

CANADA'S QUALITY IMPROVEMENT CONUNDRUM:

Should Canada achieve a whole that is greater than the sum of its parts?

Proceedings Report and Commentary on the National Symposium on Quality Improvement — Towards a High-Performing Health Care System: The Role of Canada's Quality Councils

December 2013

QUALITY



Health Council of Canada
Conseil canadien de la santé

INTRODUCTION

On October 29 and 30, 2013, the Health Council of Canada hosted a National Symposium on Quality Improvement titled *Towards a High-Performing Health Care System: The Role of Canada's Quality Councils*. The forum provided an opportunity for 200 senior leaders from across Canada to discuss health system performance measurement and reporting, as well as the need to build the capacity and capability for quality improvement. The symposium highlighted the work of the provincial health quality and patient safety agencies in these respective areas, and explored opportunities for further interprovincial collaboration on quality improvement.



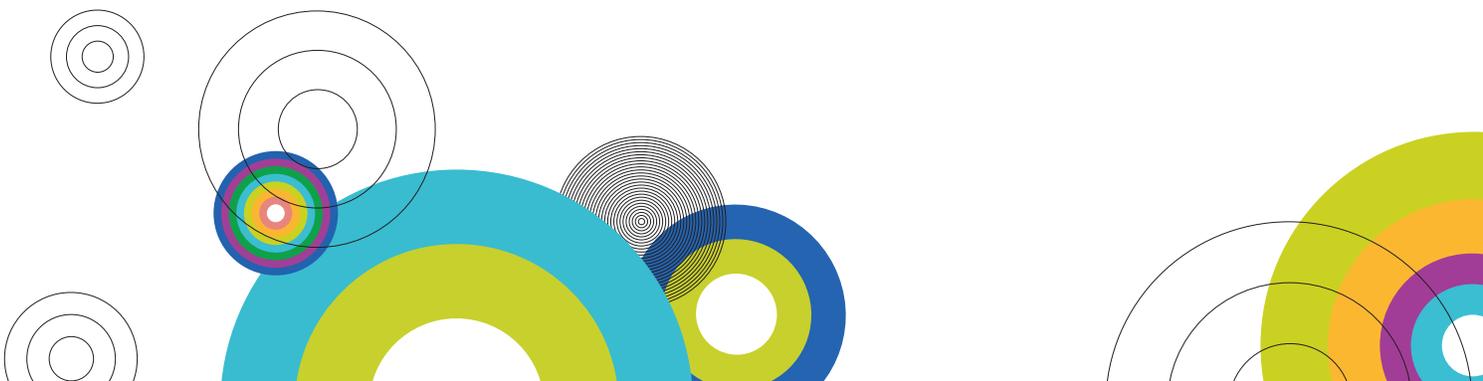


Quality has become the watchword for health care systems throughout the developed world, and for good reason — a high-quality system is safer for patients, more efficient (and therefore more sustainable), and generally more satisfying for the people who work in it. Seven Canadian provinces have established health quality or patient safety agencies; other jurisdictions keep these functions within their health ministries. Numerous other national and provincial agencies are dedicated to promoting safety and quality in specific areas of the health system.

And yet, Canada is not doing a good job on quality. International comparisons that reflect the quality of care that health systems deliver, such as the *2012 Commonwealth Fund International Health Policy Survey of Primary Care Physicians*, show Canada lagging behind many other nations. For example, only 48% of Canadian primary care doctors in 2006, and 47% in 2012, reported that most of their patients could get a same-day appointment when it was requested; France ranks highest on this dimension of quality (at 95%). We are in our infancy on quality, as one speaker put it. This disconnect, between effort and the results of where we are today, was evident throughout the two-day symposium.

Senior leaders presented on, and heard about, the work and the successes of each health quality and patient safety agency. They also examined some of the gaps in measuring, reporting, and overall quality improvement that persist despite nearly 10 years of effort. And they had the opportunity, in a final workshop, to share ideas about how to fix that.

