Rapid Review

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Healthcare Quality Councils: A Pan-Canadian Scan

A Rapid Review Prepared for The Canadian Foundation for Healthcare Improvement

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Correction to Milligan et al. (2018)

In the original published report "Healthcare Quality Councils: A Pan-Canadian Scan" there was an error in Table 1 and the fifth paragraph of the "Governance" subsection.

The first row of Table 1, "Saskatchewan" results were corrected under the "Legislated council" column to "Yes". The corresponding text in the fifth paragraph of the "Governance" subsection was updated accordingly.

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List of Abbreviations

BCPSQC	BC Patient Safety and Quality Council
CFHI	Canadian Foundation for Healthcare Improvement
CIHI	Canadian Institute for Health Information
CPSI	Canadian Patient Safety Institute
CSBE	*Commissaire à la santé et au bien-être,* or Health and Welfare Commissioner
HQCA	Health Quality Council of Alberta
HQO	Health Quality Ontario
INESSS	*Institut national d'excellence en santé et en services sociaux,* or National Institute of Excellence in Health and Social Services
MIPS	Manitoba Institute for Patient Safety
MOH	Ministry of Health
NBHC	New Brunswick Health Council
P/T	Provincial and territorial
QI	Quality improvement
SHQC	Saskatchewan Health Quality Council

Introduction and Background

The public sector in Canada arrived late to the quality improvement (QI) movement compared to the United States and United Kingdom. In 2002, both the Kirby and Romanow Reports called for greater accountability for quality of care (1,2). Following the Romanow Report's recommendation for a pan-Canadian council to regularly assess health system performance, including QI, the 2003 First Ministers' Accord on Health Care Renewal established the Health Council of Canada (3).

Fifteen years later, the Health Council of Canada is no longer operating[1] but five provincial quality councils have been established. In 2002, the Saskatchewan Health Quality Council (SHQC) was the first to be established, one year after Saskatchewan's Commission on Medicare recommended its creation as part of a larger effort to improve the quality and safety of the province's healthcare services (4). The second was the Health Quality Council of Alberta (HQCA) in 2006. The third and fourth quality councils – the BC Patient Safety and Quality Council (BCPSQC) and the New Brunswick Health Council (NBHC) – began operating in 2008. Health Quality Ontario, established in 2010, was the fifth such council.

Beyond the formal establishment of quality councils, the remaining provincial and territorial (P/T) governments have used other means to initiate QI in their respective jurisdictions. In addition, pan-Canadian organizations such as the Canadian Foundation for Healthcare Improvement (CFHI), the Canadian Institute for Health Information (CIHI), and the Canadian Patient Safety Institute (CPSI), have also played important roles in the Canadian healthcare quality landscape.

There is no shared definition of healthcare QI in Canada. Quality improvement has been described as a strategic philosophy or culture focused on systematically embedding quality into daily practice (5). The Institute of Medicine proposes six domains to measure and describe healthcare quality: effectiveness, efficiency, equity, patient-centeredness, safety, and timeliness (6). Despite proposed definitions for quality and QI in scholarly and management literature, there is inconsistency across Canada, with each P/T jurisdiction adopting different understandings of quality (7), and different approaches to QI.

Forging a common language and shared direction is necessary if Canada is to achieve equitable, quality healthcare for all its citizens. This is particularly relevant in today's era, marked by the United Nations Declaration on the Rights of Indigenous Peoples (8), the Truth and Reconciliation Commission's Calls to Action (9), and the health disparities that exist between Indigenous and non-Indigenous peoples living in Canada.

With this rapid review, we provide a broad understanding of quality councils and QI activities throughout Canada—their structural features, mandates, and roles. We also identify complementarities as well as suggest some potential opportunities for collaboration across jurisdictional lines.

[1] The Health Council of Canada ceased operations in 2014.

Methods

The scope of this rapid review is limited to the structural features, mandates, objectives, and functions of quality councils and other prominent organizations or units leading QI initiatives in Canada. This report is not, therefore, an exhaustive review of all the various partner organizations that contribute to healthcare QI across Canada, nor does it provide a comprehensive analysis of QI legislation or frameworks.

Data were collected through a review of academic and grey literature as well as key informant interviews. Academic literature was gathered through a search using medical subject headings and keywords in academic databases (Ovid MEDLINE, Embase Classic+Embase, CINAHL Plus with Full Text, and Scopus) and Google Scholar. An abbreviated search equation used during this rapid review was: (health*) AND (quality improvement OR quality of healthcare OR quality) AND (council OR governance) AND (Canada OR [P/T jurisdiction name]). Grey literature was gathered using the same keywords in Google Search. Documents in English and French were included or excluded based on the scope, as defined above. In addition, more targeted searches through quality council and government websites retrieved additional reports, legislation, frameworks, and other publicly accessible documents.

Requests for a 30-minute interview were sent to leaders within each of the five quality councils, as well as to leaders within government units or other organizations engaged in QI initiatives. Representatives from each P/T jurisdiction were invited to participate. From May 23-June 1, 2018, interviews were conducted with 12 key informants representing eight P/T jurisdictions. As a result of scheduling conflicts within this short time period, one jurisdiction provided a written response with input from several members of its team. Each of the five quality councils participated in this phase of the rapid review, as well as representatives from Manitoba, Newfoundland, Nova Scotia, and Yukon.

All data were aggregated and analyzed within two domains:

1. **Governance—**to identify how QI is governed across the P/T jurisdictions
2. **Core functions**—to understand the current depth and breadth of QI activities across the P/T jurisdictions.

A narrative synthesis of each of these domains is presented in the following section.

Analytic Overview

Here we present key findings and analysis organized within the domains of *governance* and *core functions.* Additional detail on each P/T jurisdiction is summarized in the appendix.

Governance

There is no single QI governance model in Canada. In this section, we describe how P/T jurisdictions vary by mandate and governance structures.

P/T business plans, legislation, and formal organizational mandates reflect different areas of focus in healthcare quality (Table 1), and different conceptualizations of QI. However, two dimensions of the Institute of Medicine's domains of healthcare quality (6)—*patient safety* and *patient-centered care*, or care that respects and responds to patient preferences, needs, and values—were common to all provincial and territorial QI efforts. P/T governments also articulate commitment to a number of other guiding concepts including: *sustainability,* the balance between the availability of resources and the healthcare system's ability to meet identified needs; *integrated healthcare,* describing the coordinated delivery of services; and *quality assurance,* seen as the maintenance of desired quality through service and outcome monitoring. However, there is inconsistency in the way these concepts are defined (if at all) and applied in practice across jurisdictions, as is detailed below.

Dissimilar mandates and a lack of common definitions related to QI make comparison across P/T jurisdictions challenging. Despite these differences, most of our informants suggested that ensuring citizen, patient, and family voices are heard is a critical aspect of the governance of quality healthcare and QI. Each P/T jurisdiction[2] engages the public through means such as public events, patient and family advisory boards, regional councils, or formal partnerships with vulnerable communities.

Provincial and territorial governments have placed responsibility for QI with different agencies or various levels of government, which we refer to as the "jurisdictional leads" in healthcare QI. Publicly constituted provincial quality councils are the jurisdictional leads in Alberta, British Columbia, New Brunswick, Ontario, and Saskatchewan. The councils in Alberta and Saskatchewan are accountable to their respective provincial legislatures, unlike the other three, which are accountable to their respective ministries of health. The other provinces and territories have integrated QI and jurisdictional lead responsibility to varying degrees within their ministries of health, health authorities, and healthcare systems.

The influence of legislation may warrant closer examination. All P/T jurisdictions have legislation in relevant areas such as patient safety, protection of privacy of personal information, and review of adverse events, but QI is rarely mentioned explicitly. In Alberta, Ontario, Saskatchewan, and New Brunswick, the provincial governments enacted legislation to create their quality councils. In Ontario, this legislation (the *Excellent Care for All Act* of 2010) has been described as the impetus behind a system-wide cultural shift toward integrating QI into daily practice at all organizations that deliver healthcare services—with Health Quality Ontario (HQO) leading the charge (3). In this case, legislation may have enabled the implementation of a comprehensive quality mandate. Conversely, our informants from Alberta and New Brunswick cited legislation as the reason for a more limited scope. Our informants from British Columbia—

[2] Newfoundland and Labrador anticipate the establishment of a provincial patient safety and quality advisory committee in 2018.

whose council is not legislated—spoke favourably about their organizations' potential to adapt and respond to changing needs.

