A GUIDE TO DEVELOPING AND ASSESSING A QUALITY PLAN

For Healthcare Organizations

An Initiative of
The Collaborative for Excellence in Healthcare Quality

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PREFACE

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

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

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

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

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

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

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

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

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

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EXECUTIVE SUMMARY

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

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

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

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

KEY PRINCIPLES

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

ACCOUNTABILITIES

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

CONSULTATION

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

MULTI-YEAR PLANNING

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

BUILDING/DEVELOPING THE QUALITY PLAN

Alignment

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

Key Components of a Quality Plan

There are nine suggested key components to an effective Quality Plan

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

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

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

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

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

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

7. Activities
   Activities outline the 'how' of the Plan. This section of the Plan describes the specific actions that need to be taken. Key activities will indicate how various parts and levels of the organization will be involved in achieving the performance targets. Activities are examined in Section 6.2.7.

8. Timeframe and Resources
   The steps involved in developing the Quality Plan are not sequential. Factors such as timeframes and resources must be considered as performance targets are established. The process may also be iterative as draft objectives and targets are examined in the light of available resources. This topic is covered in Section 6.2.8.

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

COMMUNICATION

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

REPORTING

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

ASSESSING THE EFFECTIVENESS OF THE QUALITY PLAN

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

EXAMPLES OF QUALITY PLANS AND REPORTING TEMPLATES

Section 10 provides examples of Quality Plans from different types of organizations along with examples of reporting templates.

CONCLUSION

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

TABLE OF CONTENTS

1.0 INTRODUCTION

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

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

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

(The Ottawa Hospital Quality Plan Framework 2011-2114)

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

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

Board of Directors

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

Senior Executive Team

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

Clinical Leadership

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

Quality Officials

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

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

HOW TO USE THE GUIDE

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

The Guide is divided into two main areas:

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

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

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

2.0 PRINCIPLES

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

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

KEY CONCEPTS

A Quality Plan is:

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

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

3.0 ACCOUNTABILITIES

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

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

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

Board of Directors

The Board will normally delegate much of the responsibility for the Plan to the CEO, however, an engaged Board will play an active role by:

- Ensuring quality and safety are at the core of the organization's vision;
- Ensuring that quality and safety values are embedded in guiding the organization's strategic plan;
- Ensuring that the Quality Plan is aligned with the strategic plan;
- Setting key overarching quality priorities to guide the Quality Plan;
- Approving the Quality Plan;
- Allocating appropriate resources for the implementation of the Plan;
- Providing ongoing monitoring of progress and performance against the Plan; and
- Championing the quality agenda, both internally and externally.

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

Senior Executive Team

The CEO and the Senior Executive Team are responsible for:

- Establishing the quality framework for the organization;
- Establishing the process for the development of the Plan;
- Setting the scope, priorities, guidelines and parameters for the Plan, including ensuring the Plan is aligned with strategic priorities;
- Ensuring the Plan is cohesive and feasible to implement with available resources;
- Ensuring provincial mandates are adhered to;
- Motivating and supporting staff to achieve Plan targets;
- Determining how to measure progress; and
- Monitoring the effectiveness of the Plan and the achievement of results.

Clinical Leadership

The clinical leadership team is responsible for:

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

Quality Officials

The quality officials are responsible for:

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

4.0 CONSULTATION

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

Specifically, best practice suggests that:

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

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

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

QUICK FACTS

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

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

(Hunter et al., 2011)

5.0 MULTI-YEAR PLANNING

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

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

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

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

6.0 BUILDING/DEVELOPING THE QUALITY PLAN

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

6.1 Alignment

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

KEY CONCEPTS

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

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

6.2 Key Components

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

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

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

6.2.1 Quality Framework/Dimensions

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

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

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

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

Table 1: Comparison of various quality frameworks

Dimensions	Accreditation Canada	IOM	BC Patient Safety & Quality Council	Health Quality Council of Alberta	Health Quality Ontario	New Brunswick Health Council
Population focus	X				X	
Accessibility	X		X	X	X	X
Safety	X	X	X	X	X	X
Work life	X					
Patient/Family-centered	X	X			X	
Continuity of services	X					
Effectiveness	X	X	X	X	X	X
Efficiency	X	X		X	X	X
Equitable		X			X	X
Timely		X				
Acceptability			X	X		
Appropriateness			X	X		X
Appropriately Resourced					X	
Integrated					X	

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

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

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

6.2.2 Strategic Corporate Goals

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

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

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

6.2.3 Background and Context

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

Examples of contextual factors include:

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

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

- Progress or challenges meeting quality objectives in the previous years;

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

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

6.2.4 Objectives

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

QUICK FACTS

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

- **S**pecific
- **M**easurable/**M**eaningful
- **A**ttainable
- **R**elevant/**R**esults oriented
- **T**ime-bound

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

Figure 1.0 – Example of Objectives

Quality Dimensions	Objectives	P M O in
ACCESS	Reduce wait times in the ED by 15% for admitted patients by March 31, 2012.	
EFFECTIVENESS	Reduce unnecessary hospital readmission from 10.80% to 10.70% for General Medicine patients by March 31, 2012.	
SAFETY	Reduce *Clostridium difficile* associated diseases (CDI) from 0.62 to less than 0.42 per 1,000 patient days by March 31, 2012.	

In setting the goals and objectives for the current year, several factors should be taken into consideration:

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

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

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

6.2.5 Performance Measures

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

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

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

Indicators must be carefully chosen to be:

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

QUICK FACTS

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

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

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

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

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

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

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

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

An example of a balancing measure includes:
- Verify that there is no increase in readmission rates when trying to reduce length of stay

Different stakeholders have different focal points for monitoring quality and accordingly, indicators need to be measured at different levels. A common framework is to classify indicators as Big Dots or Little Dots (Martin et al., 2007):

Big Dots are the key focal point for the Board and the Senior Executive Team. They are:

- whole-system measures used to evaluate overall organizational performance and the effectiveness of strategies;
- institution-wide;
- outcome driven;
- a reflection of the organization's strategic priorities and quality definition;
- multi-faceted connections to the "Little Dots" or processes.

Little Dots are the focal point of the Quality Committee, Senior Executive Team responsible for quality and staff and are:

- the operationalization of Big Dots
- specific and targeted to measure activity progress, including:
    - Measures of outcomes;
    - Process measures;
    - Structure indicators (measuring people, space or money).