The Health Council of Canada published two reports on quality leading up to the symposium: *Measuring and Reporting on Health System Performance in Canada* (May 2012) and *Which Way to Quality?* (March 2013). Co-chair Dr. Dennis Kendel, in his opening remarks, pointed to a diagram of sets of concentric circles seen in *Which Way to Quality?*. They illustrate the work done by the seven health quality and patient safety agencies and the nine selected pan-Canadian organizations, including the Health Council of Canada. Every one of the circles has a blue “collaboration” ring, indicating that all of the provincial agencies, and most of the national organizations, are committed to identifying best practices and sharing health innovations. But despite that, Dr. Kendel noted, no established forum exists that is mandated by governments to share and implement what they have learned. That is not consistent with good quality improvement processes such as measuring, reporting, identifying best practices, and building capacity for improvement.



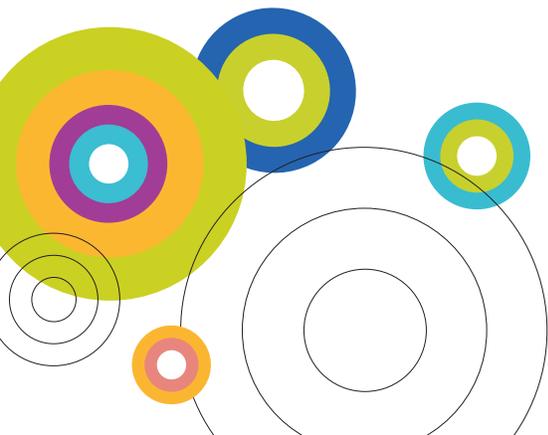


“EACH JURISDICTION HAS ITS OWN SET OF CHALLENGES. WE COULD ALL BENEFIT FROM LEARNING WHAT EACH OTHER DOES.”

Of course, because the quality councils are provincial, they are mandated to serve their own people; however, learning cannot stop at provincial borders. “Each jurisdiction has its own set of challenges. We could all benefit from learning what each other does,” Dr. Kendel said. If the parts of Canada’s work on quality improvement are to ever add up to a greater whole, we will have to share and maximize the work of everyone involved.

Certainly, over the two days, it was striking how many experiences the participants have had in common. Presentations on how each of the quality councils works and on the quality improvement situation in Australia, as well as the discussions that followed, built a larger picture of common gaps and challenges. Fortunately for the benefit of all attending, participants had the chance to talk about what can be done, on both the micro and macro levels, to give quality improvement the boost it needs across Canada.

This report will first summarize some of the challenges, and then look at the opportunities.

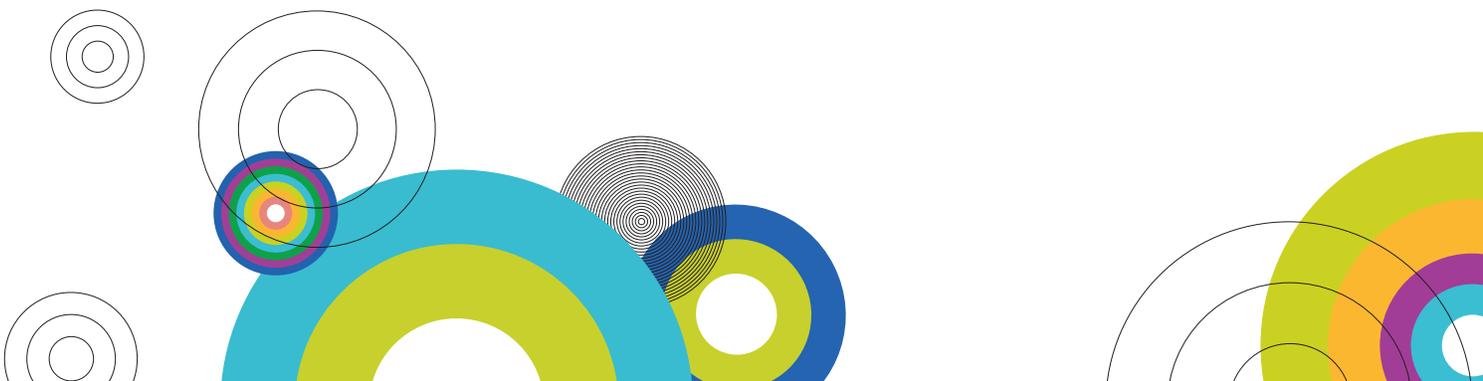


WHERE WE ARE

One of the significant issues raised during the symposium has been the general failure to convey how urgently quality improvement is needed. While some issues — such as waiting lists — have driven national debate and change, quality, so far, has not. As John G. Abbott, CEO of the Health Council of Canada, observed in a blog post after the symposium, evidence shows that quality is a critical issue in health care, but that does not seem to be enough to capture the attention of Canadians, including physicians.

