Alberta Health Services

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Continuing Care
Quality Management Framework

Quality Management Framework

Alberta Health Services

QHI Quality & Healthcare Improvement

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Executive Summary

The AHS Continuing Care Quality Management Framework outlines the structure, functions, responsibilities and accountabilities for monitoring, improvement and operational delivery of quality[1] safe care and service[2] that may influence or impact the safety of individuals[3] receiving continuing care services.

This framework is not a standalone document and is supported by the: *AHS Quality and Health Care Improvement Quality Management Framework 2014 (draft); Health Quality Council Matrix 2004; AHS 2013-2016 Patient Safety Strategic Plan; AHS Enterprise Risk Management Framework 2010; AHS Ethics Framework, 2014; AHS Progressing the Continuing Care Strategy: the Right Care in the Right Place 2010; Government of Alberta Health System Outcome and Measurement Framework 2013; Alberta Health Continuing Care Healthcare Standards 2008(amended 2013): Alberta Health Continuing Care Accommodation Standards 2010; and, Standards for Infection Prevention and Control Accountability and Reporting 2011.*

As outlined in this Provincial AHS Continuing Care Quality Management Framework, the quality vision, quality enablers, quality outcome indicators and risk management mechanisms have been developed through wide stakeholder engagement and informed evidence. AHS Community Seniors Addiction and Mental Health (CSAMH), and Quality and Healthcare Improvement (QHI), in collaboration with clients, residents and their families, Zone Operations, Contracted Providers, and Alberta Health (AH) are leading the ongoing development and implementation of this Framework through the establishment of the Continuing Care Quality Committee (CCQ). The CCQ will provide the governance structure and vital link to ensure provincial consistency; to consolidate all risk and quality activities into a single registry; to enhance the ability to identify quality of care issues earlier; and to reduce the time and administrative burden for operators by better coordinating quality activities.

Introduction

The Alberta Health Services Continuing Care system provides ongoing care services and accommodation that support Albertans to remain independent and receive the appropriate amount and type of service to meet their health care needs. Continuing care clients are defined by their need for care and not by age, diagnosis or the length of time they may require service.

Continuing care healthcare services are intended to supplement and complement, not replace, care provided by primary healthcare, individuals, families, and communities.

> ***"The continuing care system in Alberta generally does not fail people but continuing care processes are very confusing from the client's perspective - it is like learning a foreign language."***
>
> *~Client/Family Stakeholder Feedback*
> *February 26, 2014*

[1] Quality as defined by the Health Quality Council of Alberta Quality Matrix, including the six dimensions of Quality
[2] Safe care and service relates to individual(s) receiving publicly-funded continuing care healthcare
[3] Individuals include patients, residents, clients and the individual's family or legal representative

- These services are provided across living arrangements including those that are community based and facility based; and,
- these services and supports are provided through a combination of internal AHS, external contracted providers, and carers / informal supports.

The following diagram (Figure 1) provides an overview of AHS' publically funded Continuing Care System. The purple sections represent the service supports and location where they are provided. The blue sections represent accountabilities and supports to meet those accountabilities.

AH, AHS, and community partners in delivery of continuing care services have been working to ensure that Albertans are receiving the right care, in the right place, at the right time no matter where they live in the province. As outlined in the *AHS Progressing the Continuing Care Strategy: the Right Care in the Right Place 2010,* AHS has been deliberate through this Seniors Health Strategy to provide a consistent approach to continuing care across Alberta. With these changes well underway, the focus must now be on developing a Continuing Care Quality Management Framework supported by a leadership, and a structure to support continuous quality improvement.

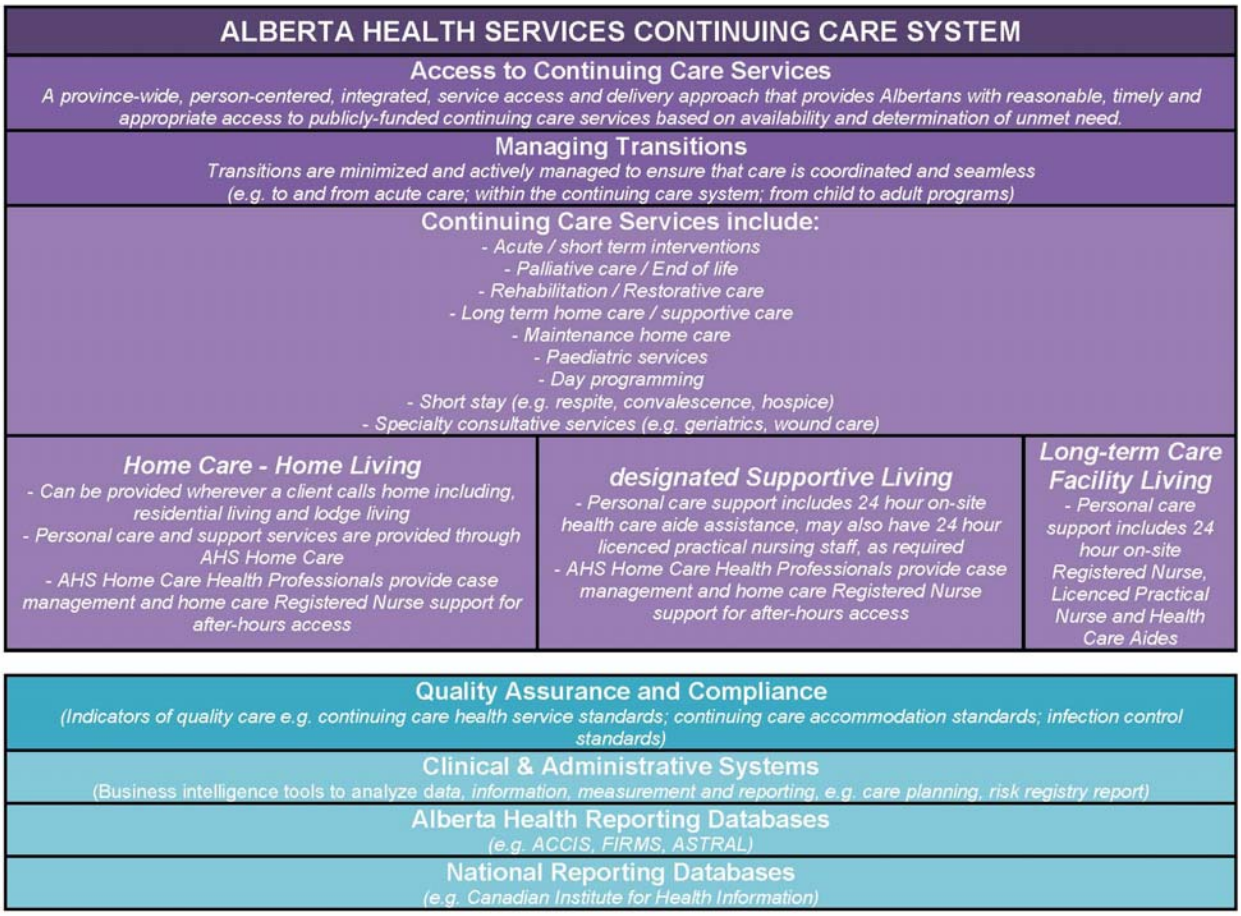

Figure 1: AHS' Publically Funded Continuing Care System

The Wellness Paradigm

Continuing Care Services are grounded in a wellness paradigm focused on abilities, strengths, and maintaining independence across a person's lifespan, and based on the following assumptions:

- Aging is a normal part of the lifespan;
- health is defined by individuals themselves in terms of their own unique strengths and challenges, value systems, quality of life, and integral interdependent relationships;
- individuals are responsible for their own lives and make choices in relation to their own health and wellbeing;
- individuals with chronic illness, frailty related to aging, or disability can, and do, lead healthy and productive lives;
- restorative care can influence the wellness and independence of even the most health compromised;
- those with chronic health conditions usually spend more time in caring and supporting themselves than do the health professionals involved in their formal healthcare services;
- individuals and their families are capable of learning new skills and acquiring new competencies.
- family and natural support networks are full partners in care and bring their own strengths and resources;
- most individuals, families and communities value improvements that increase their competence, enhance control over their lives, and promote their functioning at the highest possible level while remaining in their own home or close to home, as long as possible; and
- inability to recognize and support people's self-care efforts encourages unnecessary dependency on formal health care services.

Background: Building the Continuing Care Quality Management Framework

Since 2007 with the implementation of Continuing Care Health Service and Accommodation Standards, government and industry have been establishing and streamlining clinical business structure (e.g. InterRAI tools), information management systems, quality improvement processes and audit processes to monitor quality of care and service. However, gaps still occur which have influenced public trust in the continuing care system. (e.g. sentinel events; media). Available information and data systems are not currently able to provide timely and consistent evidence on whether or not there is consistently efficient, effective or exceptional quality continuing care services nor to provide consistent feedback to our operators; there is a fragmented performance auditing reporting system that needs to be simplified and streamlined; and there is a need for open exchange of ideas and information sharing of learning and best practices. Consequently, AHS' Continuing Care Services launched a collaborative process for development and implementation of a provincial Continuing Care Quality Management Framework.

With the Wellness Paradigm as the foundation of the AHS Continuing Care Quality Management Framework, the framework intends to address the need to:

- Have the individuals' voice embedded, as it is critical for the delivery of safe care;
- Identify, categorize and prioritize issues for improvement that impact quality of care and service or introduce risk within the continuing care system in Alberta;
- Seek out, monitor and respond to quality and safety issues;
- Identify emerging knowledge and evidence, internal and external trends or innovations that may impact the quality of care and service;
- Inform and support the development and implementation of key strategies / initiatives that directly or indirectly influence the ability to successfully provide high quality safe care and service, and;
- Assess and inform the resourcing, infrastructure, processes and relationships required to facilitate continuous quality improvement in order to achieve desired outcomes inclusive of quality assurance[4], risk management, monitoring and auditing.

The Minister of Health is ultimately responsible for public assurance; consequently, the oversight role of AH provides strategic and directional policy, legislation, and setting standards for public assurance. AHS is responsible for ensuring delivery of high quality continuing care health and care services throughout Alberta. AH is in development of an *Assurance Strategy*, and *Continuing Care Performance Measurement Framework* which will further inform the AHS Continuing Care Quality Management Framework.

The AHS quality goals and the Health Quality Council of Alberta Quality Matrix for Health dimensions of Quality are foundational concepts for this Framework.

A literature review and feedback received informed how to define quality of care and the quality enablers within the Framework.

Stakeholders have been instrumental in the development of, and will be key in implementation of, the AHS Continuing Care Quality Management Framework. These stakeholders include (but are not limited to): Patients, Residents, Clients and family members; AHS (Seniors Health; Seniors Health Strategic Clinical Network; Zone Operations; Quality Healthcare Improvement; Finance; Contracting, Procurement and Supply Management(CPSM); Capital Planning; Infection Prevention and Control; Nutrition & Food Services and Linen & Environmental Services); Affiliates; Contracted Providers (inclusive of their three recognized Associations); and, Alberta Health.

Principles underpinning the Continuing Care Quality Management Framework

The following set of principles is the underpinning for continuing care quality assurance and continuous improvement:

- **Put people and their families at the centre of their health care** – *"The only true measures of quality are the outcomes that matter to the individual receiving the care and their family"*

[4] The quality assurance cycle (Figure 6, page 16) is designed to provide a robust structure to ensure continuous quality improvement and risk management of all continuing care services.