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

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

Figure 2.0 – Example of Performance Measures

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

6.2.6 Targets

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

QUICK FACTS

As general guidelines, optimum targets:

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

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

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

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

Figure 3.0 – Example of Performance Targets

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

QUICK FACTS

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

6.2.7 Activities

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

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

QUICK FACTS

In determining the activities, some guidelines to consider are:

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

Many actions that will be identified may be projects that will require much more detailed project plans. It is not necessary to include this level of detail in the Quality Plan.

The following are examples of activities, related process measures and targets related to the specific objectives (Figure 4.0):

Figure 4.0 – Example of Activities, Process Measures and Targets

Quality Dimensions	Objectives	Performance Measure Outcome indicator	Current Performance	Performance Target	Activities	Process Measure	Target
ACCESS	Reduce wait times in the ED by 15% for admitted patients by March 31, 2012.	**ED wait times**: 90th percentile ED length of stay for admitted patients *(National Ambulatory Care Reporting System – NACRS, Canadian Institute for Health Information - CIHI)*	32.5 hours	<15%	1. Develop and implement the ED process	Physician consult to decision time Number of patients discharged from inpatient unit by 1200 hours	>90% within 3 hours 15% improvement
EFFECTIVENESS	Reduce unnecessary hospital readmission from 10.80% to 10.70% for General Medicine patients by March 31, 2012.	**Readmission rate:** Readmission within 30 days for all patients readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions *(CIHI)*	10.80%	10.70%	1.Reduce readmissions for General Medicine patients 1.1. Complete medication reconciliation at discharge 1.2. Provide medication education for patient and family at discharge 1.3. Follow-up telephone call to patient/family within 72 hours of discharge	Completed for all patients # of patients receiving education at discharge # of patients receiving a follow-up call after discharge	>90% at discharge >90% >90%
SAFETY	Reduce *Clostridium difficile* associated diseases (CDI) from 0.62 to less than 0.42 per 1,000 patient days by March 31, 2012.	**CDI rate per 1,000 patient days:** Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 *(Canadian Nosocomial Infection Surveillance Program - NISP)*	0.62 per 1,000 patient days	<0.42 per 1,000 patient days	1.Improve environmental cleaning in particular high touch areas 2. Antibiotic stewardship	Audits Implement recommendations from Infection Control	80% implemented 80% of the recommendations are implemented

6.2.8 Timeframe and Resources

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

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

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

QUICK FACTS

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

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

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

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

Continuing the examples presented earlier, the relevant timeframe and resources are identified in Figure 5.0:

Figure 5.0 – Example of Timeframe and Resources

Quality Dimensions	Objectives	Performance Measure Outcome indicator	Current Performance	Performance Target	Activities	Process Measure	Target	Timeframe & Resources
ACCESS	Reduce wait times in the ED by 15% for admitted patients by March 31, 2012.	**ED wait times**: 90th percentile ED length of stay for admitted patients *(National Ambulatory Care Reporting System – NACRS, Canadian Institute for Health Information - CIHI)*	32.5 hours	<15%	1. Develop and implement the ED process	Physician consult to decision time Number of patients discharged from inpatient unit by 1200 hours	>90% within 3 hours 15% improvement	March 31, 2012 • ED Physicians • Quality coordinator
EFFECTIVENESS	Reduce unnecessary hospital readmission from 10.80% to 10.70% for General Medicine patients by March 31, 2012.	**Readmission rate:** Readmission within 30 days for all patients readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions *(CIHI)*	10.80%	10.70%	1.Reduce readmissions for General Medicine patients 1.1. Complete medication reconciliation at discharge 1.2. Provide medication education for patient and family at discharge 1.3. Follow-up telephone call to patient/family within 72 hours of discharge	Completed for all patients # of patients receiving education at discharge # of patients receiving a follow-up call after discharge	>90% at discharge >90% >90%	March 31, 2012 • Med Rec steering committee • RN/RPN on inpatient units
SAFETY	Reduce *Clostridium difficile* associated diseases (CDI) from 0.62 to less than 0.42 per 1,000 patient days by March 31, 2012.	**CDI rate per 1,000 patient days:** Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 *(Canadian Nosocomial Infection Surveillance Program - NISP)*	0.62 per 1,000 patient days	<0.42 per 1,000 patient days	1.Improve environmental cleaning in particular high touch areas 2. Antibiotic stewardship	Audits Implement recommendations from Infection Control	80% implemented 80% of the recommendations are implemented	March 31, 2012 • Infection Control • Housekeeping

Further examples of Quality Plans are available in Section 10.

6.2.9 Assigning Responsibilities

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

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

Accountability is defined as the person 'most responsible' for achievement of a target or completion of an action or task. It is preferable that the accountability be assigned to a specific person but there may be instances where it is assigned to a group.

When considering assignment of accountability within the Quality Plan some factors should be taken into consideration. In order to be held accountable, an individual must have:

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

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

7.0 COMMUNICATIONS

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

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

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

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

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

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

There are many approaches to how the communication strategy for the Quality Plan can be developed and implemented. If the organization has a Public Relations or Communications department, they would normally play a key role in devising the strategy and materials for the roll-out. Some organizations may have a broader communication plan that encompasses all aspects of communication for the year. In this instance, the communication around the Quality Plan may be addressed as a sub-component of the broader plan. Others may charge the team that develops the Quality Plan with the task of also devising the communication strategy to go with it. Irrespective of which of these approaches is taken, common tactics of a Quality Plan communication strategy may include the use of:

- CEO presentations or speeches;
- Town Hall or small group meetings;
- Posters, bulletin boards and websites;
- Internal and external newsletters; and
- Training and education forums or seminars.

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

8.0 REPORTING

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

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

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

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

The Working Group identified some key characteristics of effective reporting mechanisms.

KEY CONCEPTS

An effective reporting mechanism should:

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

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

Table 2: Reporting Format by Stakeholder

Stakeholders	Reporting Format
Board	• Dashboards/Scorecards - focus on 'Big Dot' indicators or system level measures
Quality Committees	• Dashboards/Scorecards • Performance Report s– detailed report based on organization's Quality Plan
Senior Executive Team	• Dashboards/Scorecards • PowerPoint Presentations • Stop Light Reports
Physicians	• Dashboards/Scorecards • Stop Light Reports
Middle Management	• Dashboards/Scorecards • Written reports
Clinicians	• Quick Fact Sheets • PowerPoint Presentations
Patients and Families	• Summary

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

Examples of the some of the identified reporting mechanisms are included in Section 10.