Table 1: QI mandates and governance by jurisdiction

	Mandate focus	Quality council	Legislated council	Governance
Alberta	High quality, stable, accountable, and sustainable healthcare	Yes	Yes	Legislature
British Columbia	Quality and sustainable services	Yes	No	MOH
New Brunswick	Sustainable healthcare	Yes	Yes	MOH
Ontario	Patient-centered, integrated, and sustainable healthcare	Yes	Yes	MOH
Saskatchewan	Best care, experience, and health	Yes	Yes	Legislature
Manitoba	Quality and patient safety	No	N/A	MOH
Newfoundland	Quality assurance and patient safety	No	N/A	MOH
Northwest Territories	Quality, safety, client experience	No	N/A	MOH
Nova Scotia	QI, safety, patient relations	No	N/A	MOH
Nunavut	Excellent healthcare	No	N/A	MOH
Prince Edward Island	Safety, patient/family-centered care, engagement	No	N/A	MOH
Québec	Integrated quality services	No	N/A	MOH
Yukon	Integrated quality services	No	N/A	MOH

MOH = ministry or department of health

Manitoba is unique in having an independent, non-government body with a provincial mandate related to QI. The Manitoba Institute for Patient Safety (MIPS), a non-profit charitable corporation, is nearly fully funded through a service agreement with Manitoba's Department of Health, Seniors, and Active Living. It was established in 2004 to initiate, coordinate, and advise on patient safety, a component of quality care. This rapid review considers the MIPS as its province's jurisdictional lead.

In Québec, the situation recently changed. From 2006 through 2017, Québec had a government-appointed Health and Welfare Commissioner (*Commissaire à la santé et au bien-être*, CSBE) who, together with a small support team, operated similarly to the quality councils profiled here. In 2016, the Québec government announced a decision to cease all activities of the CSBE's office (10), which closed in December 2017. The CSBE's functions were then reassigned to a new jurisdictional lead, the National Institute of Excellence in Health and Social Services (*Institut national d'excellence en santé et en services sociaux,* INESSS), a government agency which, based on the findings of this rapid review, appears to engage in QI initiatives only as they relate to technologies for health and social services. How jurisdictional mandates are interpreted and put into practice is described in the next section.

Core Functions

The types and depth of QI activities implemented within each province and territory vary considerably in practice. In exercising their core functions, some jurisdictional leads fall short in fulfilling their P/T mandates, while others exceed them. As shown in Table 2, we have compared each jurisdictional lead across seven core QI functions, and rated them on a scale of *low*, *medium*, and *high*.

1. **Monitoring and evaluation** is a process to oversee and contribute to performance, including healthcare quality, effectiveness, and patient outcomes. We consider monitoring to be the measurement of progress over time, whereas evaluation includes an assessment of merit for a given design, process, or result. Considering monitoring an integral component of evaluation, only jurisdictional leads that fully engaged in both monitoring and evaluation received a rating of *high*.
2. **Public reporting** is defined as the dissemination of information about the healthcare system, including monitoring or evaluation data, to inform public understanding of healthcare quality and QI. Ratings (*low*, *medium*, or *high*) are commensurate with the regularity and completeness of their reporting. Only jurisdictional leads that report on an annual basis (at minimum) and cover a comprehensive range of service areas and dimensions of quality received a rating of *high*.
3. **Capacity building** involves the development of QI skills and competencies among healthcare providers, administrators, and other actors within the healthcare system. Capacity building in non-QI areas was not considered. *High* ratings were given where jurisdictional leads provide numerous opportunities for learning, and support for these opportunities is sustained over time.
4. **Quality standard setting** relates to the establishment of quality standards for the provision of healthcare. A *high* rating indicates that the jurisdictional lead actively produces new standards for application throughout the province or territory.
5. **QI initiative implementation** refers to QI interventions specifically designed for improvement that are directly informed by QI philosophy and methodologies. Jurisdictional leads received a rating of *high* for being intimately involved, in partnership with healthcare service providers, in the rollout of QI initiatives that influenced the healthcare system.
6. **Spread and scale-up of innovations** involves facilitating the expanded use of an innovation so as to reach and benefit a larger number of people. A *high* rating indicates that the jurisdictional lead maintains an extensive sphere of influence and invests significant resources into spreading and scaling-up innovations throughout this sphere of influence.
7. **Policy analyses** involve reporting and discussing how system structures and policy leavers are used and could be adapted to enhance performance of healthcare quality. A *high* rating reflects policy analysis that considers jurisdictional system structures and policy leavers, and a *low* rating reflects policy analysis that focuses only on organizational structures.

Table 2: Core QI functions by jurisdictional lead

	Monitoring & evaluation	Public reporting	Capacity building	Quality standard setting	QI initiative implementation	Spread & scale-up of innovations	Policy analyses
Alberta	Med	High	High	Low	None	Low	None
British Columbia	None	None	High	Low	High	Low	None
New Brunswick	High	High	None	None	None	Low	None
Ontario	High	High	High	High	High	High	Med
Saskatchewan	High	Med	High	Low	High	Med	Low
Manitoba	None	Low	Low	None	None	Low	Low
Newfoundland	Med	Low	Low	None	Med	Low	Low
Northwest Territories	Med	Low	Low	Low	Med	Med	*
Nova Scotia	Med	Med	Low	None	Med	Low	None
Nunavut	Low	Low	Low	*	Low	Med	*
Prince Edward Island	Med	Low	Low	Low	Med	Med	Low
Québec	Low	Low	Low	Low	Low	Low	*
Yukon	Med	Low	Low	None	Low	Low	None

Med = Medium
* *Rapid review results inconclusive*

Monitoring and evaluation

In Manitoba, the MIPS does not have capacity to monitor or evaluate on behalf of the provincial system, and in British Columbia, the BCPSQC leaves all monitoring and evaluation to the responsible unit within the Ministry of Health. The INESSS in Québec engages in some monitoring and evaluation, but with a focus on health and social services technologies. The Nunavut Department of Health recently developed capacity to track deliverables across strategies, plans, and programs, which allows it to begin monitoring progress in implementing work plans and recommendations from external reviews. Other jurisdictional leads engage in regular monitoring, which is the core QI function taken up to the greatest extent. Evaluation, on the other hand, is conducted on an irregular, ad hoc basis, except in New Brunswick, Ontario, and Saskatchewan, whose quality councils conduct regular evaluations of system performance.

Public reporting

In Alberta, the HQCA monitors and reports within various strategic priority areas such as primary care, continuing care, emergency care, and patient satisfaction. The HQO in Ontario reports on a large number of indicators across many health sectors and dimensions of quality, and produces an annual report, *Measuring Up.* In New Brunswick, the NBHC has adopted a population health model grounded in the social determinants of health (11), thus extending its data collection and reporting beyond the health sector to a range of government departments whose programs and activities influence citizen health and wellness. Apart from these three examples, very few jurisdictions produce regular, comprehensive reports on healthcare system performance. The BCPSQC in British Columbia leaves public reporting to the unit within the Ministry of Health responsible for monitoring and evaluation.

Capacity building

One of the strongest themes to emerge during this rapid review pertains to the variability of QI knowledge and skills throughout Canadian health systems, and thus a need for capacity building. Many informants stated that a crucial first step towards embedding QI into daily practice required basic QI training to enhance knowledge and awareness of quality needs and QI methodologies. At present, QI knowledge and skills are concentrated within the quality councils in Alberta, British Columbia, New Brunswick, Ontario, and Saskatchewan. Though New Brunswick's NBHC considers capacity building outside its purview, the four other councils provide a range of QI capacity-building opportunities, from one-hour seminars to partnering with universities to offer training programs implemented over several months. By contrast, other jurisdictions initiate an assortment of capacity-building activities when resources allow, but these may be sporadic and unlikely to reach all staff. Yukon Health and Social Services and the BCPSQC are currently exploring a formal partnership to give Yukon personnel access to training in British Columbia. In the view of many of our informants, the BCPSQC is seen to have been particularly successful in its mentorship approach to capacity building throughout the province.