In a panel discussion, participants also expressed widespread concern over the capacity of different systems, organizations, and clinicians to improve the quality of care. We have been very focused in Canada on setting up measurement and reporting systems; but if people are not trained on how to turn the information into improved care, that work is of little value. Dr. Ross Baker, keynote speaker on the second day and the moderator of that day's panel, is a proponent of thorough training in quality improvement. "Unless we take these methods and spread knowledge, we have no hope of achieving system reform. You can't hope to improve system performance by telling people to try harder," he said. Some provinces are working hard on the education piece, Dr. Baker pointed out. For example,

Saskatchewan is committed to ensuring that every one of the 40,000 people who works in health care in that province has at least one day of Kaizen training. British Columbia set up its Quality Academy in 2010; the seventh cohort of 200 people is going through it now — with the understanding that part of their jobs in the future will be advising and mentoring others on quality. "We're trying to work ourselves out of a job by building capacity and then stepping away," said Andrew Wray, Director of Learning and Strategic Initiatives at the British Columbia Patient Safety & Quality Council.

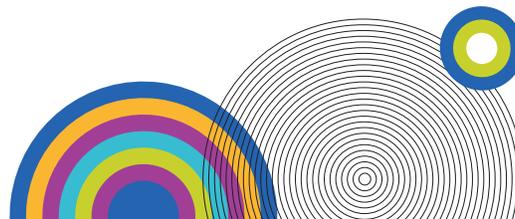




Dr. Baker also touched on another resonant issue — the importance of leadership. In a recent study of high-performing health systems, he found that they shared a number of critical characteristics; leadership, aligned with goals, is one. Among the others are an organizational design that puts patients at the centre and emphasizes teamwork, and a commitment to improving capabilities in knowledge, learning strategies, and skills.

There is probably no greater perceived impediment to quality improvement in Canada than the data we depend on to guide that work. Electronic records in this country are nowhere near where they need to be to provide data quickly enough to persuade front-line caregivers that the hard work of collecting it pays off in improved care. The old line — waiting for data from the Canadian Institute for Health Information (CIHI) to make improvements is like using a rearview mirror to plan where you're going — was quoted. CIHI's CEO John Wright said data could be produced more quickly if people were prepared to trade off timeliness for quality. Dr. Michelle Rey, of Health Quality Ontario, said they cannot wait for perfect data. "If something's good enough, that's where we start."

Interestingly, however, even more attention was paid to the failure to produce data that's locally relevant. Dr. Diane Watson, a Canadian who is the inaugural CEO of Australia's National Health Performance Authority, raised this issue. She said that there are 60 Medicare Local regions in Australia, established to ensure primary health care services are responsive, coordinated, and integrated and there are vast differences among them. Aggregated, national, and state data camouflages the strengths and challenges that face local areas and does not tell health professionals in local communities what they need to know to efficiently target interventions to improve health and care to deal with its reality. "If you have to drive local change, you must customize your information to local circumstances," she told the participants. Later, in a panel on user perspectives on measuring and reporting, Vickie Kaminski, CEO of Eastern Health in Newfoundland and Labrador, said she's concerned that some performance indicators provide data that's politically motivated and expedient (e.g., wait times), rather than giving patients information about how the organization will meet their challenge of "Don't hurt me; Help me; Be nice to me while you're doing it."