- **Be committed to quality and safety** – *"All processes and standards drive towards quality improvement for improved patient outcomes"*
- **Foster a culture of trust and respect** – *"Transparency in sharing the journey with all stakeholders inclusive of the public is the key to reporting quality outcome"*
- **Be focused on wellness and public health** –*"Fostering the shift in mindset and culture from a focus on illness and treatment to recognizing that a person's quality of life is determined as much or more by their outlook of wellness and independence"*
- **Enable decision-making using the best available evidence** – *"Quality assurance and continuous improvement is embedded in everything we do and is integral part of our daily practice and work"*
- **Ensure equitable access to timely and appropriate care** – *"Right care in the right place at the right time will be guided by best practices in quality assurance both nationally and internationally"*

A foundation for a better health system, Alberta Health, January 2010

Vision

The vision to guide the AHS Continuing Care Quality Management Framework journey over the next five years is:

Individuals and their families will access and receive quality safe continuing care services from a high performing, highly reliable Continuing Care System.

Quality Management Definition

There must be a clear and accepted definition of what quality continuing care service looks like for individuals[5] receiving continuing care services, and the health system providing the care and service. HQCA articulated that high-quality health care is based on excellent performance through maturing to the right balance within the context of HQCA six dimensions of quality which will result in a sustainable health system (HQCA 2010).

"Quality is the ongoing process designed to improve performance within a particular institution and setting . . . Some element of risk is always embedded with quality improvement and evaluation" (AHS Ethics Framework, 2014).

[5] Individuals include patients, residents, clients and the individual's family or legal representative

Within this context of the Quality Management Framework (Figure 2) high quality care comprises of the following:

- **Bringing appropriate care to the community that is person-centred and continuously improving** - we support a culture where staff and leaders in operational areas implement practices that enhance the care experience and improve key outcomes through the inclusion of, responsiveness to, and partnering with clients/residents and their families to gain their perspective at the point of care.
- **Partnering for better outcomes delivered within a fair and consistent learning culture that is evidence informed** – We support clients/residents and their families, staff, and leaders to build relationships in a learning environment where reporting and learning are key elements of accountability. This learning environment results from a range of resources (e.g. experience, evaluations, research, and context) that has been subjected to testing and is found credible (Higgs &Jones 2000; Seidel et al. 2009).
- **Achieving health system sustainability through seamless and reliable team work that is measurable** – we support clients/residents and their families in transitions between care providers and healthcare services that ensure the right information and interventions are provided at the right time by a high functioning group of healthcare providers using quantitative and qualitative data, quality assurance, risk management and continuous improvement processes in reflecting the quality of care provided.

The AHS Quality Management Framework (Figure 2) describes the characteristics, enablers, and HQCA six dimensions of quality to support the integration of quality into daily work, promotes continuous quality improvement, and aligns improvement work to the AHS vision and strategic directions.

Figure 2: AHS Quality Management Framework

The AHS Quality Management Framework represents a shared understanding of how quality of care will be operationally defined, measured, reported and continuously improved upon including identification and mitigation of risk, with the ultimate goal of assurance of quality safe care.

The context of Continuing Care, for our vision to become a reality (Figure 3) we must be able to substantiate outcomes from the perspectives of: the individual receiving the services as the foundation of the system; of frontline providers; health system oversight; and to ensure our provincial health system reflects the six dimensions of quality described in the Alberta Quality Matrix for Health (HCQA, 2004).

Figure 3: Goals and Outcomes of Continuing Care Quality Management

At the same time, we must acknowledge that the provision of high quality care is an inherently complex and fragile operation that is a collective endeavor, requiring collective effort and collaboration at every level of the system (NHS 2013), and be able to identify the critical components which allow quality safe care to prevail. Figure 4 illustrates the continuing care quality management quality initiative critical components to drive this change:

- The **vision (green)** that Individuals and their families will access and receive quality safe continuing care services from a high performing, highly reliable Continuing Care System to keep our focus;
- The balance of the **six dimensions of quality (blue)** reflecting the lived experience of the individual and their family receiving the care, and;
- The **risk categories (yellow)**[6] which represent the key components of quality assurance to measure performance, and understand the business risks facing every level of the continuing care system in the delivery of care and service.

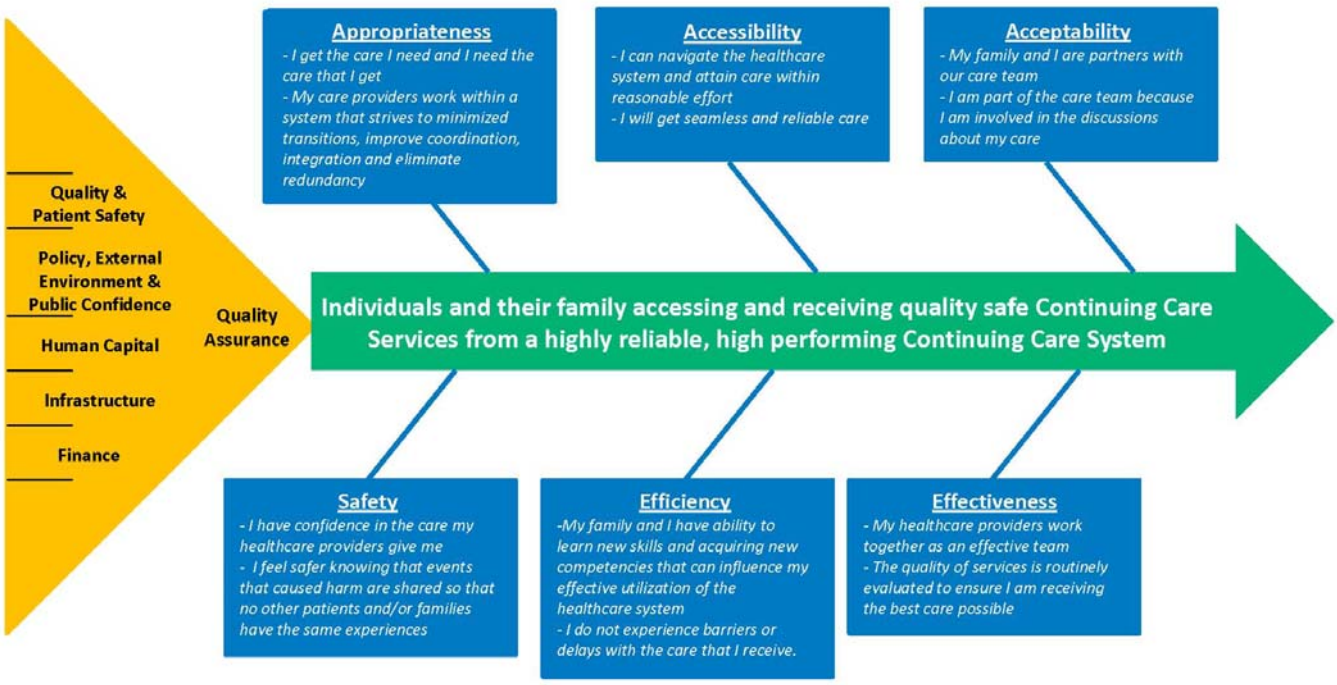

Figure 4: Drivers of the vision

[6] Risk categories as per AHS Enterprise Risk Management
Quality & Patient Safety: Events / risks that could affect the provision of key services causing major problems for quality and/or patient safety and could cause significant disruption to health service delivery
Policy, External Environment & Public Confidence: Results could be inconsistent with political/strategic mandate for health care delivery. Significant legal or contractual risks. Risks to the reputation of AHS.
Human Capital: Risks that could affect the delivery of health service delivery or that could threaten the safety or wellness of AHS personnel
Infrastructure: Risks that lead to disruption of service affecting patients provincially or in several areas due to absence of appropriate infrastructure.
Finance: Risk resulting from in adequate or failed internal financial systems and/or from business practices that are inconsistent with generally accepted financial regulations and practices or that would have significant impact on AHS financially.

Enablers of Quality Management

The identified quality enablers from the Quality Management Framework (Figure 2) are essential for maturation into a high performing, highly reliable continuing care system and provides the actions required in our emerging vision. These enablers have required actions to achieve the emerging vision as outlined in this continuing care quality management framework. (see Appendix 1: Defining enablers of continuing care quality management).

Continuing Care Quality Management Governance Structure

There are many stakeholders/ roles within the Continuing Care system such as patients/clients/residents/families, primary care physicians and teams, professional consultative providers, continuing care operators, AHS, and AH. All of these stakeholders and their roles are accountable for pieces of the quality journey of service continuing care service delivery. However, continuing care quality processes sometimes overlap and are complex. The Continuing Care Quality Management Framework includes the governance structure required to identify the roles and accountabilities.

As an identified enabler of the Quality Management Framework (Figure 2), governance is the structure by which entities and individuals share responsibility and are held accountable for client care, minimization of risks to consumers and for continuously monitoring and improving the quality of care (reference). The Continuing Care Quality Committee (CCQ) will provide coordinated and collaborative oversight to the monitoring and improvement in the delivery of continuing care services in Alberta.

The committee will be accountable for ensuring all quality improvement structures, processes and outcomes, including those related to patient safety and quality assurance, are necessary, sufficient and effective in achieving quality and safety within the continuing care health sector.

To enable the mandate of this committee there needs to be a clear understanding of the governance and oversight role of AH and the services oversight role of AHS.

AH membership will inform and provide consultation to ensure awareness and collaboration; strategic and directional policy; performance measurement and compliance assurance related to quality and safety of continuing care services.

The CCQ will provide the structure and processes to share knowledge, learning, and build consensus in the development and implementation of the Continuing Care Quality Governance Structure and Quality Management Framework (see Appendix 2 and 3 for Continuing Care Quality Governance Structure, and CCQ Terms of Reference).

The CCQ is where information related to quality safe care can be enacted upon to influence improvement of the continuing care system in delivery of quality safe care. HQCA (2010) states, “Effective and integrated health information is vital to both system and clinical level decision making”. As shown in the HQCA (Figure 5), establishment of an integrated health information system supports this decision making process.