9.0 ASSESSING THE EFFECTIVENESS OF THE QUALITY PLAN

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

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

Two Level Review Process

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

Top Level Assessment

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

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

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

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

Second Level Assessment

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

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

2. Are we measuring the right things? Are there other measures that may be more appropriate?

3. Are we using the right performance indicators? What other measures could we use?

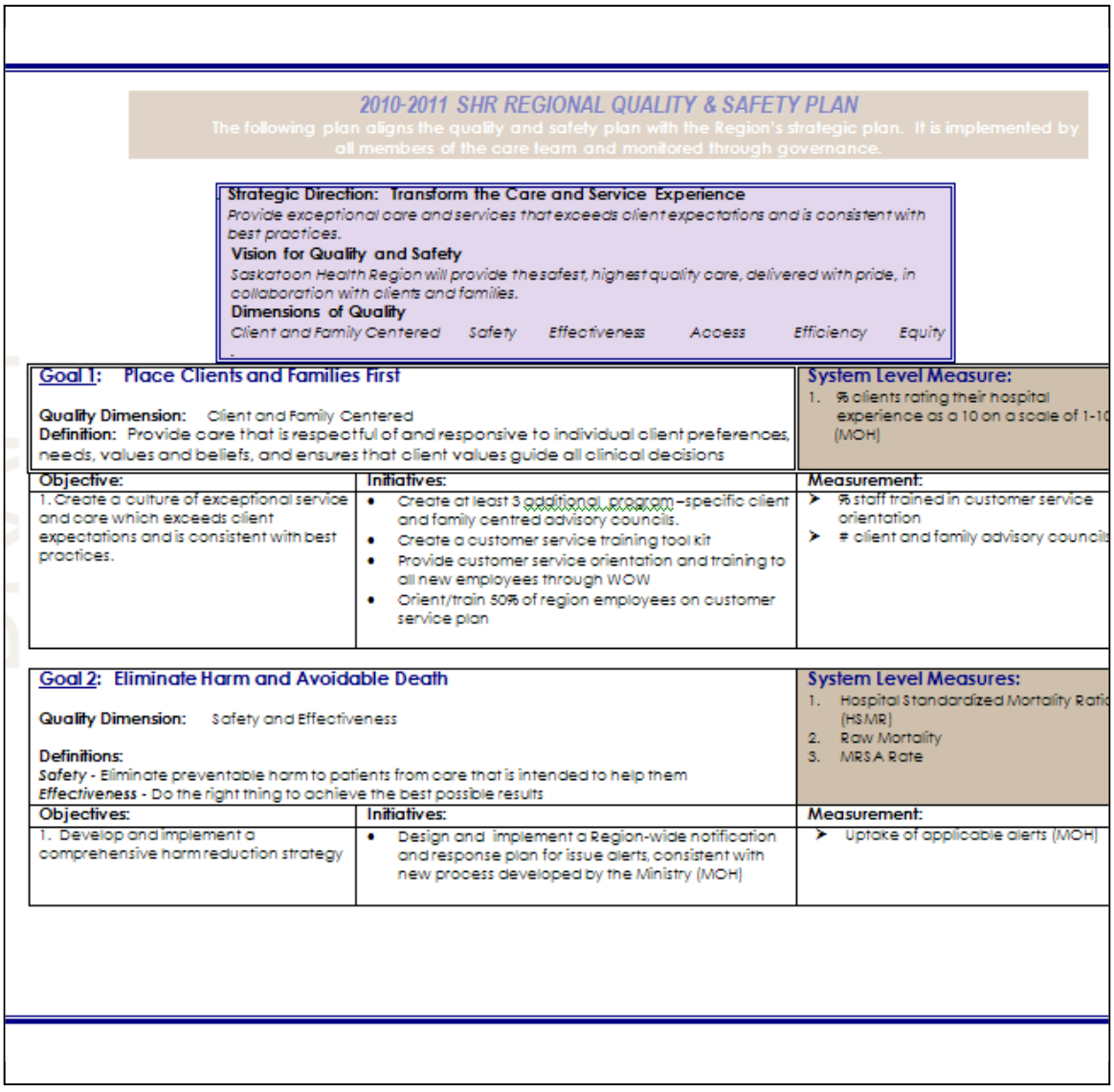
4. Are we motivating the right behaviours? Are we impacting the culture in the desired way?

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

10.0 HIGHLIGHTS OF QUALITY PLANS

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

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



2010-2011 SHR REGIONAL QUALITY & SAFETY PLAN

The following plan aligns the quality and safety plan with the Region's strategic plan. It is implemented by all members of the care team and monitored through governance.

Strategic Direction: Transform the Care and Service Experience

Provide exceptional care and services that exceeds client expectations and is consistent with best practices.

Vision for Quality and Safety

Saskatoon Health Region will provide the safest, highest quality care, delivered with pride, in collaboration with clients and families.

Dimensions of Quality

Client and Family Centered *Safety* *Effectiveness* *Access* *Efficiency* *Equity*

Goal 1: Place Clients and Families First

Quality Dimension: Client and Family Centered

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

System Level Measure:

1. % clients rating their hospital experience as a 10 on a scale of 1-10 (MOH)

Objective:	Initiatives:	Measurement:
1. Create a culture of exceptional service and care which exceeds client expectations and is consistent with best practices.	• Create at least 3 additional program-specific client and family centred advisory councils. • Create a customer service training tool kit • Provide customer service orientation and training to all new employees through WOW • Orient/train 50% of region employees on customer service plan	➢ % staff trained in customer service orientation ➢ # client and family advisory councils

Goal 2: Eliminate Harm and Avoidable Death

Quality Dimension: Safety and Effectiveness

Definitions:

Safety - Eliminate preventable harm to patients from care that is intended to help them

Effectiveness - Do the right thing to achieve the best possible results

System Level Measures:

1. Hospital Standardized Mortality Ratio (HSMR)
2. Raw Mortality
3. MRSA Rate

Objectives:	Initiatives:	Measurement:
1. Develop and implement a comprehensive harm reduction strategy	• Design and implement a Region-wide notification and response plan for issue alerts, consistent with new process developed by the Ministry (MOH)	➢ Uptake of applicable alerts (MOH)

Another example is the Quality Plan used by St Michael's Hospital which identifies objectives, outcome measures, current performance, activities and targets based on their quality framework. Below you can see three objectives under the quality dimension of safety.

