sustainable approaches are found, efforts are made to spread such best practices. This results in a reduction in clinical variation. Such systems use peer mechanisms and sometimes incen-

tives or disincentives to motivate people to embrace change and work together effectively. Barriers to improvement are removed. The sense of collaboration increases somewhat as people have the opportunity to work together, across disciplines, to achieve shared goals. This approach promotes shared responsibility and accountability and appears more successful than the potentially judgment-laden



*“People came into healthcare to serve; how do I make it easier for them to do it right?”*

approach of performance management.

The approach to leadership that has led to shifts in organizational culture toward quality and has resulted in more effective and efficient health services is more service oriented than the leadership style one typically finds. Observations on leadership by Brent James include noting, “People came into healthcare to serve; how do I make it easier for them to do it right?” and, “The role of leadership is to build infrastructure” (Personal communication, June 2009). This supportive and empowering style of leadership, coupled with the creation of shared priorities and approaches, results in quality being embraced broadly by people working in healthcare and leads to the development of leadership throughout the system. This is a key feature of highly effective healthcare systems that are able to support sustainable improvement in many areas at once.

While the landscape in Canada has many similarities to those of other countries, we do have our unique features as well. The different mandates and cultures of the federal versus provincial governments make it highly unlikely that a directive federal agenda will be embraced. There are, however, benefits to

this. As demonstrated, a centralized approach, if incorrect, can cause significant difficulties. Further, successful approaches have been much more supportive than directive methods. A federal approach will more likely succeed through a “coalition of the willing,” composed of organizations and “individuals who have an ability and determination to change practice and improve care,” working together to construct a shared quality agenda.

### Conclusion

An increased focus on quality and sustainability is required for the Canadian healthcare system. By avoiding the common pitfalls that we and others have experienced, by broadening the engagement and by constructing a shared agenda for improvement, we will be doing a great service to Canadians.

Healthcare in Canada is in the public domain and so, by necessity, is a political matter. Ultimately, successful change will require political support. As there are few politicians who have an understanding of the nuances of our healthcare system and the activities that will lead to successful improvement, it is unlikely that political leadership will be grasping nettles anytime soon. It is up to the many of us who are more directly engaged within the system – as clinicians, administrators, researchers, educators etc – to grasp this nettle and deliver a shared vision of what our healthcare system can be. Such a shared vision will be more easily embraced by those at the political level and will therefore make progress more likely to occur.

This is an exciting time in healthcare. Let's make it work for Canadians.

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THE AUTHORS RESPOND  
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# In Search of A4Q



THE AUTHORS RESPOND

*Terry Sullivan, Fredrick D. Ashbury, Jason Pun, Barbara Pitts,  
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ACCOUNTABILITY FOR REASONABLENESS (A4R), widely popularized by Daniels and Sabin (2008), has become a widely used ethical framework to work through the challenging issues of resource allocation with fairness and deliberation. There are certainly significant issues with the framework, but it has helped many delivery organizations open up the discussion of the allocation process in a principled and responsible fashion within an institutional framework (Daniels and Sabin 2008). What this framework has brought us for ethics, we are lacking for quality. We need clearer accountability for quality (A4Q).

As Owen Adams points out in his excellent commentary on the opening paper, Canada has much strength as the home of evidence-based medicine (EBM). EBM embraces the idea of appropriate care, implicitly incorporating the best available knowledge

on how to treat and manage patients. As we have noted in the lead paper, this same zeal to ensure that we treat individual patients with a specific condition using best evidence has not yet been fully embraced by institutional leaders across the country. And it is only just beginning to find its way into the organization, financing and delivery of services in this country. But, as became obvious in speaking to leaders across Canada and polling the leadership attendees at the Canadian Health Services Research Foundation's CEO Forum (Dobrow et al. in press), we lack some common understanding of how responsibility and accountability for quality should be advanced in our delivery system, other than letting a thousand flowers bloom, which as Wendy Nicklin and Gail Williams (2011) and others have noted, is neither sustainable nor acceptable for a model of delivery predi-

cated on person-centred care. Janet Davidson's commentary reminds us that there is nothing complex or magical about quality; it is really a dimension of care that starts with "tone at the top" that sets an expectation that quality is not negotiable (Davidson 2011). She argues for some simple "big dot" indicators to set the sights for all members of an organization and get them engaged as part of the establishment of a quality culture. Certainly, organizational engagement and mobilization are starting points for any organization-wide quality campaign, as are measuring and reporting progress as ways to ratchet up expectations, performance and accountability. Just get on with it, is Davidson's plain spoken prescription.