Setting quality standards

While most quality councils perceive quality standard setting as the role of ministries of health, the HQO is the only one that sets quality standards to a high extent. In other jurisdictions, though ministries of health may establish clinical practice guidelines, there is nonetheless reliance on national bodies such as Accreditation Canada for quality standards.

QI initiative implementation

The quality councils in British Columbia, Ontario, and Saskatchewan have been given ratings of *high* in their implementation of QI initiatives. The councils in Alberta and New Brunswick and MIPS in Manitoba do not implement QI initiatives. Other P/T jurisdictional leads tend to implement QI initiatives in a piecemeal fashion and when fiscal and human resources allow. Our informants underlined the importance of allowing front-line healthcare providers to assume leadership roles in all QI initiatives. During Saskatchewan's recent rollout of Lean reforms across the entire healthcare system, the SHQC standardized and coordinated Lean training, events, and planning throughout the province (12). Healthcare system actors, namely nurses and physicians, initially resisted these reforms due to a perceived top-down approach (13).

Spread and scale-up

The ability of P/T jurisdictions to identify, spread, and scale up innovations depends on resources and external support, especially in small jurisdictions. Numerous informants in this rapid review stressed the need for pan-Canadian and intra-jurisdictional networks to facilitate spread and scale-up of innovations. Despite having only recently instituted frameworks to monitor performance management and patient safety, the Nunavut Department of Health recently engaged external partners to support innovations, including eConsult to improve access to specialist care (14) and recent electronic health record upgrades that place Nunavut second in the country behind Northwest Territories in terms of jurisdictional e-health coverage (15). Certainly, significant investment is required for spread and scale-up of innovations throughout a jurisdiction. All quality councils identify innovations but differ in the extent to which they get involved in their spread and scale-up. The HQO appears to be involved in the spread and scale-up to the greatest extent. For example, it is co-lead on a program that funds proposals for high-impact interventions to improve patient outcomes and quality of healthcare.

Policy analyses

None of the P/T jurisdictions assess how policy leavers and system structures affect healthcare quality or how they can be used to improve healthcare quality to a high extent. Ontario has been given a rating of medium since the HQO advises Ontario's Ministry of Health on policy as it pertains to all aspects of provincial healthcare system quality, such as modernizing legislation and regulations linked to quality and frequently reports on health systems and structures related to its QI initiatives. The SHQC in Saskatchewan was active in preparing similar policy analyses when it was first established but has reduced these activities in the last several years. Like Saskatchewan, Newfoundland and Labrador, Manitoba, and Prince Edward Island have received low ratings for their policy analysis activity as they assess mainly organizational structures and monitor policy implementation activities. The MIPS in Manitoba and the Department of Health and Community Services in Newfoundland and Labrador have occasionally conducted policy analyses related to patient safety. Health PEI has a role in monitoring the implementation of policy such as the Family Presence Policy that aims to improve patient- and family-centered care by removing formal visiting hours.

Conclusion

Around the world, clearly stated QI strategies are a feature of countries with high quality healthcare (16). To date, no pan-Canadian strategy has emerged. Many P/T jurisdictions have incorporated QI approaches into their Ministry of Health business plans or set QI-related goals within their health service authorities. P/T governments share similar aspirations, in particular that of achieving better healthcare quality. In addition, some provincial governments have invested heavily in QI efforts and expressed a desire for knowledge exchange and collaboration with other P/T governments. However, this desire is hampered by a lack of common definitions, data, and an organizational venue for knowledge exchange, structured comparison and collaboration on key QI initiatives.

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Appendix A: Health Quality Councils in Canada

Health Quality Council of Alberta

www.hqca.ca
2016-2017 total expenditures: $7.75 million[3]

Structural features

The Health Quality Council of Alberta (HQCA) was established in 2006 and continues as a corporation under the 2012 *Health Quality Council of Alberta Act.* With a mandate to monitor, measure, and survey the health system, the HQCA is at arm's length from Alberta Health, and directly accountable to the provincial legislature. In this way, the council serves a check and balance function in the Alberta health system.

The HQCA collaborates with Alberta Health, Alberta Health Services, and other stakeholders to guide health service quality and patient safety across the provincial health system. Governed by an independent board of directors, the HQCA embeds a citizen, patient, and family perspective through its Patient and Family Advisory Committee, and is supported in knowledge translation by the Health Quality Network.

Mission and objectives

One of four anticipated outcomes outlined in Alberta Health's 2018-2021 business plan is a *high quality, stable, accountable,* and *sustainable* health system.[4] The HQCA commits to contributing to this mandate through collaboration, innovative approaches to measuring and monitoring performance, identifying improvement opportunities, and supporting improvement initiatives. The *Health Quality Council of Alberta Act* outlines additional responsibilities, including surveying patient experience and satisfaction, appointing panels for public inquiries related to the health system, and making recommendations for system improvement.

These responsibilities are arranged within four strategic areas of focus: build capacity, monitor the health system, measure to improve, and engage the public.[5] The HQCA work is further organized through the Alberta Quality Matrix for Health, a simple tool that helps the public, patients, providers, and organizations to visualize the various intersections between dimensions of quality focused on patient experience and different health service categories.[6] For example, following the integration of 12 separate

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[3] Health Quality Council of Alberta. (2017). *HQCA Annual Report 2016-17*. Retrieved from https://d10k7k7mywg42z.cloudfront.net/assets/59e659fd23f8125fcf013430/2016_17_HQCA_Annual_Report_FINAL_Online_Copy.pdf
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[6] Alberta Quality Matrix. (2018). Retrieved from http://hqca.ca/about/how-we-work/the-alberta-quality-matrix-for-health-1/

health service delivery organizations into Alberta Health Services in 2009, this matrix was used to facilitate QI discussions.[7]

Table A1: QI functions of HQCA at a glance

Monitoring and evaluation	The HQCA measures, monitors, and reports within various strategic priority areas within the health system such as primary care, continuing care, and emergency departments. The council surveys patient satisfaction, access, and other experiences, making the patient perspective available to policy and service delivery decision makers. Where possible, performance trends over time are also measured to contribute to system-level performance reporting and indicator development, population-level surveys, and monitoring and reporting of clinical standards. Findings are shared with the public, healthcare providers, professionals, and policymakers.
Building capacity	In partnership with the University of Calgary, the HQCA builds healthcare provider capacity through the Centre for Collaborative Learning and Education, a quality and safety education program. The council collaborates with Alberta Health Services on initiatives such as communications skills training to support positive relationships between patients and their healthcare providers. The HQCA also publishes checklists, toolkits, and frameworks that may be used as capacity-building tools.
Setting quality standards	The HQCA does not develop quality standards though it may contribute to the process, which is led by Alberta Health.
Implementing QI initiatives	The HQCA does not implement QI initiatives. Its role is focused on informing such initiatives through monitoring, measuring, and reporting.
Identifying innovations in care provision and participating in spread and scale-up	The HQCA identifies innovations in care provision. The HQCA has a legislated mandate to identify effective practices in patient safety and health service quality.
Conduct policy analyses	The HQCA does not conduct policy analyses.
Public inquiries and reviews	The Alberta legislature requests the HQCA to appoint panels for public inquiries related to events or issues within the health system that may need addressing.

Informant opinion

The HQCA does not engage in work that falls outside its legislated mandate. As the only QI body in Alberta with a provincial perspective, it allocates resources to fill the most pressing quality gaps identified at the system level, while community-level quality gaps are considered outside the HQCA purview. Our informant suggested that the agencies best positioned to lead initiatives are those that operate on equivalent levels of QI leadership. In other words, local organizations are best positioned to meet local needs, provincial organizations should address provincial needs, and pan-Canadian organizations should focus on meeting needs from a national perspective.

[7] Cowell, J., & Harvie, M. (2012). HQCA: Building a credible, transparent, and independent healthcare quality and safety organization in Alberta. *Healthcare Management Forum* (Vol. 25, pp. 185–187).