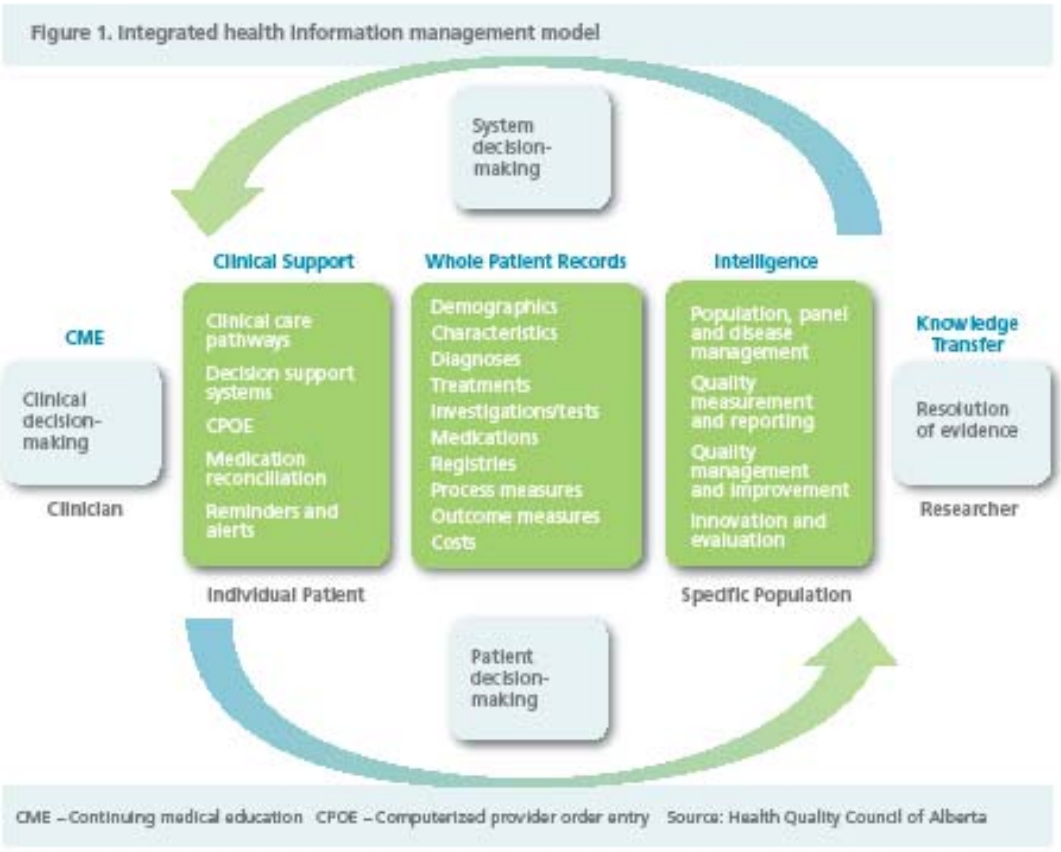

Figure 5: HQCA Integrated Health Information Management Model
(*2010 Measuring and Monitoring for Success, HQCA, Nov. 2010*)

Measurement and Reporting

The Quality Management Framework enablers (Figure 2) of information, technology and access to data will make possible the ability to provide the evidence of indicators of quality safe care. These indicators of quality safe continuing care services need to be able to stand alone as well as be able to have fluidity to report the performance of the system with the ability and agility to identify and mitigate potential risk to achieve optimal performance, and sustainable health care service delivery.

HQCA (2010) states, “The power of measurement, as a business strategy, is most evident when measures of quality and safety are embedded at every level of the system”. And goes on to state, “Health information and measurement have considerable potential to enable improved patient management and health care quality as well as better decision – making at all level of the system- strategies are pillars of sustainability” (HQCA 2010).

As noted in the *Provincial Continuing Care Reporting Framework* (Appendix 3), the goal for continuing care measurement and reporting will be to support person-focused and quality continuing care health programs and services that are accessible and sustainable

for Albertans. This framework outlines the processes to identify, develop, publish, report, and cycle measures / indicators. As well, insight into the type of measure required (i.e. transactional, tactical, strategic, or outcome measure). As well, AH is in development of an *Assurance Strategy* and *Continuing Care Performance Measurement Framework* that will further inform the AHS Continuing Care Quality Management Framework and guide the identification and development of the indicators / measures related to quality safe care.

> ***"A simple but powerful (quality assurance) focus is measuring satisfaction – client/resident satisfaction; family satisfaction; health provider / staff satisfaction"***
>
> ~Stakeholder Feedback
> February 26, 2014

Quality Management Cycle

The Continuing Care system relies upon a variety of service delivery models and providers/operators including public and private operators. Coordination and overall monitoring of this complex system requires examination of both quality indicators and risk levels from both the patient and system sustainability perspectives. In order to do this, the Continuing Care Quality Management Framework incorporates a risk management component (Figure 2 enabler of quality assurance /quality controls).

To be able to better react to anticipated, perceived or actual risk (to the client, and/or system viability and sustainability), it is important for all stakeholders to work together for effective risk management that would include:

- Capability across the continuing care system to manage risk through standard operational quality management process for consistent application;
- established benchmarks indicative of levels of risk;
- monitoring and analyzing trends in identified actual or potential risk;
- proactively establishing risk mitigation strategies; and
- establishing a culture of continuous quality improvement to decrease the likelihood and severity of potential risk.

The quality assurance cycle (Figure 6) is designed to provide a robust structure to ensure continuous quality improvement and risk management of all continuing care services.

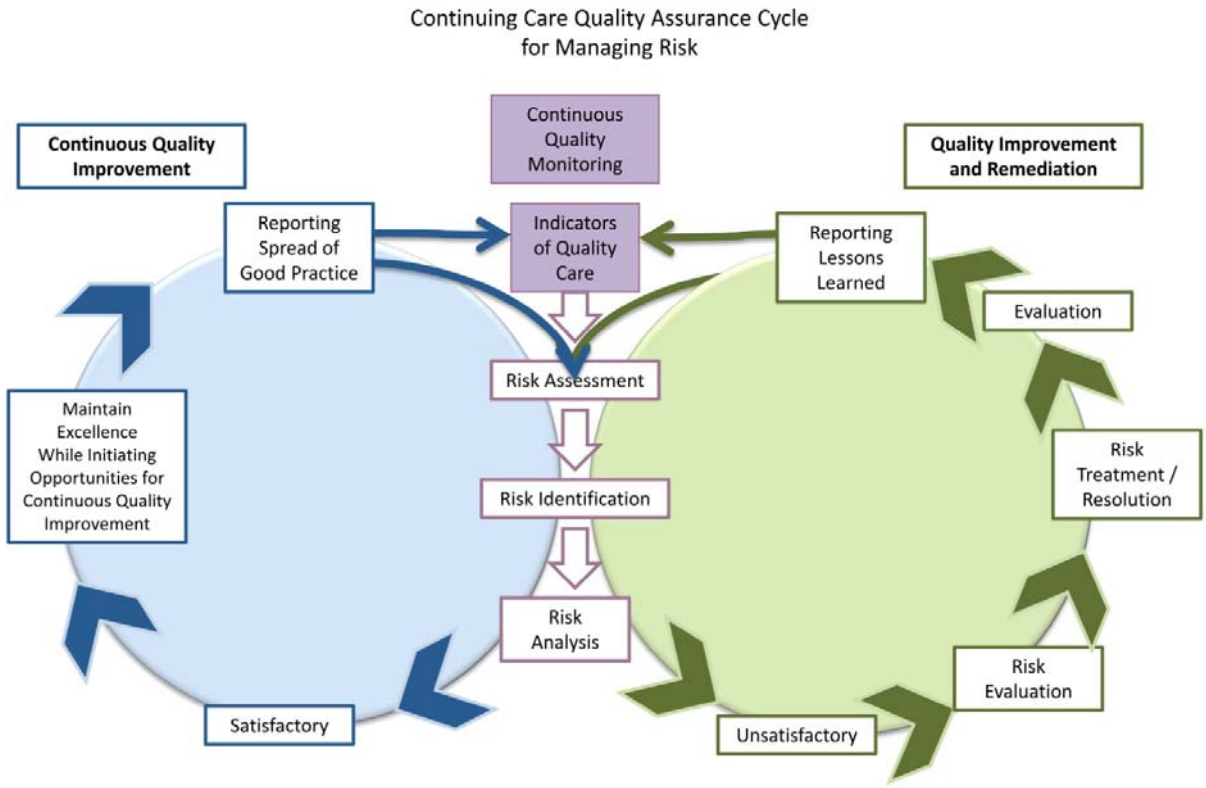

Figure 6: Continuing Care Quality Management / Assurance Cycle[7]

The AHS Patient Safety Strategic Plan 2013-2016 states that, “Delivering quality and safe care to Albertans is the foundation of all activities undertaken by Alberta Health Services. While patient safety is implicit throughout the strategic direction of the organization, patient safety efforts tend to be ad hoc and reactive, rather than proactive”. AHS Enterprise Risk Management (ERM) Framework and Guidelines provide the context, structure and processes to mature the continuing care quality management and assurance cycle to become proactive in addressing risk.

With the learned ERM, continuing care assurance activities will be a more intentional component to the continuous quality improvement process. This will be enabled through systematic knowledge transfer and exchange between multiple stakeholders, sites, organizations and zones with the overall goal with each audit to meet or exceed indicators (i.e. criterion) of quality and safe care.

Each specific criterion carries with it a level or degree of significance to overall health outcomes for Albertans. The cycle of auditing will depend on the regular audit results and the level of risk associated with those results. Continuing Care Audits have been

[6] Risk definitions as per AHS Enterprise Risk Management
Risk Assessment: The overall process of risk identification, risk analysis and risk evaluation.
Risk Identification: The process of finding, recognizing and describing risk.
Risk Analysis: A systematic use of available information to determine how often specified events may occur and the magnitude of their consequences.
Risk Evaluation: The process of comparing the results of risk analysis with risk criteria to determine whether the risk and/or its magnitude is acceptable or tolerable.
Risk Treatment: Selection and implementation of appropriate management options for dealing with identified risk.

regularized in AHS to occur once every two years which has been limiting to the extent that the quality feedback loop is lengthy and hence can be less effective. Output feedback from the audits is important in order to drive the input for quality improvement activity.

Continuous quality improvement with maturing of the quality improvement and remediation component will embed the principles and practices of ERM into the auditing process with the overall goal of reducing or eliminating quality gaps, especially for those areas/criterion, which carry higher risk for Albertans.

Complex audit cycles can be added to assess high risk trends and repetitive non-compliancy status with the standards. These complex audits will require multidisciplinary team members that are experts in interpreting standards, practices and principles and have excellent relationship management and communication.

All Audit cycles, whether they are regular or complex will provide valuable, independently produced information to sites, operators and zones. This will assist in coordinating goals along with providing assurance to Albertans that the healthcare they receive is of the highest quality and care providers, clients, residents and families understand their roles and accountability for the delivery of continuing care services.

To better understand risk and manage risk, a risk classification matrix arises from this Continuing Care Quality Management Framework (Figure 7) to estimate degree of potential risk, evaluate the risk and prioritize the risk. The *Provincial Continuing Care Reporting Framework (*Appendix 4) will further inform this work along with current legislation, directional policy, and standards that are already in place. A consistent approach to risk management from a system perspective will be based on continuous quality improvement. The response of the continuing care system at every level (site, operator, zone, and province-wide) will become more agile to predict and proactively ensure quality safe care.

Information from a number of agreed upon care and service delivery, satisfaction, workforce, environment, and financial indicators will be combined and used to identify levels of risk to quality and safety for residents/clients across the system. Intensity of response will be based on the level of risk and will define subsequent actions.

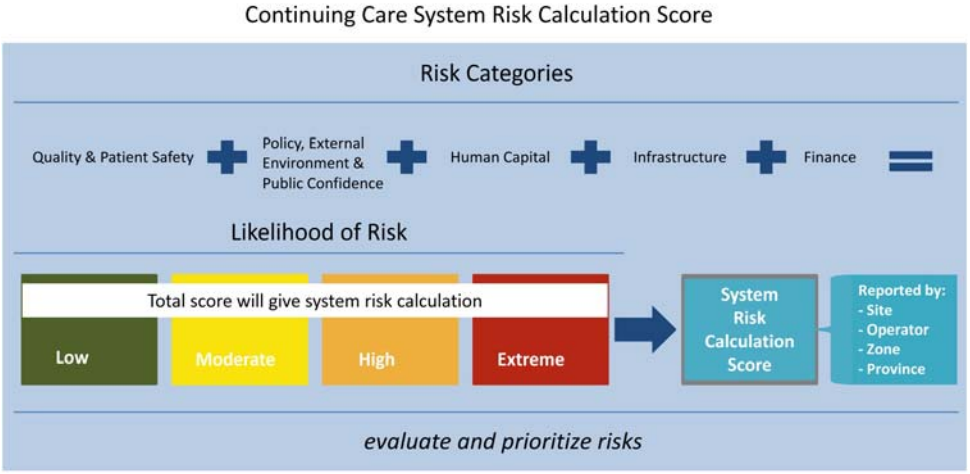

Figure 7: Risk Management of the Continuing Care System

Capacity and Capability Development

The Quality Management Framework enablers of capacity and capability (Figure 2) require a focus on building learning organizations that nurture development and delivery of continuous quality improvement throughout all aspects of care delivery; quality and safety education, change management and knowledge transfer for individual receiving the care, frontline staff, organizations and, leaders of the system. This formalizes interconnections between organizations of the continuing care system and it supports the value of building capacity and capability (Figure 8).