Don't expect a big dividend in "bending the cost curve," suggests Dan Horvat.(2011). He points out the expansion of spending that followed the growth in performance and quality in the United Kingdom, an intentional growth that has altered improved quality and performance in the United Kingdom. However, the appealing aphorism of bending the cost curve sadly does not address the real problems of price (the *Ps*) and quantity (the *Qs* or volumes of services), especially when it comes to procedures and procedure codes (Lomas et al. 1989). The problem, for example, with change efforts directed toward a more appropriate use of imaging in most institutions is that if doctors get paid more, the hospitals get paid more and the technicians have longer working hours – why would anyone want to reject more imaging, even inappropriate imaging?

Flemons et al. do point out elegantly that the individual model that may have been at the heart of EBM does not function well at the level of clinical micro-systems or meso-systems. Nor does it function well at the level of the macro-system, which has responsibilities for seamless coordination and transitions between the meso-systems, a point elegantly

underlined in the commentary by Sharon Goodwin and Ariella Lang (2011).

The framework by Flemons et al., however, does represent a very simple and appealing model to think about the "hierarchy" of quality initiatives and interventions required to *design, deliver and respond* to quality in our healthcare systems. The question of what to report on very much tracks the three areas of design, deliver and respond.

As Arlene Bierman (2011) points out in her thoughtful commentary, the use of patient report outcome measures (PROMs) holds the promise to help us reshape our efforts based on quality, and may allow us to accelerate the quality and accountability agenda if we keep the patient outcome as the guiding point in our efforts.

Hugh MacLeod's commentary jumps off from the question of what kind of system we might have in the future, pointing to the challenge of "disruptive technology" (MacLeod 2011). Indeed, the entire presence of health technology assessment (HTA) organizations is designed to deal with disruptive technologies and determine when and how they are effective and cost-effective. Canada has been a leader in early HTA and has a strong national organization as well as provincial organizations emerging in several provinces, with Quebec being the earliest pioneer. How we can effectively coordinate the assessment of the technology explosion is certainly an important part of the quality and efficiency agenda for Canada going forward. (Does this drug, device or procedure work? Under which conditions, for which classes of patient and at what cost per quality-adjusted life-year?) We will need all of the HTA capacity we currently possess and more to do an effective job of managing technology based on evidence.

Ontario has been an early pioneer in the field of *coverage through evidence development*, and it takes well-developed capacity, political

will, strong research competence and the capacity to withstand some heavy public criticism to stick with unpopular coverage decisions that are well rooted in evidence (Levin et al. 2011). Where MacLeod's concern is most appropriate is in the embrace of electronic health supports, where we remain a laggard, despite diligent efforts by both provincial agencies and Canada Health

*Despite setbacks, we are making progress.*

Infoway. Electronic health supports hold the promise of allowing better prompting based on evidence, better tracking of disease state management according to protocols, better reporting and comparison of performance data to enable accountability and better engagement of patients in their own care. Despite setbacks, we are making progress.

Macleod's commentary also skilfully underlines the levels of quality leadership echoed in the paper by Flemons et al., noting that while a "once size does *not* fit all" approach is required, the quality agenda is spread across (1) front-line providers, (2) leadership and management, (3) health service governance and (4) government. Let's consider these four areas as arenas for the future.

Virtually all of the commentaries mention the essential importance of clinical engagement, be it at the level of the micro-system, meso-system or macro-system. Physicians are an essential part of this engagement. But as Goodwin and Lang as well as Rachel Bard and Mary-Anne Robinson (2011) point out, the leadership of nursing and other professionals is required at every step of the way to ensure the inter-professional embrace of the quality agenda and a quality culture in an

organization. Indeed Horvat asserts that this is in fact the excitement of the quality challenge, that it holds the prospect to create a common theme for alignment among and between organizations that have conflicting objectives.