Our informant indicated that despite significant opportunities to strengthen and expand the field of QI in Alberta, there is still room for improvement, particularly with regard to strategy and target setting. Our informant added that this lack of direction is felt even more acutely at the national level, citing the varied mandates among the quality councils that exist across the country. There is an opportunity for a pan-Canadian organization such as the CFHI to identify priority areas, set standards and guidelines, and put health service quality in a national context. Shared definitions and standards of quality care are seen as essential to reduce the variation and duplication that exists nationally and within P/T jurisdictions. In turn, enhanced clarity and coordination may assist the spread and scale-up of quality initiatives and innovations.

BC Patient Safety and Quality Council

www.bcpsqc.ca
2016-2017 operating budget: $5.7 million[8]

Structural features

In 2008, the British Columbia Ministry of Health established the BC Patient Safety and Quality Council (BCPSQC) in response to a need for a single organization to coordinate patient safety and QI within the province. An arm's length organization accountable to the minister of health, the BCPSQC collaborates with regional health authorities, patients, and others working within the health system to promote and inform patient-centered quality across the province. The minister of health appoints seven council members including the chair. Two ex-officio members—a senior Ministry of Health representative and the University of British Columbia Academic Chair for Patient Safety—bring the total number of council members to nine. The chair is responsible for hiring a chief executive officer, who hires and manages the operational team.

The BCPSQC prepares and submits its multi-year strategic plan and annual operating plans with input from ministry staff before receiving approval from the minister. These plans align with strategic government priorities and may also indicate other areas of priority for healthcare quality. The council provides the minister with advice both solicited and unsolicited, and responds to other requests from the minster as they arise.

Mission and objectives

In 2014, the ministry set the strategic direction for the provincial healthcare system to achieve *quality* and *sustainable* service delivery.[9] Within this formal mandate, the BCPSQC works on four strategic priorities: provide system-wide leadership on quality in collaboration with stakeholders; engage patients, caregivers, and the public as partners; build capacity in healthcare system transformation and improvement; and support improvements in quality of care.[10] The council aims to bring a provincial perspective to patient safety and QI in a manner that is transparent and accountable to patients and the public.

[8] BC Patient Safety and Quality Council. (2017). *How Are We Getting There? 2016/17 Annual Report*. Retrieved from https://bcpsqc.ca/wp-content/uploads/2018/02/AccRep_2017_newmargins_smallsingle.pdf

[9] Setting Priorities for the B.C. Health System [Internet]. British Columbia Ministry of Health; 2014 Feb. Available from: http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf

[10] BC Patient Safety and Quality Council. (2017). *How Are We Getting There? 2016/17 Annual Report*. Retrieved from https://bcpsqc.ca/wp-content/uploads/2018/02/AccRep_2017_newmargins_smallsingle.pdf

Table A2: QI functions of BCPSQC at a glance

Monitoring and evaluation	The BCPSQC does not have a role in monitoring system performance. The Ministry of Health manages a separate monitoring framework and may periodically request the BCPSQC to advise on the monitoring of QI. The council is interested in expanding into analytics as a means to identify variation within the province as well as areas for improvement
Building capacity	The BCPSQC offers training and education opportunities that range from one-hour webinars to intensive professional development programs over several months. Notable learning opportunities include a 13-week series for communication and teamwork skills development; the Quality Academy, a project-based, professionally mentored program; and, in partnership with the First Nations Health Authority, there is emerging work to promote cultural safety, cultural humility, and an Indigenous lens onto understanding quality. A mentorship approach, wherein the BCPSQC advises or trains health system actors on QI initiatives as they are rolled out, is considered crucial to promoting change toward a mindset of safety and quality as being integral to daily practice. Rather than acting as external consultants, the council attempts to embed QI skill development in most stakeholder interactions. The Health Quality Network, composed of members from health authorities, academic institutions, the Ministry of Health, and other interested organizations, has created additional opportunities to promote quality as a daily practice and thinking "like a system."[11]
Setting quality standards	The BCPSQC does not set provincial quality standards. It does provide input into the development of provincial clinical practice guidelines on an as-needed basis.
Implementing QI initiatives	The BCPSQC leads and supports initiatives to improve quality of care in numerous clinical areas, in partnership with those who deliver health services as well as patients and families. These initiatives range from large-scale provincial clinical improvement programs to collaboratives and communities of practice.
Identifying innovations in care provision and participating in spread and scale-up	The BCPSQC identifies and spreads awareness of innovations but typically does not have capacity to purposely engage in their spread or scale-up, particularly if those innovations fall outside provincial priorities or Accreditation Canada standards
Conduct policy analyses	The BCPSQ does not conduct policy analyses. However, it does prepare policy advice and responds to related requests from the Ministry of Health.

Informant opinion

It appears that the BCPSQC has been fundamental to instilling a sense of ownership of QI within the British Columbia health system. The BCPSQC believes in a community-development approach to embed capacity and leadership at all levels until all core components of QI are considered inherent to health service delivery. With this in mind, our informant underlined that enforcement should not play into the quality council role; rather, this should rest with the Ministry of Health.

[11] Krause, C., & Cochrane, D. (2012). BC Patient Safety & Quality Council: Using Network and Social Movement Theory to Improve Healthcare. *Healthcare Management Forum*, *25*(4), 181–184.

Our informant also suggested that current gaps in quality of care in British Columbia do not necessarily indicate gaps in QI, and that the council may be approaching a juncture where, having ably strengthened capacity across the provincial system, the BCPSQC must reconsider its value proposition in a changing environment. For this reason, the BCPSQC makes an effort to anticipate what is next in QI, and prepare provincial system actors to move forward.

Nationally, a comparable opportunity may exist for the CFHI. Sustainability is challenged when, within the bounds of current funding, grants are awarded in the absence of coaching and mentorship to encourage QI as an intrinsic component of such work. As a leader with a national system perspective, the CFHI can continue to play a role in this regard while facilitating more purposeful collaboration between P/T jurisdictions. A network approach—wherein local and regional networks are preserved and have a voice provincially and nationally—may facilitate engagement and the spread of ideas or innovations across all levels.

New Brunswick Health Council

www.nbhc.ca
2016-2017 total expenditures: $1.97 million[12]

Structural features

In 2008, New Brunswick embarked on significant health system reform characterized by the move from eight regional health authorities to two. At that time, two new public bodies were created: a shared services agency that has since been integrated into a larger provincial government-wide service; and the New Brunswick Health Council (NBHC), an arm's length organization with a dual mandate to engage with citizens and patients and incorporate their experience into health system decision making, as well as to measure, monitor, and report on health system performance. The objectives of the council are mandated under the *New Brunswick Health Council Act*.

Twelve members representing health professionals, managers, academia, public policy, and community sit on the NBHC, which hires its own chair. The Government of New Brunswick hires the chief executive officer of the NBHC operational team. The NBHC annual work plan is developed in consultation with the minister of health and regional health authorities, and approved by the minister. The council does not develop or implement health QI programs or policies.

Mission and objectives

New Brunswick's 2013-2018 provincial health plan provides a framework for building a sustainable healthcare system.[13] Within this mandate, the NBHC aims to promote transparency, engagement, and accountability by: engaging citizens in meaningful dialogue; measuring, monitoring, and evaluating population health and health service quality; informing citizens about health system performance; and recommending improvements to the minister of health.[14] To strengthen its ability to positively impact health outcomes, the council has adopted a population health model grounded in the social determinants

[12] New Brunswick Health Council. (2017). *2016-2017 Annual Report*. New Brunswick. Retrieved from https://www.nbhc.ca/sites/default/files/documents/nbhc-annual-report-2016-2017.pdf
[13] Rebuilding Health Care Together: The Provincial Health Plan 2013-2018 [Internet]. Fredericton, NB: Province of New Brunswick; 2013. Available from: https://www.gnb.ca/0212/values/pdf/9129%20english.pdf
[14] Mandate. (2016). Retrieved from https://www.nbhc.ca/about-nbhc/mandate

of health.[15] The NBHC reports framed within this model serve not only as valuable sources of information, but also as accountability mechanisms for a range of government departments.