This refocused intent on building capacity and capability associated with Continuing Care Quality Management will mature the continuing care system from a position of consensus building to an intuitive system in relationship to quality assurance from high performing, highly reliable continuing care system for Albertans.

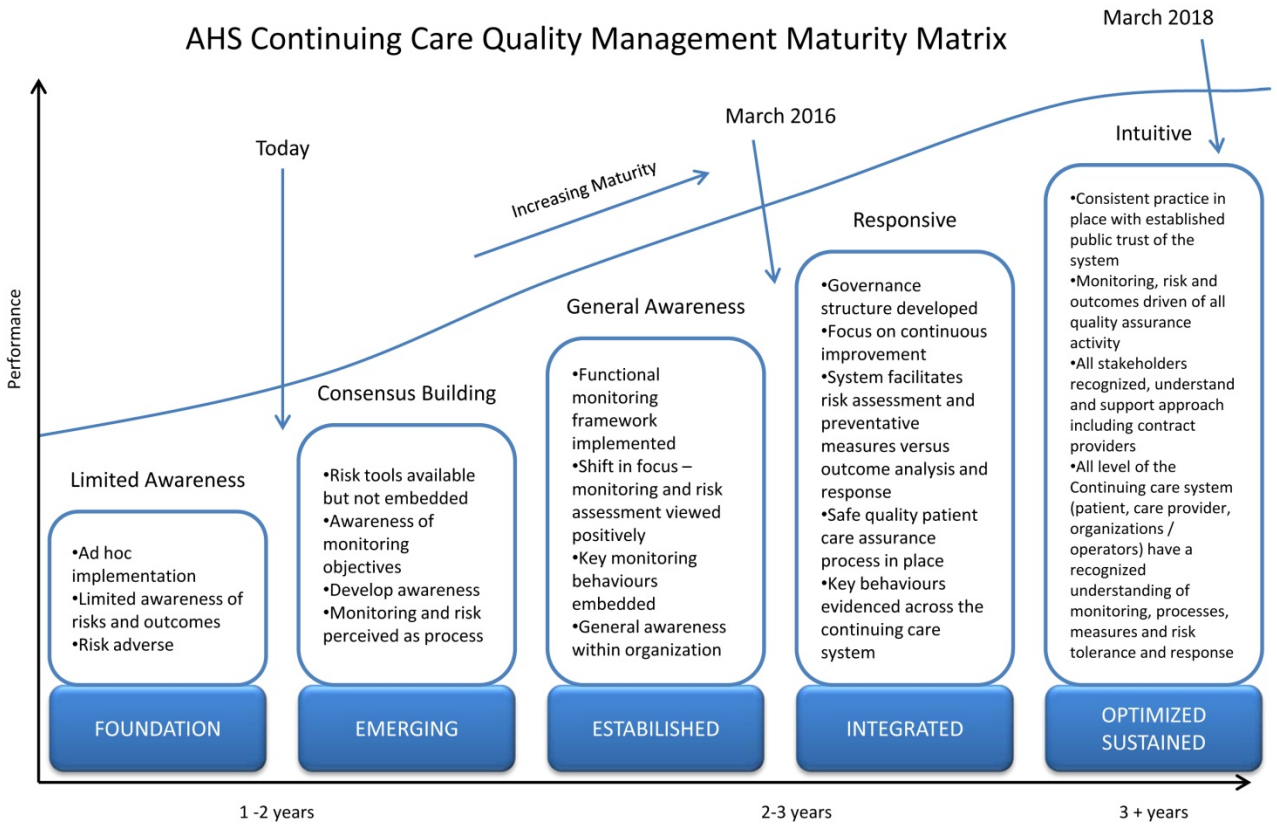

Figure 8: AHS Continuing Care Quality Management Maturity Matrix

Acknowledgements

Development of the *Continuing Care Quality Management Literature Review and Leading Practices* document has provided a solid foundational in the advancement of the Continuing Care Quality Management Framework. This leading practice document is intended to include evidenced based, research informed, and leading practices that are already in place within and across Alberta (AHS, contracted providers and AH). This leading practice document has eight areas of focus: Governance; Elements/enablers of a quality management structure; Performance measures; Risk management models; Maturity matrix (e.g. change management); Evaluation approach (related to evaluation of the implementation and impact of the CCQMF); Performance and Monitoring (e.g. Auditing), and; Best practice reporting tools.

Thank you and acknowledgement to the large number of stakeholders who have provided input and feedback:

Quality Management in Continuing Care Stakeholder Engagement
September 25, 2013

Annjanette Weddell	Alberta Health	Lara Check	AHS, CPSM
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Stakeholder Engagement Workshop: Continuing Care Quality Management and Assurance Framework
February 26, 2014

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Linda Mattern	Alberta Health
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Trudy Harbidge	AHS, CSAMH
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Wendy King	SHSA
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AHS Patient & Family Advisory Group Consultation on the Continuing Care Quality Management Framework
March 14, 2014

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June 6, 2014

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Appendices

Appendix 1: *Quality Enablers for Continuing Care Quality Management*
Appendix 2: *Continuing Care Quality Committee Governance Structure*
Appendix 3: *Continuing Care Quality Committee Terms of Reference*
Appendix 4: *Continuing Care Reporting Framework*

The identified quality enablers from the quality management framework (Figure 2) are essential for maturation into a high performing, highly reliable continuing care system and requires the actions in our emerging vision. These enablers have required actions to achieve the emerging vision as outlined in this Continuing Care Quality Management Framework.

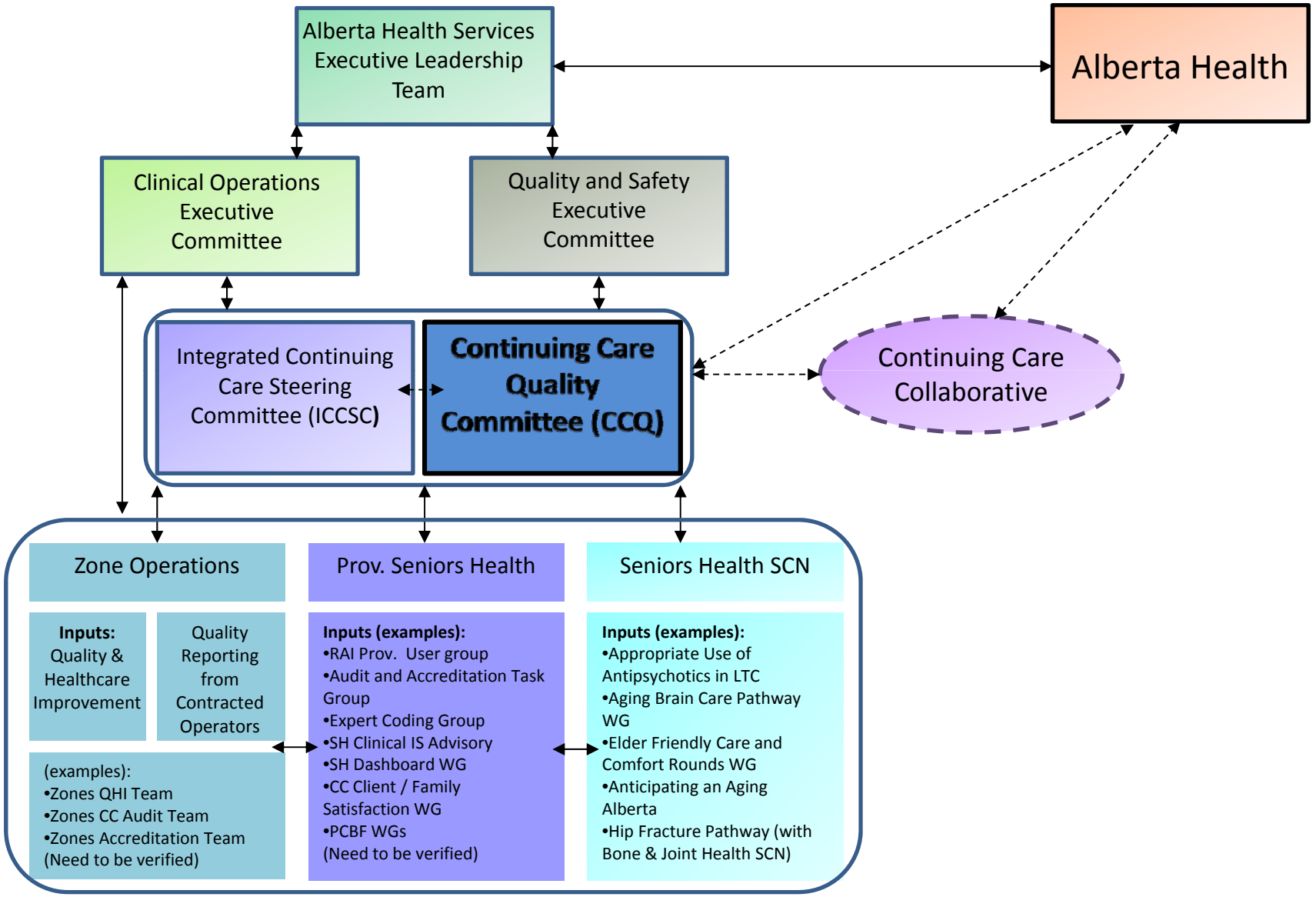
Quality Enablers	Required Actions to achieve Quality	Emerging Vision for Continuing Care Quality Management
Partnerships between patients, families and care teams	*Partner with patients, family members and care teams* in the design and delivery of healthcare services as well as those delivered to the applicable broader patient population. Include and honour the patient voice in care plans. Increase patient and community awareness of quality work. Reflect Just Culture principles in everyday behaviour.	The wellness paradigm underpins delivery of the continuing care system, focused on strengths, and maintain independence across the lifespan while upholding an individual(s) right to make decisions about themselves and their care (health, spiritual, cultural, social, economic). Services provided for individuals respect their preferences and values, addresses assessed unmet needs, and incorporates the support provided by their community. A culture of openness operates such that it is easy for others to see what actions are performed.
Governance and Accountability	Create, implement and evaluate a *quality governance and accountability* structure, oversight processes and policies.	Clear definition of roles and responsibilities identifies who needs to be responsible, accountable, consulted and/or informed (RACI). All levels of government, AHS and operators work proactively to advance quality and client / resident safety across the continuing care system in Alberta.
Staff and Medical Staff Engagement	Foster staff and medical staff *engagement*.	Collaborative practice is supported and acknowledged as the norm. Relationships are intentionally deliberately built. The Stakeholder voice is heard and acknowledged.. Issues and barriers are communicated and addressed in a collaborative and equitable manner.
Communication and Information Sharing	Ensure lines of responsibility and decision-making structures are clear and create avenues for two-way *communication* between leadership and providers. Be transparent and *communicate* effectively at the level your patient needs. *Share information*, lessons learned, recommendations, and successes from quality improvement activities.	Providers are comfortable with communication with their leaders around quality care, and leaders are accessible to discuss issues that may arise. Meaningful information (thoughts, ideas, feelings) is communicated with awareness of non-verbal messaging. Communication is consistent and coordinated, and with consideration of multiple modalities to be readily available, understandable and meaningful. Good communication is a natural consequence from the enablers of partnerships between clients /residents/families and care teams, staff and medical engagement, and collaboration.