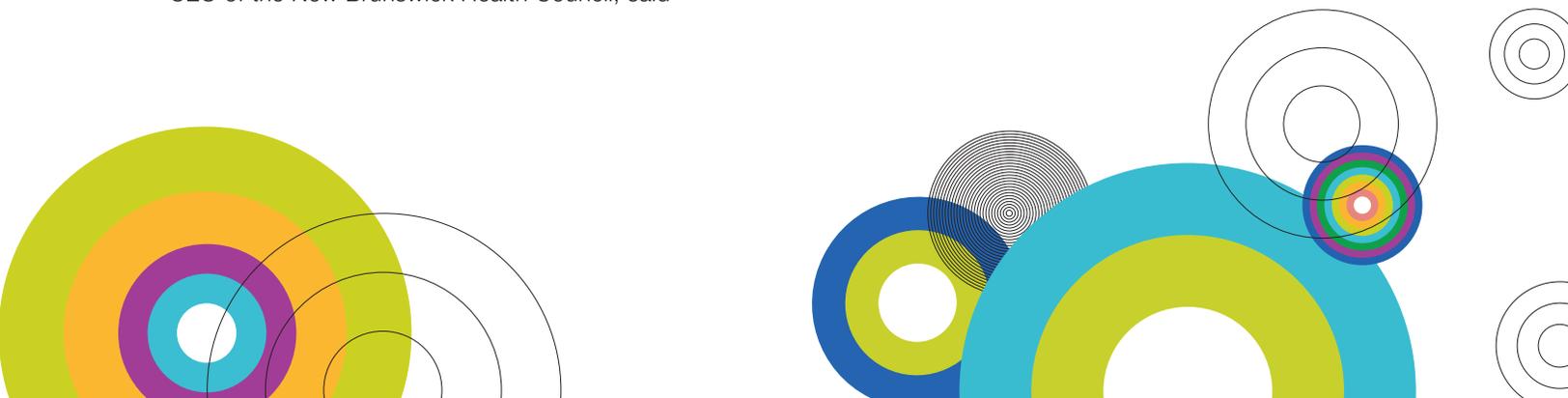
WHERE WE SHOULD BE HEADING

It was Dr. Watson who offered the first call towards making quality improvement more than the sum of its parts. She said public reporting and quality improvement organizations are effective when they have statutory powers, “because then you can be more bold in describing the state of quality and the impact, or not, of improvement efforts.” Later, she urged CEOs to take full advantage of their arms’ length status: “Chief executives! You’re not being bold and brave enough. Exercise your statutory power to tell the public and providers about the quality of care in your local community and the impact of local efforts to improve.”

Others suggested that governments should be kept away from setting quality agendas. “We have to remove health care from politics,” said Dr. Markus Lahtinen of the Health Quality Council of Alberta. “Health care shouldn’t be on the political platform every two years; it needs stability... it need not have a new priority every few months that throws the system into chaos.”

Participants recognized the need to include patients’ perspectives, insights, and self-defined needs in order to achieve meaningful quality improvement. That may tacitly be the case, said Yukon Minister of Health and Social Services Doug Graham. “The primary driver behind change is the public,” he said. Stéphane Robichaud, CEO of the New Brunswick Health Council, said

New Brunswick involves citizens to put their work in context, and there’s a move to formalize the role of the public. Dr. Olivier Sossa of the Commissaire à la santé et au bien-être told the symposium that Quebec’s Health and Welfare Commissioner is guided by three groups: a decision-maker panel, an experts seminar, and a consultation forum made up of members of the public that brings the public perspective; together they form an innovative, deliberative body that fosters real dialogue between citizens and experts.





Informing the public is a central part of most quality councils' work, but being informed by the public is a more recent evolution, and one which Heather Thiessen, a patient representative from Saskatchewan, welcomes. "You need to try to think about what the patient wants, not what everyone else thinks the patient wants," she told the symposium.

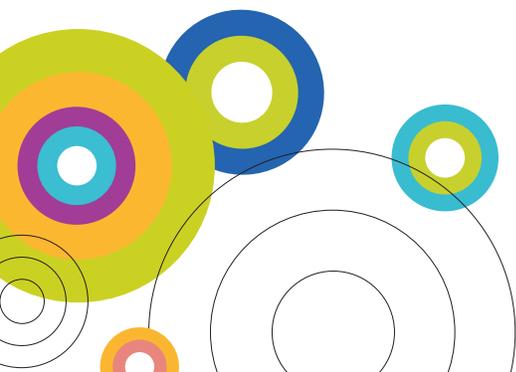
Participants talked extensively about how to better engage physicians, particularly family physicians who are often left out of quality improvement programs. They expressed the need to make better use of technology, including improving electronic health records for better, faster data. They also highlighted the need for a common language around quality improvement.