PART B: Improvement Targets and Initiatives

St. Michael's
Inspired Care.
Inspiring Science.

St. Michael's Hospital
30 Bond Street
Toronto, Onatio, M5B 1W8

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Safety	Reduce clostridium difficile associated diseases (CDI)	**CDI rate per 1,000 patient days:** Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	0.42	0.42	Priority 3	1) Improved Environmental cleaning by using glitter bug technique (to increase compliance with cleaning of high touch areas)	Audit and feedback	80% implementation of measurement and feedback	Based on research literature and best practice	The introduction of PCR in the hospital can be expected to increase the detection rate of C difficile in the upcoming year
						2)Antibiotic stewardship	Acceptance of recommendations made by the Stewardship Team will be tracked in a database.	80% acceptance of the recommendations made	The degree of uptake on the recommendations made regarding antimicrobial use is a clinical marker of the perceived relevance and utility of the program.	The degree of implementation of Antibiotic Stewardship is contingent on the fiscal situation in the upcoming year.
	Reduce incidence of Ventilator Associated Pneumonia (VAP)	**VAP rate per 1,000 ventilator days:** the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	0.44	0.44	Priority 3	1) Improve upon the existing compliance with VAP Safety Bundle.	Monthly audits and PDSA around the bundle elements	95%	Safer Healthcare Now benchmark	
						2) Start measuring compliance with oral care	Monthly audits and PDSA around the bundle elements	95%	evidence supporting use of oral care for VAP prevention	
	Improve provider hand hygiene compliance	**Hand hygiene compliance BEFORE patient contact:** The number of times that hand hygiene was performed BEFORE initial patient/patient environment contact divided by the number of observed hand hygiene indications for BEFORE initial patient/patient environment contact multiplied by 100 - (consistent with publicly reportable patient safety data-2009/2010)	26.0%	36.0%*	Priority 1	1) Encourage units with successful QI initiatives in hand hygiene to expand and roll out their initiatives to other units within their programs (e.g. roll out of Semmelweis clean hands campaign across heart and vascular)	Number of units with unit based hand hygiene QI initiatives	Increase from 2 units to 5 units with successful QI initiatives resulting in a sustainable and statistically significant improvement in hand hygiene compoliance..	Local initiatives often achieve better buy in from front line healthcare workers and may be more effective in improving compliance; currently we have two units with well defined improvement initiatives (6 bond, 7CVN) but planned rollouts across heart and vascular should lead to inclusion of at least 2 additonal units (CCU, 7CS)	* The performance goal for 2011/2012 was set considering the adoption of a new and improved hand hygiene compliance audit tool (HandyAudit). The introduction of this tool in a number of different hospitals has resulted in an observed drop in the audit results.
		Hand hygiene compliance AFTER patient contact: The number of times that hand hygiene was performed AFTER patient/patient environment contact divided by the number of observed hand hygiene indications for AFTER patient/patient environment contact multiplied by 100 - (Consistent with publicly reportable patient safety data 2009/2010)	37.0%	47.0%*	Priority 1	2) 70% of current front-line staff educated on hand hygiene best practices via e-learning.	Learning Management System (LMS) quarterly reports	70% of current staff will complete hand hygiene education.	Training and education is 1 of 5 core elements from the evidence based 'Just Clean Your Hands Program' (MoHLTC) and 'Stop! Clean Your Hands (CPSI/SHN).	* The performance goal for 2011/2012 was set considering the adoption of a new and improved hand hygiene compliance audit tool (HandyAudit).

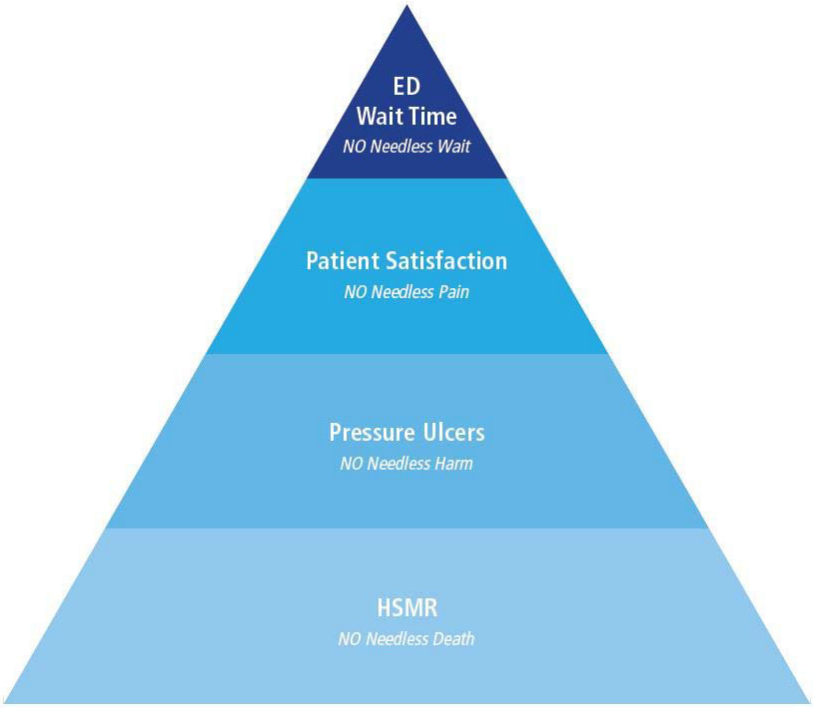
The following example is The Ottawa Hospital's 3-year Quality Plan which identifies goals, objectives, indicators, activities, dates, targets and accountabilities based on their chosen quality framework. Below you can see the start and end dates for the various activities.