Quality Enablers	Required Actions to achieve Quality	Emerging Vision for Continuing Care Quality Management
		Quality improvement is how we do business; we routinely share our quality success stories, and our lessons learned. Successes, changes, challenges, improvements, proposals, and resolutions are communicated through an open and transparent system-wide continuing care reporting system.
Capability and Capacity Building	Cultivate active participation and *build capacity* as well as *capability in quality and safety*. Undertake orientation and career-long education in quality and safety. Nurture development and delivery of improvement through a "bottom up" approach with "top down" support. Promote patient options for self-care and self-management.	At a minimum, all continuing care staff have access to AHS QHI Quality and Safety online educational opportunities. Individual clients /residents and their families are active participants in their care team built upon the wellness paradigm. Orientation for clients, residents and families when they enter into the continuing care system provides a better understanding of roles, responsibilities and expectations (e.g. client, resident, Case Manager, Facility Staff). Publicly available, easy to access way- finding tools and supports are readily available.
Collaboration	*Collaborate* and network within and across teams for innovative ideas. Foster inter-organizational & Inter-professional *collaborative practice*.	Inter-organizational collaborative practice, and inter-professional collaborative practice, and communities of practice support innovation and practice improvement.
Process improvement	Review and *improve processes*, revise / eliminate areas of inefficiency or waste. Facilitate implementation of shared improvement tools, such as AIW. Start small (e.g. PDSAs) and build on improvements. Ensure protected time for staff / teams to address quality improvement. Develop, implement and measure "always events" (events you should always get right) to optimize the patient's experience.	Consistent and standardized utilization of InterRAI suite of tools/ assessment system (i.e. RAI CA, HC, 2.0). Improvement tools are part of care planning processes (i.e. RAI, PDSA, AIW). Streamlined collaborative quality assurance process and outcome reports available by site, program, zone, and province (AHS) provide frontline staff, clients /residents and their families, operators, zones access to meaningful information on how the continuing care system is providing quality and safe care. Coordinated and consistent auditing provides valid, reliable, trustworthy performance and evaluation information.
Accreditation	Develop processes to ensure inclusion of accreditation status	Accreditation standards are seamlessly incorporated with CCHSS compliance.

Quality Enablers	Required Actions to achieve Quality	Emerging Vision for Continuing Care Quality Management
	and reporting measures; most specifically the *Required Operational Practices* (ROPs)	Clients/ Residents, families and frontline providers have available and easy access to review the Accreditation Canada Standards Public reporting.
Innovation	Establish structures and processes to spread successful *innovation* across the organization. Access / leverage existing tools and resources to connect to information and expertise.	Communities of practice support innovation and practice improvement. .
Information Technology and Access to Data	Use available *information technology and access to data* to build action plans and assess outcomes.	System performance measures are balanced and aligned with desired system outcomes. Correct level of data collection support desired reporting.
Leadership	Ensure *leadership* support is visible, frequently communicated and demonstrated. Integrate and coordinate organizational strategies and priorities at all levels. Establish criteria and clear roles to initiate and lead improvement activities.	Continuing care quality governance structure provides a platform of shared learning, creating cutting edge innovations and implementing best evidence informed practice throughout the continuing care system; focused on quality assurance and improvement.
Quality Assurance / Quality Controls	Know and address the top risk areas for your patient group(s). Be knowledgeable about how to prevent and/or resolve patient concerns. Support quality improvement teams and use of data and evidence to prioritize areas for improvement / build action plans / assess outcomes and report regularly. Transparently *measure*, monitor, and display the extent to which specific targets / benchmarks / goals and standards are achieved. Identify and manage risk within a systems approach. Report close calls, hazards, and adverse events and learn from	Expectations of continuing care are met or exceeded by individuals receiving care, their families, frontline caregivers, and the public, as evidenced by system satisfactionwith the delivery of continuing cares services. Continuing care quality assurance cycles are in place and continuous quality improvement is embedded within organizations, provided the knowledge, tools and awareness to identify risk at all levels of the organization and deal with risk that is present. A culture of quality is supported through accessibility of QHI (at a minimum) quality and safety educational opportunities to the continuing care operations.

Quality Enablers	Required Actions to achieve Quality	Emerging Vision for Continuing Care Quality Management
	them; review and learn from local / system-wide RLS reporting. Undertake detailed analysis of adverse events and/or close calls.	
Allocation of Resources	Align vision, goals, priorities, action plans, and allocation of resources.	As a publically funded health system, we are accountable for providing equitable and sustainable continuing care health services for all Albertans. Sustainable continuing care system that not only meets industry standards, but is recognized as a leading performer. System that is reactive to the changing demographics of individuals requiring continuing care services.
Recognition	Recognize achievements/celebrate successes and improvements.	Providers and organizations are celebrated for their approach to quality improvement and safety.

Continuing Care Quality Governance Structure



Continuing Care Quality Governance Structure

Quality and Safety Executive Committee

This AHS committee is a standing committee of the Alberta Health Services ("AHS") Executive Committee ("EC"). The purpose of the Quality and Patient Safety Executive Committee is to advance quality and safety on behalf of EC. The committee will consider and appropriately facilitate strategies and initiatives that will promote quality and patient safety as part of everyday life at AHS. This Committee will develop, review, support and approve evidence informed decisions related to patient safety and the quality, effectiveness and efficiency of care and clinical services on behalf of EC within established Delegation of Authority ("DOA") policies.
Alberta Health Services recognizes the importance of patient safety, quality care and effective and efficient clinical services. The President and Chief Executive Officer has overall responsibility for ensuring patient safety, quality care and effective and efficient clinical services. The Official Administrator, primarily through the Quality and Safety Committee, oversees the organization's quality, effectiveness and efficiency of clinical care and patient safety.
This Committee's areas of focus are: prioritizing, supporting and overseeing the implementation of strategies and initiatives that promote and ensure safe, quality care and effective and efficient clinical services; capacity building; quality improvement and assurance; sustaining quality and safety initiatives; special projects and foundational, infrastructure and maintenance initiatives as well as identification of appropriate innovations and trends to support organizational outcomes.

Continuing Care Quality Committee

This AHS committee is to provide coordinated and collaborative oversight to the monitoring and improvement of the quality of Continuing Care services in Alberta. The committee will be accountable for ensuring all quality improvement structures, processes and outcomes, including those related to safety of individuals receiving care and quality assurance, are necessary, sufficient and effective in achieving the *CCQ* mandate. The *CCQ* will provide a mechanism to share knowledge, learning, and build consensus in the development and implementation of the Continuing Care Quality Governance Structure and Quality Management Framework. Quality as defined by the Health Quality Council of Alberta Quality Matrix, including the six dimensions of quality.

Zone Quality and Healthcare Improvement Structures

North Zone | Edmonton Zone | Central Zone | Calgary Zone | South Zone

Additional statements to be determined by each zone (i.e. The zones quality and safety governance structure. The Zones governance structure to meet with contracted providers (long term care, supportive living and home care agencies). Client / Resident/ Family Councils /Communications)

Integrated Continuing Care Steering Committee

The ICCSC is responsible to ensure awareness and collaboration to advance quality and client/ resident safety with AHS and across the continuing care system in Alberta. This committee of the AHS Provincial Seniors Health – Community, Seniors, Addictions and Mental Health (CSAMH) leadership and zone seniors health medical directors and zone seniors health executive directors provides the venue to connect strategic planning to operations, and collaborate on developing and implementing the strategic direction. In doing so required actions are carried out within the Continuing Care System that will ensure successful delivery of quality services are accessible, equitable and sustainable. In doing so, the committee demonstrates respect for the needs, opinions and preference of the public, clients, residents, families and communities served. Chaired by the AHS CSAMH – Seniors Heath Executive Director.

Continuing Care Collaborative

This committee through consultation and input with CCQ ensure awareness and collaboration to advance quality and clients/resident safety across the continuing care system in Alberta. The CCC committee provides a forum for collaboration and development of joint solutions to current and emerging issues in the Continuing Care System; to help inform government policy. The membership of this committee includes: Alberta Health representatives, Vice President AHS Community, Seniors, Addictions and Mental Health and AHS medical leadership, and provincial association leadership of Alberta Continuing Care Association Representatives (ACCA), Alberta Senior Citizens' Housing Association (ASHCA) and Seniors Housing Society of Alberta Representative (SHSA).

Continuing Care Quality Committee

Terms of Reference

A. PURPOSE

The purpose of the *Continuing Care Quality Committee (CCQ)* is to ensure quality and safe care is provided through coordinated and collaborative oversight to the monitoring, improvement and operational delivery of the quality[1] Continuing Care services in Alberta.

The committee will be accountable for ensuring all quality assurance and improvement structures, processes and outcomes related to safe care and service[2] are necessary, sufficient and effective in achieving the CCQ mandate.

The CCQ will provide a mechanism to share knowledge, learning, and build consensus in the development, implementation, maturing of the Continuing Care Quality Management Framework, inclusive of the Continuing Care Quality Governance Structure.

B. SCOPE

1. Accountability

The CCQ reports to the *Alberta Health Services Quality and Safety Executive Committee (QSEC)* via the Provincial Medical Director, Seniors Health (Co-Chair), and Senior Program Officer, Quality Healthcare Improvement (Co-Chair).

2. Continuing Care Quality Mandate

The CCQ shall:

- Develop and recommend for approval, the implementation plan of the Continuing Care Quality Management Framework for Alberta Health Services (AHS) and contracted providers with the intent to simplify and streamline quality improvement activities, monitoring and reporting of Continuing Care services.
- Identify situations, internal or external to AHS that may influence or impact the safety of individuals[3] receiving continuing care services:
    - Identify, categorize and prioritize issues for improvement that impact quality of care and service or introduce risk within the continuing care system in Alberta,
    - Seek out, monitor and respond to quality and safety issues, and
    - Identify emerging knowledge and evidence, internal and external trends or innovations that may impact the quality of care and service.
- Inform and support the development and implementation of key strategies / initiatives that directly or indirectly influence the ability to successfully provide high quality safe care and service.
- Assess and inform the resourcing, infrastructure, processes and relationships required to facilitate continuous quality improvement in order to achieve desired outcomes. Including quality assurance, monitoring and auditing.
- Where appropriate, establish integrated working groups to achieve the mandate of the committee. Develop project plans (if applicable), action plans, track progress and evaluate results.

[1] Quality as defined by the Health Quality Council of Alberta Quality Matrix, including the six dimensions of Quality

[2] Safe care and service relates to individual(s) receiving publicly-funded continuing care healthcare and supportive services

[3] Individuals include patients, residents, clients and the individual's family or legal representative

- Provide at least quarterly reports to the QSEC that summarizes: key issues, risks identified, arising follow-up actions, and key quality indicator results for the previous quarter.

3. Relationships

To enable the mandate of this committee there needs to be a clear understanding of the governance and oversight role of Alberta Health and the services oversight role of AHS.

- **Alberta Health membership** will inform and provide consultation to ensure awareness and collaboration; strategic and directional policy; performance measurement and compliance assurance related to quality and safety of continuing care services.