One of the actions urged, however, was greater collaboration among quality councils, to spread success and avoid wasting time by duplicating work or reinventing wheels. Some attendees noted that this collaboration at the provincial-territorial level has already begun. In September, Ministers received a report on quality council collaboration, which included a common definition of "quality" and common dimensions. As a next step, quality councils, CIHI and ministries of health will look at the issue of indicator chaos. Dr. Joshua Tepper, CEO of Health Quality Ontario said "There's huge opportunity for pan-Canadian efforts. We need to partner."

But there were some sharp divisions in participants' visions of what ongoing collaboration should look like. Some urged fairly organized collaboration — a council of quality councils, perhaps, or at least regularly scheduled meetings. "I don't accept we can do without a national organization," said Dr. Tom Noseworthy, Professor of Health Policy and Management at the University of Calgary and VP & Leader, Health Operations, Northern Alberta, Alberta Health Services. "We shouldn't wait for government and its legislation to make it happen." Bonnie Brossart, CEO of Saskatchewan's Health Quality Council, said it could be enough to be conscientious about meeting and exchanging knowledge.

But others were quite firm in their opposition to any kind of formal organization. Pan-Canadian approaches, it was pointed out, might not align with the goals of individual provinces. Alberta's Minister of Health, Fred Horne, said that, while certain issues need broad responses, others do not. "If we are going to have pan-Canadian discussions, let's make sure they are about things that lend themselves to pan-Canadian solutions."

More ideas came out at a workshop held immediately after the symposium, at which participants drew lessons from what they had heard (see page 8). But overall, the feeling seemed to be that, while the parts that constitute quality improvement had been well-defined at the symposium, the key to adding them up into the whole that Canadians need and deserve has not yet been found.



OVERVIEW OF POST-SYMPOSIUM WORKSHOP COMMENTS

Close to 70 delegates took part in the two-hour workshop that followed the symposium. The facilitated discussion centred around three key questions:

01

Based on the preceding symposium deliberations, what did participants see as

A / The greatest *challenges* facing quality improvement in their province or territory; and

B / The greatest *opportunities* to support quality improvement?

CHALLENGES

Five main themes comprised the discussion of *challenges* to realizing the quality improvement agenda:

- making a persuasive case for quality improvement;
- getting people who govern health care organizations to really drive quality improvement;
- fully engaging key internal stakeholders, particularly physicians;
- getting a cross-provider, cross-sector perspective on providing quality care; and

- lack of real-time information due to poor integration of measurement into clinical practice and lack of meaningful local level data and reporting.

OPPORTUNITIES

The workshop participants also discussed *opportunities* to advance quality improvement:

- meaningfully engage patients in quality initiatives;
- create a common language on quality improvement and a more coherent, made-in-Canada approach to quality; and
- facilitate fuller physician participation in quality improvement.

02

If their minister of health asked them to identify three *priorities* needed to advance quality improvement, what would they be?

PRIORITIES

Priorities that our ministers of health should identify to advance quality improvement include:

- engage the full range of players in government (not just departments of health);

- invest in training to build the capacity and competency for quality improvement;
- get a universal, electronic health record up and running; and
- communicate the case for quality improvement.

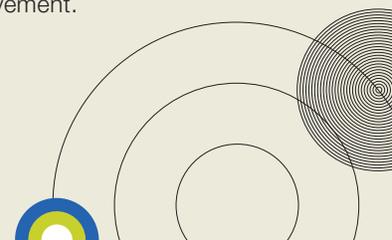
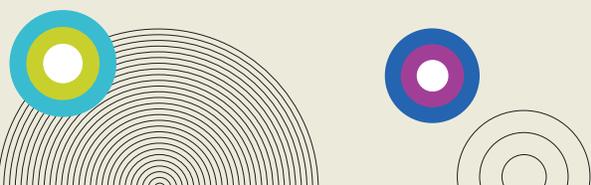
03

What are the potential areas for *collaboration* within their province or territory and/or across jurisdictions to allow them to advance their quality improvement agenda? Are current approaches for collaboration sufficient or do we need more?