3-Year Quality Plan
2008-2011

Quadrant	Goal	Objective Bold = Corporate Focus	Board Indicators	Activities	Performance Indicators	Target	Start Date (for activities)	Finish Date	Goal Accountability
	ACCESS - Patients should be able to get the right care at the right time in the right setting by the right healthcare provider (Ontario Health Quality Council - OHQC)								
	Improve access to Emergency Care, Urgent OR, Surgery and Diagnostic Imaging	**To improve access and management times for Emergency Department patients**	09/10 to be reassessed: ED Offload 90th percentile Offload Times for CTAS 1; Target – Improvement over combined Q3/4 FY07-08 performance ED Offload 90th percentile Offload Times for CTAS 2 – 5; Target – CH: 2:00 GH: 1:20 ED Access Times % admitted patients with ED LOS ≤ 8 hours; Target – 10% improvement % non-admitted waiting less than 8 hours for CTAS 1&2; Target – 10% improvement	ED Process RNs dedicated to patient flow ED Waiting Room RNs Inpatient Flow Manager Enhanced portering for patient movement Aftercare RN for follow-up on reports and free up of RNs and MDs Support Staff dedicated to ECGs in ED Maximize utilization on Clinical Decision Unit at Civic (ministry funded pilot project)	Average and median monthly ambulance off-load delay. Cumulative minutes of ambulance vehicles in off-load delay by TOH. % compliance for disposition decision time done within 3 hrs of being paged ED Access Times % admitted patients with ED LOS ≤ 8 hours % of CTAS 1 and 2 non-admit patients in ER ≤ 8hrs % of CTAS 3 non-admit patients in the ER ≤ 6 hrs % of CTAS 4 and 5 non-admit patients in the ER ≤ 4 hrs	Improvement in frequency and duration of offload delays. (target TBD) 90% Improve by 10% Improve by 10% Improve by 10% Improve by 10%	Sept 2008 Oct 2008 April 2009 April 2009 April 2009 April 2009	March 2009 Ongoing March 2010 March 2010 March 2010 March 2010	Mike Tierney Dr. Adam Cwinn

Under the performance measures section of this Guide, we discussed big dots indicators. As an example, Trillium Health Centre has identified ED Wait times, patient satisfaction, pressure ulcers and HSMR as their four big dots indicators.

Trillium Health Centre's Four Big Dots



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

Saskatoon Health Region Performance Dashboard

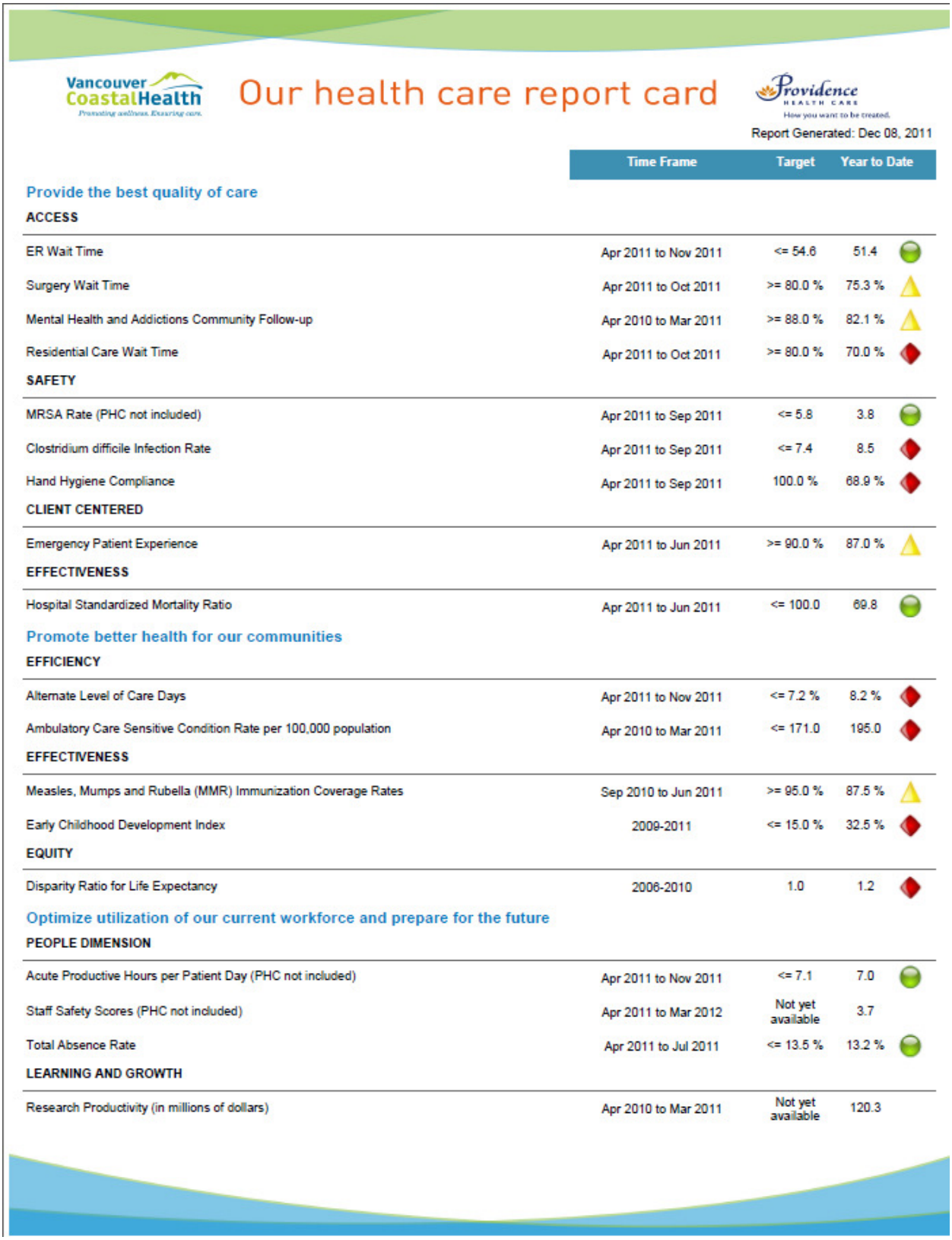
Saskatoon Health Region Performance Dashboard

Reporting Date: December 1, 2011

<75% of target Corrective action required | 75-99% of target Corrective action at discretion | 100% of target Monitor