This Committee also interacts with the following committees:

- **Integrated Continuing Care Steering Committee (ICCSC) –** Responsible to ensure awareness and collaboration to advance quality for individuals receiving continuing care services, safety within AHS and across the continuing care system in Alberta.
- **Continuing Care Collaborative Committee (CCCC) –** Consultation and input to ensure awareness and collaboration to advance quality and safety for individuals receiving continuing care services across the continuing care system in Alberta.
- **Seniors Health Strategic Clinical Network (SH SCN) Core Committee** – Input into the framework and ongoing maintenance of indicators and processes based evidence informed practice; and, liaise to promote dialogue regarding SCN (SH and other SCNs) priorities and initiatives that affect continuing care quality.

4. Governance Responsibilities

The CCQ shall review its Terms of Reference annually and recommend changes to the QSEC for approval.

C. MEMBERSHIP

Membership of AHS CCQ is comprised of the following representatives:

Public

- 2 Resident/Client/Family
- 2 Health Advisory Council member

Alberta Health Services

- Provincial Medical Director, Seniors Health, Community, Seniors, Addiction and Mental Health (CSAMH) (Co-Chair)
- Senior Program Officer, Quality Healthcare Improvement (Co-Chair)
- Executive Director, (CSAMH)
- 5 Zone representatives one from each zone as appointed by the 5 Zone SVP from:
    - Zone Executive Directors, Seniors Health (3), and
    - Zone Medical Directors (2), Seniors Health
- Senior Program Officer, Risk & Internal Controls, Contracting, Procurement & Supply Management
- Scientific Director Senior Health, Strategic Clinical Network (or designate)
- Senior Program Officer, Infection Prevention and Control
- Frontline clinician or staff member (designated by operations or SCN)

Alberta Health (4+ members)

- 2 Representatives from Standards, Licensing and Compliance Branch, Health System Accountability and Performance
- 2 Representatives from Continuing Care Branch, Health Services

Other Key Stakeholders

- 1 Representative from Capital Care or Carewest
- 1 Covenant Health Representative
- 2 Alberta Continuing Care Association Representatives (1 Home Care and 1 Congregate Living)
- 1 Alberta Senior Citizens' Housing Association Representative
- 1 Seniors Housing Society of Alberta Representative

Committee Support

- 1 Program Advisor, CSAMH
- Administrative Support, CSAMH

The CCQ may request the participation of ad-hoc members from time to time who provide expertise from their domain, division, or program (e.g. Finance; Capital Planning; Nutrition & Food Services and Linen & Environmental Service; Information System; Data Information Measurement and Reporting; Addictions and Mental Health; Primary Care)

1. Co-Chairs

The CCQ is Co-Chaired by the AHS *Provincial Medical Director, Seniors Health* and the AHS *Senior Program Officer, Quality Healthcare Improvement*.

2. Member Roles & Responsibilities of CCQ

1. Co-Chairs
   a) Jointly develop an agenda based on input from members,
   b) Alternate chairing meetings, and
   c) Provide at least quarterly reports to QSEC.

2. Administrative Support - provided by CSAMH
   a) Prepare and distribute the agenda,
   b) Record and maintain minutes,
   c) Distribute key messages from meeting for external communication,
   d) Submit the draft minutes to co-chairs for review prior to circulation, and
   e) Correct and circulate approved minutes.

3. Members
   a) Submit agenda items,
   b) Prepare for meetings, and
   c) Accept and complete delegated assignments.

Members of CCQ will be responsible to:

1. Share the perspective/opinions of their respective constituency, and
2. Communicate information and recommendations from the CCQ back to their organizations.

3. Delegates

If a Member of the CCQ is unable to attend a meeting they must identify a single consistent delegate to attend on their behalf to ensure that applicable discussions and decisions can be made at each meeting.

The delegate shall be authorized to make decisions on behalf of the absent member. All delegates require prior approval (via e-mail) by at least 1 Co-Chair.

4. Attendance
Member or delegate of CCQ are expected to participate in all meetings regardless of the initiatives under consideration.

D. MEETINGS

1. Transparency
The CCQ respects transparency of the decision making process. All agendas, meeting materials and minutes will be made available to Members of the AHS CCQ pending finalization of the material.

2. Frequency
The CCQ shall meet the 4th Thursday every month from 09:00 a.m. until 12:00 p.m. or at the call of at least 1 of the Co-Chairs.

3. Quorum
A majority of members will constitute a quorum.

4. Notice
Electronic notice of a meeting date at least 7 days where possible in advance of a meeting.

5. Report and Recommendations
The CCQ *will* report to QSEC via the Provincial Medical Director, Seniors Health, CSAMH (Co-Chair).

The Committee Co-Chairs shall provide at least quarterly regular updates to QSEC. Reporting will be in the form of:

a) key initiatives, issues, actions and decisions,
b) quarterly provincial quality report, and
c) meeting minutes approved by the Committee.

6. Committee Management
The designated CSAMH Program Advisor and Administrative Support shall be responsible for working with the Co-Chairs to develop the agenda and coordinate materials for the meetings.

7. Minutes
Minutes shall be recorded for all CCQ meetings by the CSAMH Administrative Support. Minutes for each meeting shall be approved by the Committee at their following meeting. Minutes will be shared with QSEC.

"Overview" for communication purposes will be developed for general circulation *through Continuing Care Collaborative Committee*, *Integrated Continuing Care Steering Committee, and Senior Health Strategic Clinical Network Core Committee.*

Minutes and *Overview* will be distributed to CCQ members within seven (7) business days following the each meeting.

8. Rules of Order

Unless otherwise noted in the Terms of Reference, CCQ business and conduct of the members shall follow Robert's Rules of Order and may be modified by the CCQ Co-Chairs.

Approval date: May 1, 2014 at QSEC
Amendments: June 5, 2014 at CCQ

- Updated titles for AHS CPSM, Alberta Health Representatives
- Additional member, Infection Prevention and Control

Provincial Continuing Care Reporting Framework

Developed by:
Anne Heinemeyer
Community, Seniors, Addictions, and Mental Health
Updated: April 23, 2014

PROVINCIAL CONTINUING CARE REPORTING FRAMEWORK

Purpose

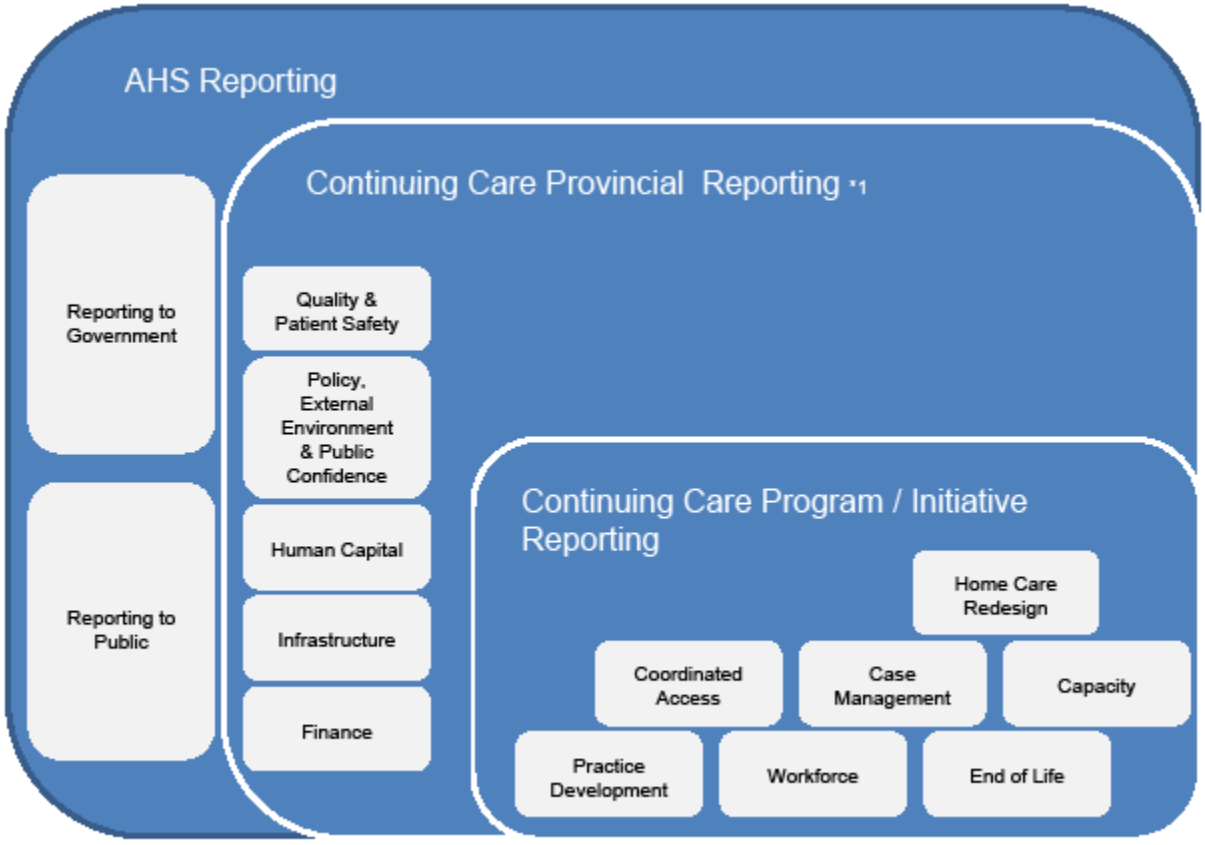
This Framework has been developed to identify the values, principles, processes and responsibilities that will enable robust and meaningful Alberta Health Services (AHS) Continuing Care measurement and reporting.

Goal for Continuing Care Reporting

> *Continuing Care measurement and reporting will support patient-focused and quality Continuing Care Health programs and services that are accessible and sustainable for all Albertans.*

Specifically, provincial Continuing Care should develop a measurement and reporting system in which

- Measurement and reporting expectations and processes are embedded into every initiative
- These initiative-specific measurement and reporting processes are incorporated into a provincial Continuing Care model that
    - supports prioritized and balanced measurement and reporting across initiatives
    - enables additional provincial Continuing Care measurements needed for broader AHS reporting



1 Category of Measuring Risk as defined in the AHS Enterprise Risk Management Framework 2014

Values

Continuing Care Reporting should reflect Alberta Health Services core values of:

- Respect
- Accountability
- Transparency
- Engagement
- Safety
- Learning
- Performance

Principles

The following principles should be the foundation of any measurement and reporting initiatives implemented within AHS Continuing Care:

Inform multiple stakeholders

Continuing Care measurement and reporting should support the information needs for key audiences and stakeholders including the following:

- Clients
- Members of the public / continuing care / seniors health organizations
- AHS zones
- AHS executive and senior leadership
- AHS front-line staff
- Other areas of AHS (Quality and Accreditation, CPSM, etc)
- Alberta Government including Alberta Health
- Contracted partners

Support strategic priorities

Continuing Care measurement and reporting should be aligned with strategic and operational priorities identified by

- zones
- provincial strategic units
- the Seniors Health Strategic Clinical Network
- AHS leadership and
- government

Measurement and reporting should be developed to both enhance understanding of the current state related to these priorities and help move programs, services and initiatives towards the desired future state.