COLLABORATION

Opportunities for further collaboration could include:

- a wider 'collaboration' of those focused on knowledge sharing and working together on agreed-upon projects of mutual interest;
- a "council of quality councils"; and
- future forums for exchange of knowledge and learning about quality improvement.



THE BOTTOM LINE

At present, we have an array of quality improvement initiatives taking place at provincial/territorial and institutional levels. And we have noticeable gaps. There is also wide variation in approaches although this, in itself, is not a bad thing because each approach is designed to meet the needs of a specific population.

However, we have seen the good results that can come from pan-Canadian approaches in areas such as patient safety and accreditation in this country. We could achieve greater system transformation and improve quality of care if we were to adopt a common quality improvement framework through which we could learn from each other.

If we wait for a burning platform to make further advancements in quality improvement, incrementalism will prevail. Canada can learn from the literature, as well as from the experiences of other countries in aggressively addressing quality of care, that it can do better, and needs to do so, if it is to enjoy the benefits of a high-performing health care system.

Finally, the Health Council of Canada has brought the issue of quality improvement to the national agenda through its reports and this symposium. With the pending closure of the Health Council, many wonder who will pick up the torch. Thus, the Health Council urges governments, health care providers, and citizens to stay focused on a quality improvement agenda for the benefit of all Canadians, best described as *creating a whole that is, in fact, greater than the sum of its parts*.



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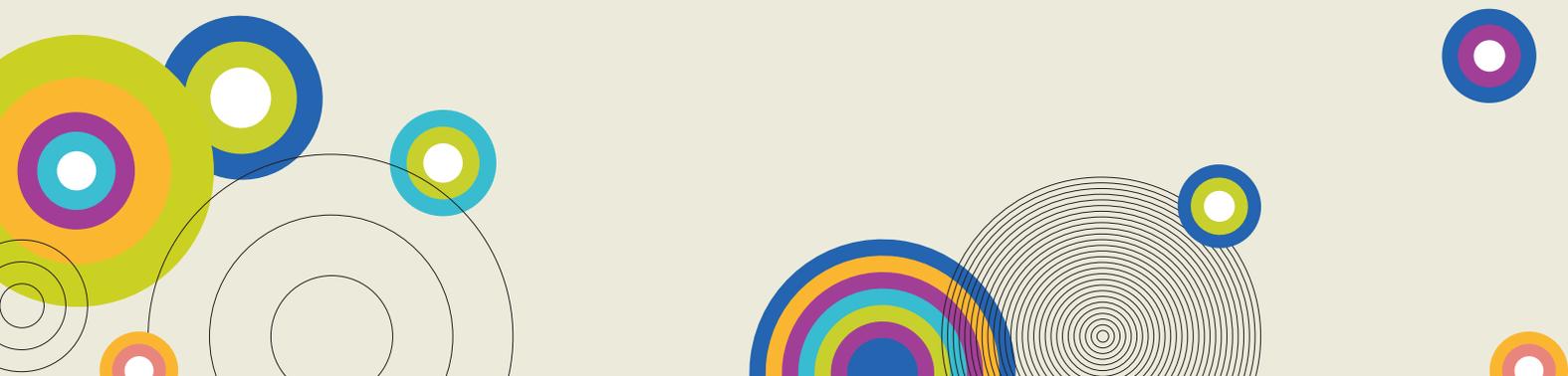
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About the Health Council of Canada

Created by the 2003 First Ministers' Accord on Health Care Renewal, the Health Council of Canada is an independent national agency that reports on the progress of health care renewal. The Council provides a system-wide perspective on health care reform in Canada, and disseminates information on innovative practices across the country. The Councillors are appointed by the participating provincial and territorial governments and the Government of Canada.

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The Health Council of Canada would like to acknowledge funding support from Health Canada.

The views expressed here do not necessarily represent the views of Health Canada.

Recommended citation format:

Health Council of Canada. (2013). *Canada's quality improvement conundrum: Should Canada achieve a whole that is greater than the sum of its parts?* Toronto, ON: Health Council of Canada. healthcouncilcanada.ca.

ISBN 978-1-926961-93-4 PDF

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