Table A3: QI functions of the NBHC at a glance

Monitoring and evaluation	Monitoring and evaluation represents one half of the NBHC's dual mandate. On a three-year cycle, the council conducts surveys in four areas: home care, acute care, primary health, and student wellness. The NBHC also produces a health system report card based on provincial performance on more than 100 quality indicators. The Population Health Snapshot is another tool that communicates information to stakeholders in healthcare, the public sector, and communities.
Building capacity	The NBHC does not lead capacity-building initiatives.
Setting quality standards	The NBHC may recommend quality standards in its reporting but does not participate in their development.
Implementing QI initiatives	The NBHC is not involved in QI initiatives.
Identifying innovations in care provision and participating in spread and scale-up	The NBHC may highlight innovations in its reporting but does not participate in their spread or scale-up.
Conduct policy analyses	The NBHC does not contribute to policy analyses.
Citizen engagement	Citizen engagement represents one half of the NBHC dual mandate. Citizen dialogue sessions have facilitated relationships between patients and the health system based in mutual learning and exchange.

Informant opinion

In our informant's view, QI within the health system depends on transparency, accountability, and a clear depiction of roles and responsibilities. Transparency and accountability are closely linked; an engaged, informed public can hold the system accountable. For this to be achieved, there must be clarity of roles and responsibilities in the governance of healthcare and QI. Until ministries of health and regional health authorities are able to integrate QI into their roles as a daily practice, there will be a need for quality councils and organizations such as the CFHI, Accreditation Canada, and the Canadian Institute for Health Information (CIHI). However, the work of others must not be seen to exempt P/T jurisdictions from their roles and responsibilities in leading healthcare QI. Pan-Canadian organizations play a supporting role through sharing credible knowledge that can be adapted for use at local levels.

Health Quality Ontario

www.hqontario.ca
2016-2017 total expenditures: $43.56 million[16]

[15] New Brunswick Health Council. (n.d.). *Population Health Snapshot Technical Document*. Moncton, NB: New Brunswick Health Council. Retrieved from https://www.nbhc.ca/sites/default/files/documents/population_health_snapshot_-_technical_document.pdf

[16] Health Quality Ontario. (2017). *Annual Report 2016-2017*. Retrieved from http://www.hqontario.ca/Portals/0/documents/about/HQO_Annual_Report_2016_2107_English.pdf

Structural features

Health Quality Ontario (HQO) is an arm's length agency which in 2010, through the *Excellent Care for All Act*, received a mandate to: advise government and healthcare providers in matters related to healthcare QI; supporting QIs; promoting healthcare driven by the best available scientific evidence; and monitoring and reporting to the public on healthcare quality.[17]

The HQO is party to an accountability agreement with the Ministry of Health and Long-Term Care, to which it regularly reports on the status of key deliverables. Business and operational plans are informed by areas of focus set out in an annual mandate letter from the minister of health and long-term care. Plans are submitted to the ministry for review, and to the minister for approval. The HQO regularly meets with ministry leadership and staff, including through membership on several HQO committees. A memorandum of understanding outlines protocol for any communications with the public. The Lieutenant Governor in Council appoints 12 members of HQO's board of directors, who collectively represent regions across the province as well as many different health and leadership backgrounds. The president/chief executive officer leads a large operational team.

The HQO facilitates collaboration between healthcare experts, providers, administrators, patients, and the public. The Patient, Family and Public Advisors Council, composed of 24 individuals from across the province, helps guide HQO initiatives and establish initiatives that are guided by patient experience.

Mission and objectives

The Ontario government's renewed healthcare action plan, *Patients First*, outlines strategy to build a patient-centered, integrated, and sustainable healthcare system.[18] In its mission statement, the HQO commits to contributing to this mandate through meaningful QI. The HQO defines a high-quality health system as one that provides "world-leading safe, effective, patient-centered services, efficiently and in a timely fashion, resulting in optimal health status for all communities."[19] Thus, the HQO focuses on six dimensions of quality: safety, effectiveness, patient-centeredness, efficiency, timeliness, and equity. The HQO also aims to create a culture of QI through the identification of opportunities to improve; connecting healthcare experts, providers, administrators, patients, and the public; building QI capacity; and increasing the uptake of innovations and best practices.

Table A4: QI functions of HQO at a Glance

Monitoring and evaluation	Monitoring health system performance is a core component of HQO's mandate. The HQO produces an annual report, *Measuring Up*, which is tabled in the provincial legislature, in addition to reports on specialized themes. The HQO reports publicly on several indicators across many health sectors, including wait times and has

[17] Excellent Care for All Act, Pub. L. No. S.O. 2010, c. 14 (2010).

[18] Ministry of Health and Long-Term Care. Patients First: Action Plan for Health Care [Internet]. Toronto, ON: Government of Ontario; 2015 Feb. Available from: http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_patientsfirst.pdf

[19] System Quality Advisory Committee. (2017, pp. 27). *Quality Matters: Realizing Excellent Care for All*. Toronto, ON: Health Quality Ontario. Retrieved from http://www.hqontario.ca/Portals/0/documents/health-quality/quality-matters-print-en.pdf

	completed some evaluative work in collaboration with the ministry (e.g., evaluation of an integrated funding model for bundled payments).
Building capacity	The HQO offers a variety of learning opportunities in support of fostering a culture of QI. The IDEAS (Improving and Driving Excellence Across Sectors) is a QI training program for all Ontario healthcare professionals. Through Quality Rounds Ontario, one-hour accredited educational talks can be attended in person or online. The Quality Compass program serves as an online repository of evidence-based resources, change ideas, targets, measures, and tools. The HQO also manages Quorum, an online QI community.
Setting quality standards	The HQO develops provincial quality standards in collaboration with clinical experts, patients, residents, and caregivers across Ontario. Quality standard topics are identified through consultation with the public, partner organizations, the Patient, Family, and Public Advisors Council, the Ministry of Health and Long-term Care, and others. Quality standards are widely disseminated with help from HQO partners, and are supported by QI strategies and tools.
Implementing QI initiatives	The HQO supports approximately 15 provincial QI initiatives across various sectors per year. For example, in collaboration with nearly 50 hospitals, it initiated a campaign to reduce infection rates as part of the surgical QI program. Audit and feedback, communities of practice, and the use of best practices are common features of all initiatives. The HQO coordinates collaborative knowledge exchange between provincial and regional health system leaders, and works with organizations in primary care, long-term care, home care, and hospitals to develop annual QI plans. The HQO also collaborates with health system partners to address challenges faced by Indigenous and francophone populations in northern Ontario.
Identifying innovations in care provision and participating in spread and scale-up	The HQO identifies innovations from throughout the system and promotes them for spread across all its large-scale initiatives. This includes actively scanning and profiling innovations on Quorum, an online QI community. It also assesses new interventions or diagnostic tests for safety, costs, and benefits in the Ontarian context. As a partner in the Health Links initiative, which aims to coordinate care for patients with multiple complex conditions, the HQO contributes to identifying innovative models of cross-sectoral, patient-centered care. The HQO also co-leads the Adopting Research to Improve Care Program, which releases an annual call for proposals for high-impact interventions to improve patient outcomes and quality of healthcare.
Conduct policy analyses	The HQO conducts policy analyses in an advisory capacity to the ministry, e.g., modernizing legislation and regulation linked to quality and developing a northern health equity strategy.
Health Technology Assessment	As part of its legislated mandate to conduct health technology assessment, the HQO prepares evidence reviews that contain recommendations for the ministry.

Informant opinion

Our informants pointed to three primary QI needs in Ontario: capacity building at all levels of the healthcare system, improved coordination and alignment among different organizations (e.g., professional associations) operating in the province, and real-time access to meaningful data. The HQO works collaboratively with its partners to narrow gaps yet does not have the resources to meet all needs. Our informants felt that understanding QI should be formalized as a key health system leadership competency, and basic skills should be incorporated into clinical education curricula, including continuing education.

Our informants also recognized that the differences between each P/T jurisdiction make it difficult for pan-Canadian organizations to support QI at the local level. The CFHI must therefore support and align with P/T priorities. Our informants believed that alignment between partners depends on transparent communication and information exchange. The CADTH, CPSI, and CIHI were all cited as agencies with a strong focus on effective partnership and collaboration in support of QI.