Optimize performance

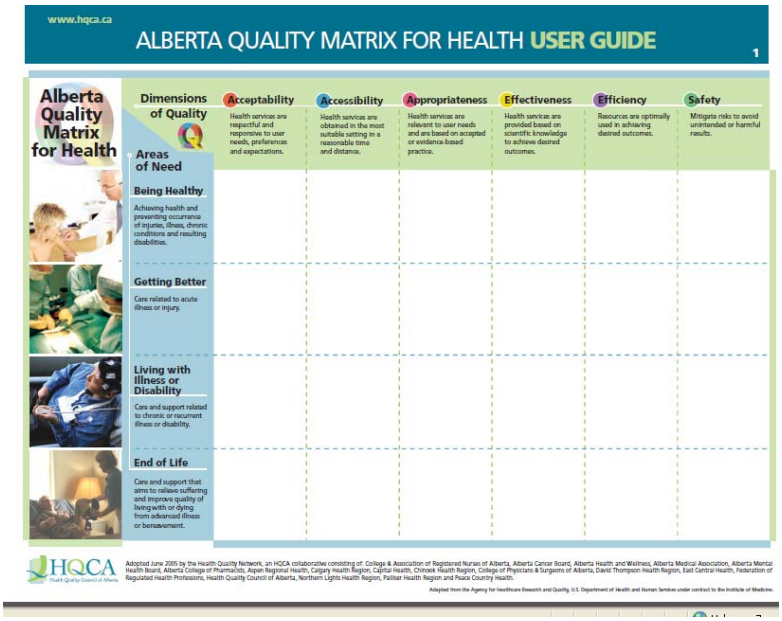
Measurement and reporting should focus on improving performance. One such model that can support this vision is the Institute for Healthcare Improvement's (IHI's) Triple Aim framework (IHI, 2014) that focuses on the following three dimensions:

- Improved patient experience
- Improved population health
- Reduced costs of health care

When possible, measurements should focus on those aspects of the health system for which Continuing Care is accountable and can effect change.

Ensure quality

Measurement and reporting should support quality care. Continuing Care should strive to balance measurement and reporting across multiple aspects of quality using a model such as the Alberta Quality Matrix of Health (2005).



Dimensions of quality

Accessibility: Health services are obtained in the most suitable setting in a reasonable time and distance.

Acceptability: Health services are respectful and responsive to user needs, preferences and expectations

Appropriateness: Health services are relevant to user needs and are based on accepted or evidence-based practice.

Effectiveness: Health services are provided based on scientific knowledge to achieve desired outcomes.

Efficiency: Resources are optimally used in achieving desired outcomes.

Safety: Mitigate risks to avoid unintended or harmful results.

Areas of need

Being healthy: Achieving health and preventing occurrence of injuries, illness, and 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.

(Health Quality Council of Alberta, 2005)

A related model that will also ensure balanced reporting across multiple aspects of quality is the Alberta Health System Measurement Framework:

Population Health						
Health Conditions	Human Function	Death	Health Behaviours	Living and Working Conditions	Personal Resources	Environmental Factors
Health Services Delivery						
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.	
Governance and Community Engagement						
Governance		Community Engagement		Accreditation		
Health System Sustainability						
Health Technologies	Health Workforce	Information Management/ Information Technology		Fiscal Efficiencies		

(Alberta Health and Alberta Health Services, 2013).

Reflect systematic thinking

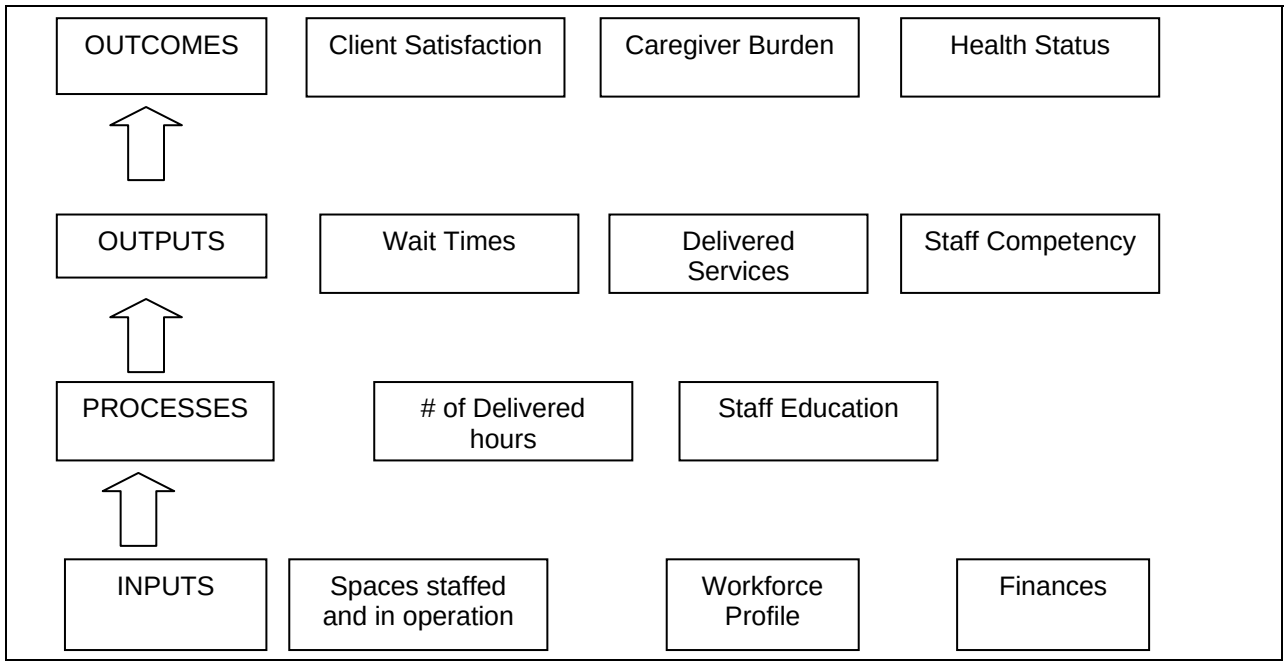
The ultimate focus of measurement should be on outcomes; however it is important to recognize that outcomes--or the relationship between programs/services and outcomes--cannot be fully understood without information about the context (e.g., determinants of health), inputs, processes, and outputs. Reporting should thus not be limited to outcome measurements but also include inputs, processes, outputs and outcomes when relevant.

Input: describes the type and amount of resources used to deliver programs or services.
Process: describes the activities and tasks undertaken to achieve program or service objectives.
Output: describes the results of processes that were completed to address program or service objectives.
Outcome: measure changes in health status or health determinant, which are attributed to health services and programs (the outputs) (provide information on progress towards desired results in key areas). Outcomes can be subdivided into

- Intervention outcomes: Direct results from services and programs. Can take 1-5 years to attain
- System Outcomes: Changes at the health system level. Dependent on achievement of Intervention outcomes. Can take up to5-20 years for results
- Population Outcomes: Changes in the population level related to health status. Dependent upon achievement of System Outcomes. Can take up to 20 years for realization

(Alberta Government, 2013; Alberta Health and Alberta Health Services, 2013).

Logic models are often used as tools to map out the causal relationships among inputs, processes, outputs and outcomes. Below is an example of a logic model incorporating Continuing Care measures.



Using a logic model to map out existing measures can help identify measurement gaps.

Present multiple perspectives

Measurement and reporting should be useful for all levels of the organization by including perspectives from the lowest (most granular) viewpoint needed for day to day decision making up to the highest (most aggregated) viewpoint required to measure outcomes and determine the performance of the entire health system. This concept is reflected in the following approach used to categorize measures:

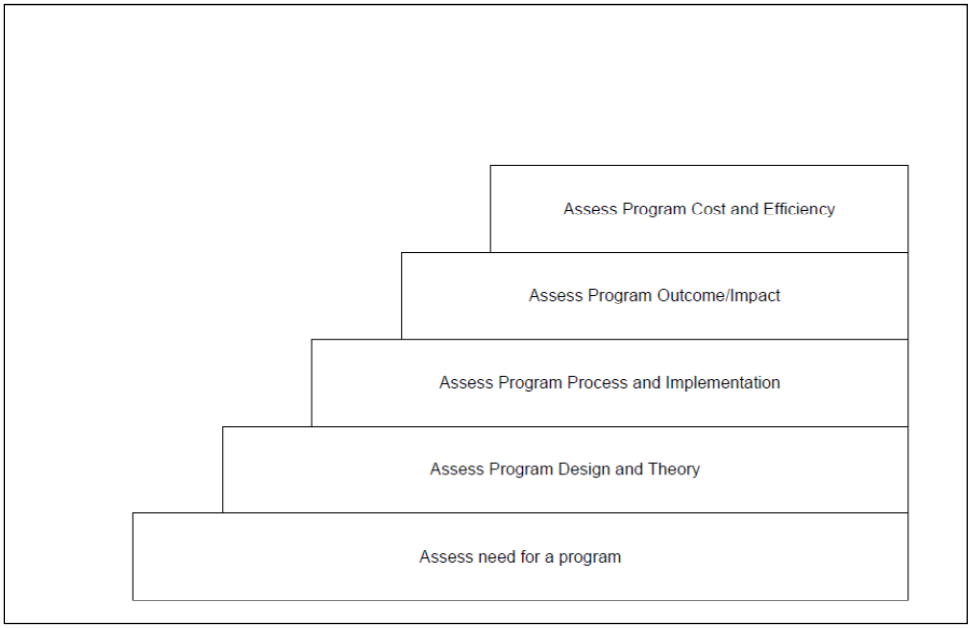
> Health system outcome: Measures used to assess health system performance from an outcomes perspective.
> Strategic: Measures performance of key priority areas requiring improvement so as to close the gap between current and targeted performance.
> Enabling strategic: Measures performance in a priority area of rising importance, but requires further development, understanding, and use before being approved as a strategic measure.
> Tactical: Informs on the performance of an operational area, or reflects the performance of key drivers of a strategic measure. Contributes to balanced performance monitoring and reporting within a performance domain at a tactical or operational level;
> Transactional: Measures program, practice, or organizational service delivery performance priorities at the site, clinical, or administrative level. Useful in setting performance expectations and monitoring performance at a local program, work unit or individual level. Provides a site, clinical, or administrative link to related strategic and tactical measures.
>
> (Alberta Health and Alberta Health Services, 2013)

Typically a program will have a limited number of outcome measures focused on top priorities. Many more tactical and transactional measures will be desired in order to support operational functions.

Make wise use of resources

Developing, maintaining, reporting and using measurements is labour intensive. It is vital to limit measurement resources to those that will be value added and actionable.

Choose measures wisely: Continuing Care services should choose measures and metrics that are consistent with the maturity of the program. Prior to implementation, programs may need to start with measures that identify the need for a program or confirm that the program design and theory are appropriate. Following the start of a program or service model, process and implementation measures may be applicable. Outcomes, impact, cost and efficiency measures are often not doable until a program is mature, and there has been sufficient time for the intervention/program being measured to result in change. It should be noted, however, that there may be a need to establish baseline measures in client status and program costs before the intervention is begun.



(Adapted from Rossi, Lipsey, and Freeman, 2004)

Use Benchmarks and Targets: Using benchmarks and targets can add value to measurement and reporting initiatives. Benchmarks are “evidence-based goals that express the amount of time that clinical evidence shows is appropriate to wait for a particular procedure or diagnostic test” (Postl, 2006).