The evolution of a quality agenda for Canada clearly involves the professional associations and colleges at the level of *individual providers*. It also requires that we build a stronger *management* and *clinical governance* layer equipped with the skills to mobilize clinical change management, redesign care pathways and collect and report on patient-related outcomes tied to quality and safety. Nicklin and Williams point out that there is no need to reinvent the wheel, as we have plenty of examples of breakthrough initiatives; what we lack is an effective method to disseminate best practice and supports to ensure the sustainability of the implementation of these practices. But it is fair to say that improving our quality record is more than knowledge transfer to enlighten a hungry crowd of health service managers.

Improvements in quality and performance require developed and dedicated management skill and technical training to advance large-scale change, skills that do not arise simply from watching PowerPoint presentations of a successful case study or attending a webinar. Skill building requires dedicated, high-quality learning time away from the home institution and working with mentoring structures focused on the strategies, tactics and tools for change required in the home institution to make this happen. The highest-quality performers in the United States, such as Intermountain Healthcare and Geisinger Health System, are not quality leaders because they have academic links. They are the organizations that have embraced quality and have made significant investments in training their people to create a central quality and performance improvement culture that permeates their organization and the care they provide,

from preventive health services to palliative care (Dhalla and Detsky, 2011). Rather than the clearing house, we need national and international collaborative efforts that expand the existing capacity and skill in several organizations in Canada to move the whole delivery field further and faster on quality

*Significantly expanded efforts are clearly required to close the skills and competence gap in this country.*

and performance. The Executive Training for Research Application/Formation en utilisation de la recherche pour cadres qui exercent dans la santé (EXTRA/FORCES) program developed by the Canadian Health Services Research Foundation has been one important attempt to build capacity (Sullivan and Denis 2011), but significantly expanded efforts are clearly required to close the skills and competence gap in this country.

*Provincial governments* can create a jurisdiction-wide and unequivocal mandate for quality, and this is a highly desirable starting point. Engaging clinical leaders to take up the call and equipping them with the managerial skills to re-engineer their home organizations will, however, require a non-trivial investment in training and capacity development for individuals and teams to effectively delivery on large-scale improvements. Training expensive talent incurs real displacement costs. We noted from the initial survey in our lead paper in this collection that some important provincial and local investments are under way in this country in a fairly uneven fashion, with “pockets” of excellence in quality surfacing here and there.

For government, accepting standardized interprovincial reporting has been challeng-

ing. Provincial governments in this country have not warmly embraced comparative public reporting for a range of largely not-so-good reasons tied to political embarrassment to the sitting governments of national outliers. If we are to push the *respond* side of the quality agenda and promote quality for accountability, we need some real and independent reporting on quality that can also be accelerated with the co-operation of the national agencies.

Additionally, we must include an important role of the public and community leaders that help bring home quality and accountability at the local level and promote and reinforce its salience. Local engagement in the quality agenda involves not only a *receiver* role to implement standards and measurement criteria from provincial and national agencies, it is has a strong *action* role to make it clear that the standards and measurement criteria are expected and potentially create additional standards and expectations that exceed minimal requirements. Public and community leaders have credibility and can shape and contribute to the atmosphere required to push the quality for accountability agenda as a critical expectation for those delivering healthcare at the local level.

To initiate a serious push on quality, we should call on the national agencies in Canada to take up the quality agenda and consider how we might expand technical training and competence in quality and safety. We know the *federal government* investment in health-care is on the agenda. We also have a majority federal government that appears interested in respecting the constitutional privilege of the provinces. Perhaps the time is right to mount a national effort based on high-quality technical training and support to improve health service quality and performance in partnerships with key provincial quality organizations and quality leaders.

We remain an outlier as a nation with no well-developed national training program to offer advanced training in quality and performance leadership and management, and we need to replace this deficiency with A4Q.

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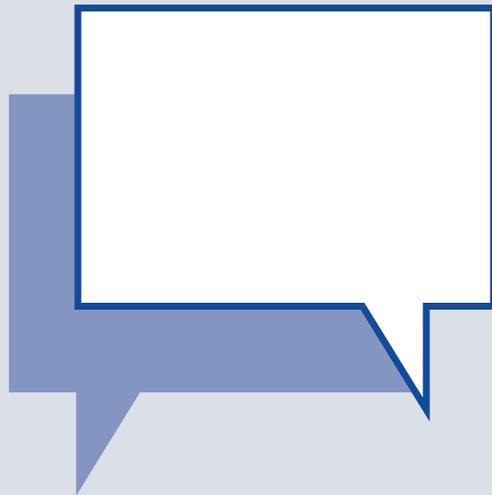
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