Saskatchewan Health Quality Council

www.hqc.sk.ca
2016-2017 total expenditures: $6.79 million[20]

Structural features

The Saskatchewan Health Quality Council (SHQC), established in 2002, has a mandate to monitor and assess the quality of healthcare, and promote improvement through training, education, and research. The SHQC is publicly funded but maintains independence from the Ministry of Health as a legislated, arm's length agency. Its board of directors, appointed by the minister of health, comprises leaders from Saskatchewan and other Canadian jurisdictions who are experts in clinical care, health services research, health policy, and other areas. The SHQC reports to the Saskatchewan legislature on an annual basis.

Mission and objectives

In its plan for 2018-2019,[21] the ministry outlines a mandate to achieve the best possible care, experience, and health for patients. The SHQC's place within this mandate is to accelerate healthcare QI throughout the province. The SHQC's current strategic plan includes four priorities: integrate patients and families as partners; build learning systems to spread knowledge about quality and safety; measure healthcare outcomes and processes to generate evidence for decision making; and drive improvements through best practices, ideas, and innovations.[22]

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[20] Saskatchewan Health Quality Council. (2017). *Health Quality Council Annual Report 2016-2017*. Retrieved from https://hqc.sk.ca/Portals/0/documents/AnnualReports/HQCAnnualReport2016-17_FINAL.pdf

[21] Ministry of Health. Plan for 2018-19 [Internet]. Government of Saskatchewan; 2018. Available from: http://publications.gov.sk.ca/documents/15/106275-HealthPlan1819.pdf

[22] Saskatchewan Health Quality Council. (2016). *HQC's Strategic Plan 2016-2019: Building improvement capability and spreading improvement in health care*. Retrieved from https://hqc.sk.ca/Portals/0/documents/HQCStrategicPlan2016-2019.pdf

Table A5: QI functions of the SHQC at a Glance

Monitoring and evaluation	In light of the December 2017 launch of the Saskatchewan Health Authority, which replaced 12 regional health authorities, the SHQC is working closely with the health authority to redesign a measurement framework for the health system. Historically, the SHQC has fulfilled its monitoring mandate by supporting system partners to conduct patient experience surveys. The SHQC also partners with provincial academic institutions to explore quality and variations in care through the analysis of administrative data.
Building capacity	In collaboration with other partners, the SHQC supports a number of initiatives to build QI capacity within the health system. The largest initiative is the Lean Improvement Leaders Training program, which trains managers, supervisors, and others to apply quality concepts and theory in their work. The Clinical QI Program is a 10-month course designed specifically for clinicians. The SHQC also offers the QI Power Hour, a monthly webinar, and basic training in QI that is used during the onboarding of new employees within the health system.
Setting quality standards	The SHQC collaborates with system partners to develop standards of practice that are meant to reduce unnecessary variation in how care is provided. However, it does not have a role in accreditation or evaluating quality standards.
Implementing QI initiatives	The SHQC has experience and expertise in large-scale QI initiatives, including recent Lean reforms of the provincial healthcare system. However, the SHQC is mandated to support the health system to embed QI within daily practice and thus prefers to serve as a collaborating partner rather than an initiative leader.
Identifying innovations in care provision and participating in spread and scale-up	The SHQC's provincial perspective enables it to identify, spread and scale-up innovations, especially during this interim period as the Saskatchewan Health Authority settles into its new structures and processes. However, as the steward of the systems into which innovations are integrated, the authority will take responsibility of such activities once this interim period ends.
Conduct policy analyses	When it was first established, the SHQC produced a number of white papers, but this activity has lessened in the last five or so years

Informant opinion

With the launch of the Saskatchewan Health Authority, operations—not high performance—are presumably at the forefront in system actors' minds. In the meantime, the SHQC is on hand to provide its provincial perspective and ensure that quality discussions remain a part of the process. Indeed, quality councils often face a balancing act between fulfilling their role as designated quality experts, and recognizing that those who manage the health system must be responsible for embedding quality within it. Our informants cited Kaiser Permanente as a model of joint administrative-clinical leadership and accountability that seems to be a driver of quality of care, and could be assessed for its suitability to the Saskatchewan context.

There is a need to foster a culture of quality as a daily practice across regions, P/T jurisdictions, and the country. Pan-Canadian organizations have a role to play in leveraging and accelerating knowledge cross-jurisdictionally, preferably through the purposeful implementation of networks. Networks facilitate connections, at minimum, between jurisdictions that may share priorities or be at similar stages in their

improvement journeys. By contrast, our informants felt that national collaboratives are less able to accommodate different priorities, availability, and local nuances.

Appendix B: Quality Improvement in Other Canadian Jurisdictions

Ministries of health, possibly in collaboration with other organizational partners, typically take up healthcare QI in jurisdictions that do not have a quality council. The following summaries do not constitute comprehensive reviews of all the various partners that contribute in this area.

Manitoba

Structural features

QI and patient safety processes in Manitoba are undertaken by individual organizations rather than led by a single organization with a provincial perspective. At present, the healthcare system is in flux as it undergoes restructuring to improve service quality, accessibility, and efficiency. The creation in 2018 of a provincial health organization, Shared Health, is meant to reduce duplication of management and administrative functions across the system, but also calls into question what structures will be in place going forward.

In response to patient safety concerns, the Manitoba Institute for Patient Safety (MIPS) was established in 2004 as an independent non-profit charitable corporation. The MIPS is the provincial patient-safety organization at arm's length from government. Governed by a 12-member board of directors, its membership includes all regional health authorities. Though it sets its own strategic direction, the MIPS is nearly fully funded through a service agreement with the government and is expected to diversify revenues to reduce dependence on government support.[23] The MIPS has a small resource base, including 3 full-time employees and one part-time employee. Collaboration with the public, patients, and families is facilitated through a patient advisory committee and numerous relationships with community groups across the province.

Mission and objectives

The Department of Health, Seniors, and Active Living contains a committee that engages in projects to support healthcare quality and patient safety. The MIPS is a member of this committee. With the view that patient safety is a foundational aspect of quality healthcare, the MIPS initiates, coordinates, and advises on patient safety initiatives in the healthcare system. This may involve resource development, education, raising awareness, and providing advice on patient safety-related policy and legislation.

[23] Thomas, P. G. (2006). From good intentions to successful implementation: The case of patient safety in Canada. *Canadian Public Administration*, *49*(4), 415–440.

Table B1. QI functions of the MIPS at a glance

Monitoring and evaluation	The MIPS does not conduct monitoring or evaluation.
Building capacity	The MIPS sponsors and provides education programming with a focus on raising awareness about effective practice in patient safety and governance. Any training offered typically targets the public as well as actors within the health system. The institute develops and distributes resources for public and healthcare organizations as needed. The MIPS also delivers public presentations related to patient self-advocacy.
Setting quality standards	The MIPS does not set quality standards.
Implementing QI initiatives	The MIPS does not lead QI initiatives. However, it does lead education initiatives to orient patients or healthcare providers in the use of patient safety resources.
Identifying innovations in care provision and participating in spread and scale-up	The MIPS may identify innovations that relate to leading patient safety practices or tools, e.g., a patient-engagement guide or surgical checklist.
Conduct policy analyses	The MIPS will occasionally conduct policy analyses related to patient safety and sit on patient safety-related policy development committees.

Informant opinion

It remains to be seen what influence Manitoba's new provincial health organization, Shared Health, will have on quality. In the absence of a provincial quality council, the MIPS and other initiatives within government structures are hard pressed to coordinate filling Manitoba's gaps in quality care and QI. The MIPS is limited in its influence due to a small budget, few staff, no operational responsibility, and no authority to investigate critical incidents or enforce change. The institute's successes to date have come through close relationships with regional health authorities and communities throughout Manitoba, as well as support from the Canadian Patient Safety Institute.

Our informant cited the BCPSQC as a model for QI and patient safety and was perceived to be successful on account of its mandate, staff, and connections with regional health authorities and other partners. The ability of pan-Canadian organizations to facilitate provincial collaboration, and to support large-scale projects with expertise and experience, were also seen as valuable.