SHR Strategic Direction	Dimension	Performance Q2 10-11 Jul-Sep	Q3 10-11 Oct-Dec	Q4 10-11 Jan-Mar	Q1 11-12 Apr-Jun	Q2 11-12 Jul-Sep	Target a=SK b=SHR	Benchmark
	QUALITY							
Transform the Care and Service Experience Partner to Improve the Health of the Community	***Access:*** *Providing timely and coordinated care and service*							
	Meeting Target Wait Time							
	Diagnostic Imaging - 70th Percentile Wait Times in Days for Urgent CT and MRI Exams (7 out of 10 patients seen within this time)	21	22	24	8 (CT)	6 (CT)	7 days[a] (CT)	7 days (CT)
		19	21	23	20 (MRI)	17 (MRI)	7 days[a] (MRI)	7 days (MRI)
	Emergency - % CTAS 2 Patients Seen Within Target (<15 min)	58.0%	55.2%	47.3%	47.5%	43.4%	70%[b]	in development
	Surgery - Number of Patients Waiting Longer than 12 Months for an Option to have Surgery	1,984	1,860	1,593	1,503	1,223	1,000 cases (step target)[b]	100% of cases offered option for surgery within 3 months as of March 31, 2014
	Surgery - Percent of Invasive Cancer Surgeries Performed within 3 Weeks	62.7%	66.0%	65.6%	69.7%	77.4%	80% (step target)[b]	95%
	Mental Health and Addiction Services % Urgent Enrollments (7 days)	67%	78%	83%	88%	81%	80%[b]	90%
	Efficiency: *Making the best use of resources by reducing waste of equipment, supplies, ideas, and energy*							
	# Patients in Acute Care Awaiting LTC Placement - Average for the quarter (% acute care beds)	70 (9.7%)	51 (7.1%)	27 (3.8%)	31 (4.3%)	59 (8.2%)	26 (3.5%)[a]	in development
	Effectiveness: *Doing the right thing to achieve the best possible results*							
	Hospital Standardized Mortality Ratio (HSMR)	86	93	90	87	pending	< 85[a] (less than reported in 2010-11)	81
	% 2 Year-old Children - Recommended Number Antigen Dose Administered (MMR)	74.7%	77.3%	73.3%	73.5%	76.5%	79%[b]	85%
	Safety: *Eliminating preventable harm to patients from care that is intended to help them*							
	Methicillin-Resistant Staphylococcus Aureus (MRSA) Rate per 1000 patient days (Urban acute & Rural acute-only sites)	0.71	0.46	0.30	0.55	0.65	0.42[a]	0.47
	Client-Centred: *Placing clients and families first*							
	Patient Experience - % Inpatients reporting that they are always satisfied with Communication with Nurses	64.9%	69.9%	66.5%	67.7%	pending	75.3%[b]	70.6% (based on 2008 CAHPS Hospital Survey Chartbook)
	Equity: *Providing care that does not vary because of personal characteristics and circumstances*							
	Deprivation Index Ratio - % 2 yrs Immunized (MMR) (top socioeconomic quintile / bottom socioeconomic quintile)	1.25	1.23	1.26	1.35	1.25	1.16[b]	ideal ratio=1.0

Vancouver Coastal Health



Vancouver Coastal Health

Promoting wellness. Ensuring care.

Our health care report card

Providence HEALTH CARE

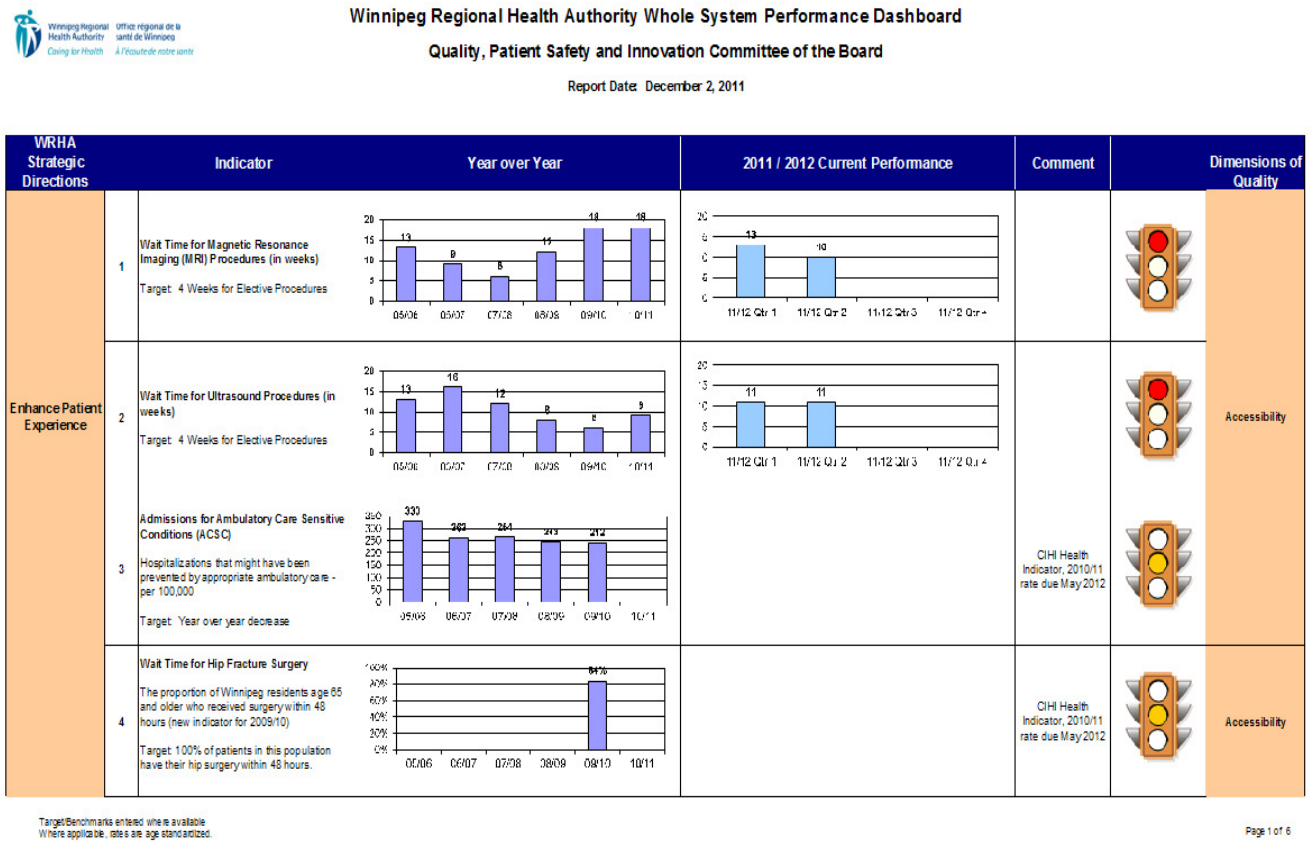
How you want to be treated.