For ongoing reporting, adopting indicators that have established national or international benchmarks will enable comparisons with other health systems

Sources for Benchmarks to consider:

- CIHI Quick stats
- Ontario benchmarks
  - http://www.hqontario.ca/Portals/0/Documents/pr/pr-ltc-benchmarking-resource-guide-en.pdf

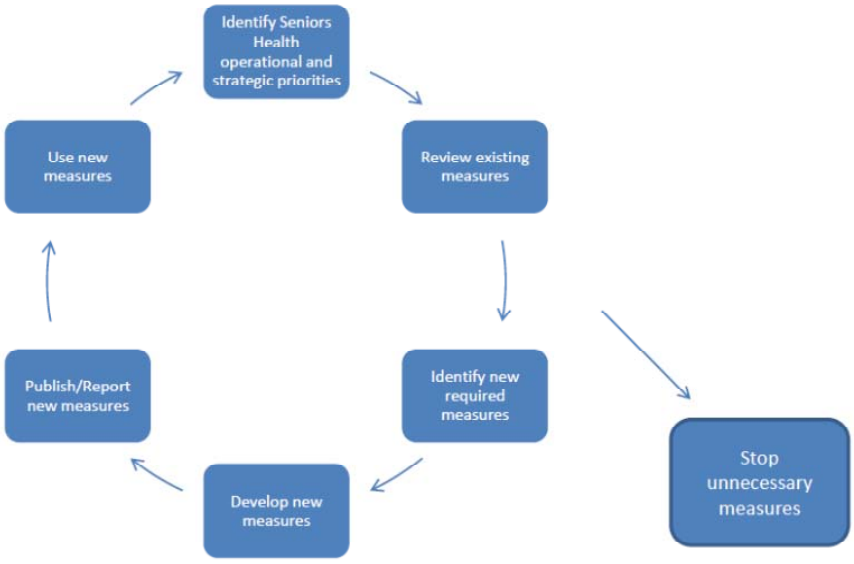
Targets refer to goals set by a jurisdiction to support achievement of benchmarks. Ideally, targets should be achievable yet challenging.

Capitalize on existing data: Continuing Care projects and programs should use existing data where available (e.g., CIHI, HQCA, HCAHPS, AHS Performance Report, other AHS dashboards etc.) rather than implementing new measurement or reporting processes.

Ensure comparability: Comparing measures and indicators across service areas and programs can only be achieved when definitions, documentation processes and data collection methods are standardized and consistent.

Remain current

Measurement and reporting processes across Continuing Care should be fluid i.e. pertinent to the current context. There should be processes in place to both add and delete performance measurements and reporting processes. Eliminating unnecessary indicators will free up resources for new measurement requirements that are needed for emerging priorities.



The next sections of this framework provide recommendations regarding processes for selecting, developing, publishing/reporting, and eliminating measures

Processes

Identifying Measures/Indicators

The selection of performance measures should be done by a group of stakeholders representing varying perspectives pertinent to the work, processes, programs, and/or projects needing to be measured.

The following steps can be used by the stakeholder group to establish new performance measures:

1. Identify the current strategic and operational priorities needing to be supported by robust measures.

2. Identify the measures, information, and reports currently available to support those priorities.

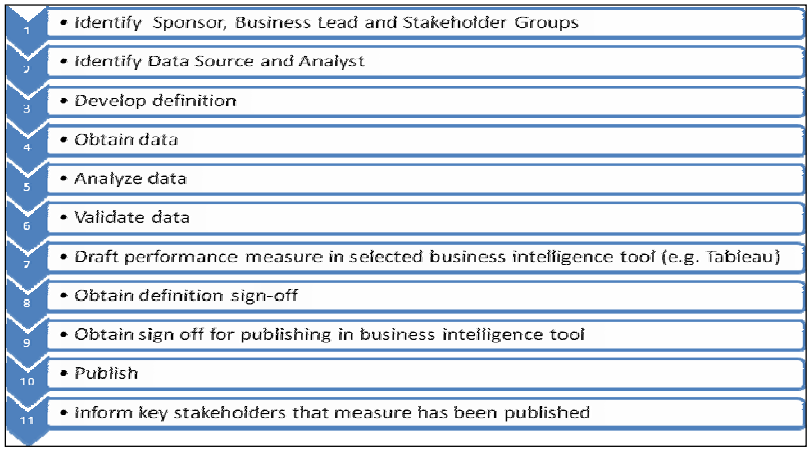
3. Brainstorm new measures required to drive these priorities forward.

4. Prioritize these potential (i.e. brainstormed) measures using criteria such as actionability and relevance to current strategic and operational priorities.

5. Establish which prioritized measures are most urgent (i.e. needed first)

Developing New Measures

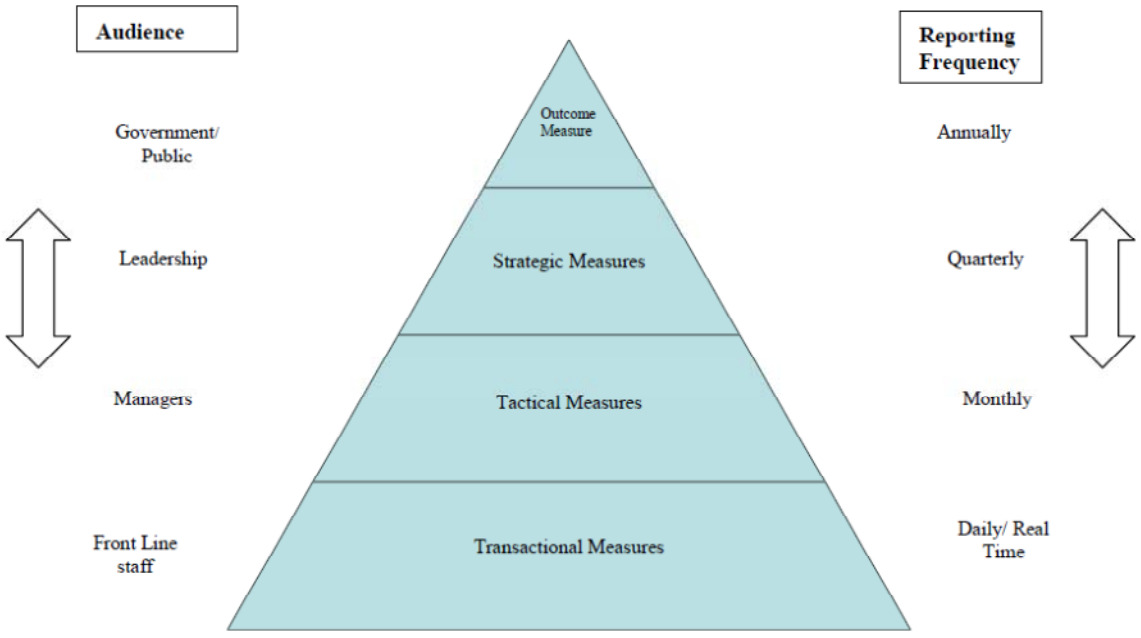
The process for developing robust measures requires several steps involving multiple parties. The following identifies the steps used by the Continuing Care Health Dashboard Working Group to develop a measure or group of related measures:



Publishing/ Reporting Measures

As measures are being developed, decisions need to be made about how to report them. The following are some guidelines related to publishing and reporting measures:

Match reporting to audience need: It is important to recognize that different audiences will have varied reporting requirements and that reporting content, frequency, method, and granularity should be adjusted to meet the audience's needs. Stakeholders such as the public, special interest groups, and the government will typically find that more aggregated and less frequent reporting will allow them to track trends and overarching performance. AHS management will need more frequent reporting (e.g., quarterly or monthly) with more detail to make operational decisions. Front line staff will require even frequent and immediate granular reporting to make care decisions.



(Adapted from Government of Alberta, 2013).

This may require reporting to come from multiple sources. Real time or more immediate transactional reporting needed for client care will typically come from the source clinical information systems, while more aggregate and less frequent outcome reporting may be pulled from repositories where the data has been cleaned.

Consider pushing vs. pulling reports: Some stakeholders may prefer have reports "pushed" to them while others may want to "pull" information. It is important that Continuing Care enable both options to best meet stakeholder need:

Push	Pull
Reports are sent to key stakeholders e.g. via email or snail mail	Stakeholders log onto site (e.g., Tableau or STATIT) and pull needed information
Does not allow self-serve: Same information is sent to all Stakeholders	Allows self-serve: Stakeholders can often customize (e.g., sort by level of aggregation, geographic area)
Stakeholder does not need to initiate request for information	Stakeholder needs to initiate request for information
Stakeholder must wait for information to be sent	Stakeholder can access information any time

One measure may be reported in many different ways and to different levels of detail depending on audience need. As an example, the following describes how waitlist data is currently being reported:

Measure: % of Clients admitted to a Continuing Care Living Option

Audience	Frequency	Level of Aggregation	Reporting method	Reporting Tool
Public	Annually	Province	• Push • Pull	• AHS Annual Report • Online AHS Performance Public Dashboard
Government	Quarterly	Zone	• Push	• Written Report (Alberta Health Quarterly CCLO Report)
Alberta Health Services Internal reporting	Monthly	Zone and living stream	• Push • Pull	• Written Report (CCLO Placed and Wait Times) • Tableau and STATIT dashboards

User-friendly formats: Regardless of the type of reporting format chosen, it is important that the report spreadsheet or dashboard be intuitive, user friendly and provide enough information to be decision-useful.

Eliminating Measures

It is recommended that any processes implemented to identify new measures should also include a review of existing measures and reporting to determine which can be eliminated or reported less frequently.

Responsibilities

Robust Continuing Care measurement and reporting processes require participation of multiple stakeholders and clearly outlined roles and responsibilities as detailed below:

Role	Responsibilities
Integrated Continuing Care Steering Committee (provincial and zone Seniors Health leadership)	• Assist in prioritizing new key measures for Continuing Care • Approve measures prior to AHS-wide publication
Continuing Care Quality Committee	• Interacts with Integrated Continuing Care Steering Committee in development, monitoring and reporting of the approved measures
Seniors Health, Community, Seniors, Addictions and Mental Health Executive Directors	• Sponsor key measures • Sign-off measure definitions
Community, Seniors, Addictions and Mental Health Director Informatics	• Coordinate measurement and reporting activities across Continuing Care initiatives • Liaise with DIMR related to analysis and publishing of measures • Liaise with Information Technology related to clinical documentation and reporting from source system
Seniors Health/QIPE Directors/Leads	• Ensure measurement and reporting functions are embedded into Continuing Care initiatives and projects
DIMR	• Provide analytic support
Information Technology	• Support input of clinical documentation that will support required measurements • Implement real time reporting out of source systems to support clinical decision-making • Implement transfer of data to AHS data repositories needed for aggregate reporting

Current State and Next steps

Since the inception of Alberta Health Services, there has been an increasing demand for information and provincial reporting related to Continuing Care. Responsibility for this reporting has been shared by multiple roles and teams. Some of the measurement development has been coordinated by the Continuing Care Dashboard Working Group, with additional measures being led by various members of Community, Seniors, Addictions and Mental Health and other AHS teams.

This diffused approach to measurement development has resulted in a siloed and fragmented system for Continuing Care provincial reporting

Recently a comprehensive inventory of current Continuing Care measures and reporting was initiated (March 28, 2014 Continuing Care Reporting Inventory). This inventory highlighted that:

- Many measures are available provincially related to Continuing Care
- These measures are not balanced across the dimensions of quality
- These measures are not balanced across health sectors
- Reporting is being done in a fragmented and siloed manner
- Some audiences are being underserved

The following are recommended next steps for Continuing Care reporting:

1. Validate the Continuing Care Reporting Framework with key AHS stakeholders
2. Validate the Continuing Care Reporting Inventory with key stakeholders
3. Distribute the Continuing Care Reporting Inventory to key AHS stakeholders
4. Develop a mechanism for updating the Continuing Care Reporting Inventory on an ongoing basis (e.g. annually)
5. Use the Continuing Care Reporting Inventory to identify measurement gaps and priorities
6. Use the Continuing Care Reporting Inventory to make a plan for a more cohesive approach to reporting Continuing Care measures
7. Establish a governance structure that will facilitate a cohesive measurement and reporting system for provincial Continuing Care

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