Newfoundland and Labrador

Structural features

In 2008, a Commission of Inquiry found Newfoundland and Labrador in need of a standardized legal framework for the protection of quality assurance data.[24] At this time, the Office of Adverse Health Events was established within the Department of Health and Community Services (HCS) to oversee the Provincial

[24] Cox, C. (2017, March 14). President's Letter: New Patient Safety Act clarifies protections for quality assurance information. Newfoundland and Labrador Medical Association. Retrieved from http://www.nlma.nl.ca/FileManager/Presidents-Letter/docs/2017/2017.03.09_Presidents_Letter_-_New_Patient_Safety_Act_clarifies_protections_for_quality_assurance_information.pdf

Adverse Health Event Management Framework and an electronic occurrence reporting system. A new patient safety act came into force in March 2017.

Mission and objectives

The *Patient Safety Act* governs four areas of quality assurance and patient safety: reporting, investigation, and release of information; establishing quality assurance committees and patient-safety plans; patient disclosure guidelines; and the establishment of a provincial Patient Safety and Quality Advisory Committee, anticipated in 2018.[25]

Table B2. QI functions of the Department of HCS at a glance

Monitoring and evaluation	The HCS monitors all adverse health events and collaborates with the four regional health authorities as needed to identify systemic factors and solutions for any given event. Evaluations are conducted on an ad hoc basis.
Building capacity	In 2009, the HCS began to build capacity in patient safety and the management of adverse health events across the department and regional health authorities. The *Patient Safety Act* provides a new standard for the system to assess capacity and identify areas for improvement.
Setting quality standards	The HCS does not have the capacity to set its own quality standards. Standards from national policies and accrediting bodies are used.
Implementing QI initiatives	The HCS may lead or support initiatives in collaboration with regional health authorities. As the largest and most well-equipped regional authority, Eastern Health often leads initiatives on behalf of the provincial system.
Identifying innovations in care provision and participating in spread and scale-up	Depending on the current capacity of the HCS and the authorities, the HCS may periodically identify best practices and work with regional health authorities to implement them.
Conduct policy analyses	The HCS leads policy analyses related to patient safety with input from the regional health authorities and provincial universities.

Informant opinion

The Newfoundland and Labrador system is arranged such that regional health authorities must report adverse health events after they have occurred. Our informants spoke of a need to develop a provincial quality framework with indicators through which the health system can more proactively address quality and safety. Conversations are needed with a wide range of stakeholders, including the provincial Patient Safety and Quality Advisory Committee that should be set up later this year under the *Patient Safety Act*.

Our informants described three potential models for supporting QI in the province: continue to work with what is currently available, including the forthcoming Patient Safety and Quality Advisory Committee; establish an independent provincial health QI council; or establish an Atlantic health QI agency to leverage resources among all the Atlantic provinces. They said a provincial council is unlikely, but there is some interprovincial discussion regarding an Atlantic agency.

[25] Patient Safety Act (SNL2017 Chapter P-3.01) (2017).

Our informants felt that the greatest role for the CFHI would be as a "bridge to opportunity." Whether this meant ranking jurisdictional quality initiatives to force a discussion about improvement or supplying best practices and guidance on how to improve, there is room for the CFHI to find meaningful ways to connect P/T jurisdictions with the knowledge and hands-on support most needed in their context.

Northwest Territories

Structural features

The Northwest Territories Health and Social Services Authority (NTHSSA), Hay River Health and Social Services Authority, and Tłįchę Community Services Agency (collectively referred to as the "authorities"), comprise an integrated territorial health system directed by a territorial leadership council responsible to the Minister of Health and Social Services (HSS). The Department of Health and Social Services (HSS) sets strategic direction for the system through legislation, policy, and other ministerial functions. Six regional wellness councils that represent the unique needs of patients, clients, and families in their respective regions play an advisory role.

A process of system transformation, whereby six regional authorities were consolidated into the newly established NTHSSA in August 2016, is the backdrop to ongoing efforts to integrate QI into a health system characterized by limited human and financial resources. Movement toward a more integrated system is anticipated to result in enhanced patient care and safety. With the creation of NTHSSA, employees from multiple regions now collaborate toward accreditation, rather than work in isolation. The NTHSSA houses a division of Quality, Safety, and Client Experience.

Mission and objectives

The NT HSS Strategic Plan outlines a vision of health service delivery and management within a single-system approach. In addition to detailing five strategic priorities related to specific health service areas, the plan contains a sixth strategic priority to achieve an effective and efficient system. This document serves as a basis for performance monitoring and reporting.[26]

[26] Government of Northwest Territories. (2017). *Caring for Our People: Strategic Plan for the NWT Health and Social Services System 2017 to 2020*. Yellowknife, NT: Government of Northwest Territories. Retrieved from http://www.hss.gov.nt.ca/sites/hss/files/resources/caring-our-people-strategic-plan-2017-2020.pdf

Table B3. QI functions of the NT health system at a glance

Monitoring and evaluation	The NT HSS collects and reports administrative and epidemiologic data, as well as performance data outlined in its strategic and business plans.
Building capacity	The NT health system currently focuses on healthcare-provider training in cultural-competency and cultural-safety components of quality care.
Setting quality standards	A clinical standards steering committee oversees development of territorial standards and clinical practice guidelines, including performance indicators.
Implementing QI initiatives	As part of system transformation, the NTHSSA and Department of HSS jointly hosted leadership learning sessions called Quality as the Business Strategy, designed to engage health system leadership in continuous QI.
Identifying innovations in care provision and participating in spread and scale-up	The NT leads the country in terms of e-health coverage. Approximately 90% of the NT population currently has an electronic medical record (EMR) chart accessible in 500 points of care. Efforts are ongoing to further extend and expand the EMR.[27]
Conduct policy analyses	Rapid review results were inconclusive about whether the NT health system conducts policy analyses related to QI.

Nova Scotia

Structural features

Although Nova Scotia does not have a provincial QI council, there are a number of structures within the Nova Scotia Health Authority (NSHA) and Department of Health and Wellness (DHW) meant to contribute to QI and safety. The DHW has its own quality and patient safety advisory committee, which provides recommendations related to quality and safety. In addition to a quality and safety committee within its board of directors, the NSHA manages a quality and system performance portfolio and houses a quality and safety council that reports to the executive leadership team.

A provincial approach to achieving quality in healthcare is guided through the use of a tool titled *Quality Framework for a High Performing Health and Wellness System in Nova Scotia.*[28] The province also aligns with legislation that mandates public reporting on key public safety indicators[29] and protects safety and quality review data.[30]

[27] Webster, P. (2017). Northwest Territories leads Canada in electronic medical record coverage. *Canadian Medical Association Journal, 189*(47),E1469.
[28] Province of Nova Scotia. (2013). *Quality Framework for a High Performing Health and Wellness System in Nova Scotia*. Retrieved from https://novascotia.ca/dhw/hsq/documents/Quality-Framework-High-Performing-Health-and-Wellness-System-in-Nova-Scotia.pdf
[29] Patient Safety Act, c. 13, s. 1 (2012).
[30] Quality-improvement Information Protection Act, c.8, s.1 (2015).

Mission and objectives

For its role as the provincial healthcare authority, NSHA is profiled in this section. Within NSHA, the quality and system performance portfolio include three main streams: privacy and policy; planning, performance, and accountability; and QI, safety, and patient relations.

Table B4. QI functions of NSHA at a glance

Monitoring and evaluation	The NSHA collects and reports administrative and epidemiologic data, as well as performance data as per strategic priorities and provincial accountability agreements. There is also a legislated obligation to report on patient safety indicators, primarily related to infection prevention and control.
Building capacity	The Quality and System Performance unit is responsible for building QI capacity within the NSHA. For example, in 2015 the NSHA, DHW, and IWK Health Centre held a joint health quality summit over three days in six locations across the province.
Setting quality standards	NSHA does not set quality standards.
Implementing QI initiatives	The NSHA aims to implement QI as part of their daily practice. However, these rapid review results were inconclusive as to how this is being achieved.
Identifying innovations in care provision and participating in spread and scale-up	No one unit within the NSHA seeks to identify, spread, or scale-up innovations in care.
Conduct policy analyses	The NSHA does not conduct policy analyses related to QI.

Informant opinion

In our informant's view, the structure of the Nova Scotia health system, characterized by a single provincial authority, reduces the need for an independent quality council. The NHSA, our informant said, leads provincial system-wide efforts to embed health QI into daily practice. Support from pan-Canadian organizations only adds to the breadth and depth of initiatives at the provincial level.