Report Generated: Dec 08, 2011

	Time Frame	Target	Year to Date
Provide the best quality of care			
ACCESS			
ER Wait Time	Apr 2011 to Nov 2011	<= 54.6	51.4
Surgery Wait Time	Apr 2011 to Oct 2011	>= 80.0 %	75.3 %
Mental Health and Addictions Community Follow-up	Apr 2010 to Mar 2011	>= 88.0 %	82.1 %
Residential Care Wait Time	Apr 2011 to Oct 2011	>= 80.0 %	70.0 %
SAFETY			
MRSA Rate (PHC not included)	Apr 2011 to Sep 2011	<= 5.8	3.8
Clostridium difficile Infection Rate	Apr 2011 to Sep 2011	<= 7.4	8.5
Hand Hygiene Compliance	Apr 2011 to Sep 2011	100.0 %	68.9 %
CLIENT CENTERED			
Emergency Patient Experience	Apr 2011 to Jun 2011	>= 90.0 %	87.0 %
EFFECTIVENESS			
Hospital Standardized Mortality Ratio	Apr 2011 to Jun 2011	<= 100.0	69.8
Promote better health for our communities			
EFFICIENCY			
Alternate Level of Care Days	Apr 2011 to Nov 2011	<= 7.2 %	8.2 %
Ambulatory Care Sensitive Condition Rate per 100,000 population	Apr 2010 to Mar 2011	<= 171.0	195.0
EFFECTIVENESS			
Measles, Mumps and Rubella (MMR) Immunization Coverage Rates	Sep 2010 to Jun 2011	>= 95.0 %	87.5 %
Early Childhood Development Index	2009-2011	<= 15.0 %	32.5 %
EQUITY			
Disparity Ratio for Life Expectancy	2006-2010	1.0	1.2
Optimize utilization of our current workforce and prepare for the future			
PEOPLE DIMENSION			
Acute Productive Hours per Patient Day (PHC not included)	Apr 2011 to Nov 2011	<= 7.1	7.0
Staff Safety Scores (PHC not included)	Apr 2011 to Mar 2012	Not yet available	3.7
Total Absence Rate	Apr 2011 to Jul 2011	<= 13.5 %	13.2 %
LEARNING AND GROWTH			
Research Productivity (in millions of dollars)	Apr 2010 to Mar 2011	Not yet available	120.3

Winnipeg Regional Health Authority Performance Dashboard

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



Winnipeg Regional Health Authority Whole System Performance Dashboard

Quality, Patient Safety and Innovation Committee of the Board

Report Date: December 2, 2011

WRHA Strategic Directions		Indicator	Year over Year	2011 / 2012 Current Performance	Comment		Dimensions of Quality
Enhance Patient Experience	1	Wait Time for Magnetic Resonance Imaging (MRI) Procedures (in weeks) Target: 4 Weeks for Elective Procedures	13, 9, 6, 12, 18, 18 (05/06 – 09/10, 10/11)	13, 10 (11/12 Qtr 1, 11/12 Qtr 2, 11/12 Qtr 3, 11/12 Qtr 4)			Accessibility
	2	Wait Time for Ultrasound Procedures (in weeks) Target: 4 Weeks for Elective Procedures	13, 16, 12, 8, 6, 9 (05/06 – 09/10, 10/11)	11, 11 (11/12 Qtr 1, 11/12 Qtr 2, 11/12 Qtr 3, 11/12 Qtr 4)			
	3	Admissions for Ambulatory Care Sensitive Conditions (ACSC) Hospitalizations that might have been prevented by appropriate ambulatory care - per 100,000 Target: Year over year decrease	330, 283, 264, 243, 212 (05/06 – 09/10, 10/11)		CIHI Health Indicator, 2010/11 rate due May 2012		
	4	Wait Time for Hip Fracture Surgery The proportion of Winnipeg residents age 65 and older who received surgery within 48 hours (new indicator for 2009/10) Target: 100% of patients in this population have their hip surgery within 48 hours.	84% (05/06 – 09/10, 10/11)		CIHI Health Indicator, 2010/11 rate due May 2012		Accessibility

Target/Benchmarks entered where available
Where applicable, rates are age standardized.

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11.0 CONCLUSION

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

12.0 REFERENCES

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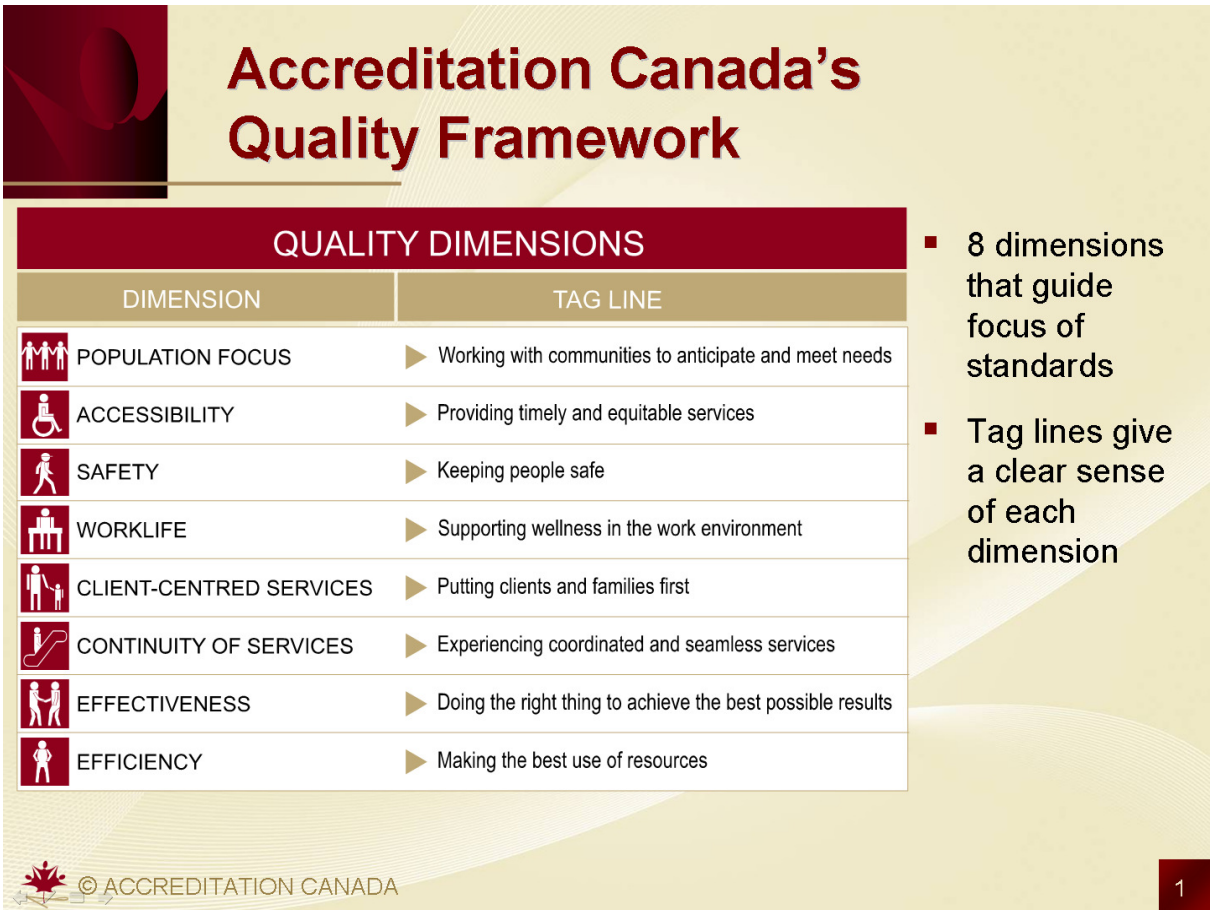
APPENDIX 1: EXAMPLES OF QUALITY FRAMEWORKS

Institute of Medicine

The quality dimensions are:

- *Safe*: avoiding injuries to patients from the care that is intended to help them.
- *Effective*: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
- *Patient-centered*: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
- *Timely*: reducing waits and sometimes harmful delays for both those who receive and those who give care.
- *Efficient*: avoiding waste, including waste of equipment, supplies, ideas, and energy.
- *Equitable*: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Accreditation Canada



New Brunswick Health Council | Conseil de la santé du Nouveau-Brunswick

Engage. Evaluate. Inform. Recommend.
Engager. Évaluer. Informer. Recommander.

QUALITY DIMENSIONS

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

OHQC Ontario Health Quality Council

COQSS Conseil ontarien de la qualité des services de santé

Reporting Framework: The Attributes of a High-Performing Health System

Ontarians want their health system to be —

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

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

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

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

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

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

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

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

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

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

EFFICIENT — The health system should continually look for ways to reduce waste, including waste of supplies, equipment, time, ideas and information.

For example, to avoid the need to repeat tests or wait for reports to be sent from one doctor to another, your health information should be available to all of your doctors through a secure computer system.

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

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

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

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

FOCUSED on POPULATION HEALTH — The health system should work to prevent sickness and improve the health of the people of Ontario.

BC Patient Safety & Quality Council

www.bcpsqc.ca

BC Health Quality Matrix

DIMENSIONS OF QUALITY

AREAS OF CARE	ACCEPTABILITY Care that is respectful to patient and family needs, preferences, and values.	APPROPRIATENESS Care provided is evidence-based and specific to individual clinical needs.	ACCESSIBILITY Ease with which health services are reached.	SAFETY Avoiding harm resulting from care.	EFFECTIVENESS Care that is known to achieve intended outcomes.
STAYING HEALTHY Preventing injuries, illness, and disabilities.					
GETTING BETTER Care for acute illness or injury.					
LIVING WITH ILLNESS OR DISABILITY Care and support for chronic illness and/or disability.					
COPING WITH END OF LIFE Planning, care and support for life-limiting illness and bereavement.					

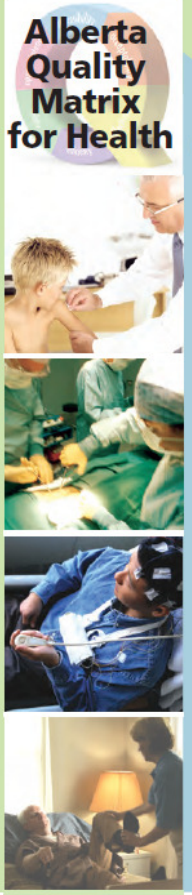
EQUITY Distribution of health care and its benefits fairly according to population need.

EFFICIENCY Optimal use of resources to yield maximum benefits and results.

The BC Health Quality Matrix was developed in collaboration with the members of the BC Health Quality Network which includes health authorities, the Ministry of Health Services, the Ministry of Healthy Living and Sport, academic institutions and provincial quality improvement groups and organizations.

www.hqca.ca

ALBERTA QUALITY MATRIX FOR HEALTH USER GUIDE



Dimensions of Quality / Areas of Need	Acceptability	Accessibility	Appropriateness	Effectiveness	Efficiency	Safety
	Health services are respectful and responsive to user needs, preferences and expectations.	Health services are obtained in the most suitable setting in a reasonable time and distance.	Health services are relevant to user needs and are based on accepted or evidence-based practice.	Health services are provided based on scientific knowledge to achieve desired outcomes.	Resources are optimally used in achieving desired outcomes.	Mitigate risks to avoid unintended or harmful results.
Being Healthy — Achieving health and preventing occurrence of injuries, illness, chronic conditions and resulting disabilities.						
Getting Better — Care related to acute illness or injury.						
Living with Illness or Disability — Care and support related to chronic or recurrent illness or disability.						
End of Life — Care and support that aims to relieve suffering and improve quality of living with or dying from advanced illness or bereavement.						

HQCA Health Quality Council of Alberta

Adopted June 2005 by the Health Quality Network, an HQCA collaborative consisting of: College & Association of Registered Nurses of Alberta, Alberta Cancer Board, Alberta Health and Wellness, Alberta Medical Association, Alberta Mental Health Board, Alberta College of Pharmacists, Aspen Regional Health, Calgary Health Region, Capital Health, Chinook Health Region, College of Physicians & Surgeons of Alberta, David Thompson Health Region, East Central Health, Federation of Regulated Health Professions, Health Quality Council of Alberta, Northern Lights Health Region, Palliser Health Region and Peace Country Health.

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