Our informant appreciated work by the CFHI to foster pan-Canadian collaboration, and felt there continued to be a need for learning and connecting between P/T jurisdictions, particularly with regard to leveraging resources to build and sustain innovative practices. The CFHI also has a role in maintaining focus on priority areas, and to support P/T jurisdictions to remain on course within those priority areas. Finally, the CFHI can engage leaders at all levels within P/T jurisdictions to contribute to achieving a true systems perspective in QI work.

Nunavut

Structural features

Nunavut healthcare is managed and delivered by the Department of Health. The Public Health Strategy guides the department in its goal to improve the health status of Nunavummiut. Achieving this goal hinges on ongoing consultation and collaboration with communities, innovation, and respect for Inuit values.[31]

Mission and objectives

Through collaboration, innovation, and integration of Inuit societal values, the Department of Health aims to provide excellent healthcare services that empower Nunavummiut to live healthy lives.

Table B5. QI functions of the NU Department of Health at a glance

Monitoring and evaluation	The Department of Health has developed a new performance-management framework to guide monitoring, analysis, and reporting. The department also recently developed capacity to track deliverables across strategies, plans, and programs, which allows it to monitor progress in implementing work plans and recommendations from external reviews. Work has begun to standardize the management of patient safety events.
Building capacity	A first cohort of Indigenous cultural competence trainers received certification in 2017 to deliver training within the territory.
Setting quality standards	Rapid review results were inconclusive about whether the NU Department of Health sets quality standards.
Implementing QI initiatives	In 2016-2017, the department began to develop systems and resources to support QI throughout the territorial health system, notably a QI framework, implementation plan, and resource kit.
Identifying innovations in care provision and participating in spread and scale-up	The Department of Health supports the spread of innovations where possible, e.g., eConsult service access to specialist care. The department also recently upgraded the MEDITECH system, putting Nunavut close behind NT in jurisdictional e-health coverage.[32]
Conduct policy analyses	Rapid review results were inconclusive about whether the NU Department of Health conducts policy analyses related to QI.

[31] Government of Nunavut. (2017). *Department of Health Annual Report 2016-2017*. Iqaluit, NU: Government of Nunavut. Retrieved from http://www.assembly.nu.ca/sites/default/files/TD-358-4(3)-EN-Department-of-Health%202016-2017-Annual-Report.pdf

[32] Webster, P. (2017). Northwest Territories leads Canada in electronic medical record coverage. *Canadian Medical Association Journal, 189*(47),E1469.

Prince Edward Island

Structural features

In Prince Edward Island (PEI), the Department of Health and Wellness (DHW) oversees policy, standards, performance, and accountability in PEI healthcare. Health PEI is responsible for health service delivery in hospitals, health centres, public long-term care facilities, and community-based programs. A quality and safety committee is located within Health PEI's board of directors, which is accountable to the minister of health and wellness. Volunteer patient and family advisors are recruited to serve on various QI committees.

The Integrated Quality and Patient Safety Framework supports the integration of quality and patient safety into the strategic direction and operations of Health PEI. The framework includes eight dimensions of quality as defined by Accreditation Canada. Quality and patient safety plans are developed annually to support the Health PEI strategic plan, business plan, and other strategic documents.[33]

Mission and objectives

Health PEI's mission is to work in partnership with islanders to support and promote health through the delivery of safe and quality healthcare. Quality and safety also comprise the first goal within the Health PEI strategic plan to 2020. Three strategic priorities are outlined under this goal: improve patient and workplace safety and security; embed patient- and family-centered care; and increase engagement with patients, staff, members of the public, and communities.[34]

Table B6. QI functions of Health PEI at a Glance

Monitoring and evaluation	Quality and patient safety plans include targets and indicators that are measured to track progress in new processes, programs, and services. Employees have been recognized for integrating quality monitoring and evaluation into their scope of practice, e.g. development of a Mammography Radiology Report Card to improve quality and performance monitoring.
Building capacity	Health PEI builds capacity within the context of its Integrated Quality and Patient Safety Framework and other strategic documents. Health PEI hosts health, wellness, and development sessions for healthcare providers as one way to promote quality care.
Setting quality standards	On occasion, Health PEI may develop and update provincial standards according to best practices and Accreditation Canada standards.
Implementing QI initiatives	Health PEI implements a number of initiatives to improve care, e.g., electronic medication reconciliation to ensure information is communicated consistently among healthcare providers across transitions.

[33] Health PEI. (2017). Health PEI Board of Directors Meeting: September 12, 2017. Retrieved from https://www.princeedwardisland.ca/sites/default/files/publications/september_12_2017_health_pei_board_meeting_1.pdf

[34] Health PEI. (2017). *Health PEI Strategic Plan: 2017-2020*. Retrieved from https://www.princeedwardisland.ca/sites/default/files/publications/health_pei_strategic_plan_2017-2020.pdf

Identifying innovations in care provision and participating in spread and scale-up	Health PEI supports the spread of innovations and best practices, e.g., an innovation series featuring small-scale projects was held in provincial long-term care homes. Employees are recognized for innovative work through the Leadership Excellence in Quality and Safety Awards.
Conduct policy analyses	Though the PEI DHW develops policy, Health PEI has a role in monitoring the implementation of policy, e.g., the Family Presence Policy, which aims to improve patient and family-centered care by removing formal visiting hours.

Québec

Structural features

From 2006 through 2017, Québec had a government-appointed Health and Welfare Commissioner (*Commissaire à la santé et au bien-être*, CSBE) who, together with a small support team, worked with the mandate to appraise health system performance; consult with citizens, experts, and healthcare stakeholders; and make informed recommendations to the minister of health with regard to healthcare performance. In a controversial 2016 budget decision, the Québec government announced that all activities of the CSBE would cease.[35] The CSBE office closed in December 2017.

The CSBE's functions were reassigned to the National Institute of Excellence in Health and Social Services (*Institut national d'excellence en santé et en services sociaux,* INESSS), an organization of healthcare professionals, researchers, clinicians, and managers with a mandate to assess technologies for health and social services. The INESSS has established several advisory councils and committees for various initiatives, each of which includes members of the public.

Mission and objectives

The mission of the Ministry of Health and Social Services is to provide an integrated suite of high quality services.[36] Within this mandate, the INESSS is committed to promoting clinical excellence and the efficient use of resources. It also assesses the clinical utility and costs of healthcare technologies, medications, and interventions, and makes recommendations related to their implementation. The INESSS strategic plan to 2020 identifies three priorities: generating scientific and solution-based insight adapted to the needs of the health and social services network; building knowledge and expertise within its network of collaborators; and strengthening organizational capacity to respond to new challenges.[37]

[35] CBC Radio-Canada. (2016, March 21). Québec élimine le commissaire à la santé. Retrieved May 28, 2018, from https://ici.radio-canada.ca/nouvelle/771770/quebec-actions-barrette-organisme

[36] La Direction des communications du ministère de la Santé et des Services sociaux. Plan stratégique du ministère de la Santé et des Services sociaux du Québec 2015-2020 (Mise à jour 2017) [Internet]. Gouvernement du Québec; 2017. Available from: http://publications.msss.gouv.qc.ca/msss/fichiers/2017/17-717-01W.pdf

[37] Institut national d'excellence en santé et en services sociaux (INESSS). (2016). *Plan stratégique de l'INESSS 2016-2020*. Montréal, QC: Gouvernement du Québec. Retrieved from https://www.inesss.qc.ca/fileadmin/doc/INESSS/DocuAdmin/plan_strategique2016-2020.pdf

Table B7. QI functions of INESSS at a Glance

Monitoring and evaluation	INESSS determines service performance evaluation criteria and service implementation and monitoring mechanisms as needed to assess the costs and benefits of technologies, medications, and other healthcare interventions.
Building capacity	The INESSS promotes implementation of its clinical practice guidelines for technologies, medications, and other healthcare interventions through webinars.
Setting quality standards	The INESSS prepares clinical practice guidelines related to healthcare technologies and medications.
Implementing QI initiatives	The INESSS has supported QI initiatives in collaboration with the Ministry of Health and Social Services. For example, one initiative involved the development and assessment of performance indicators along the continuum of trauma and critical care.
Identifying innovations in care provision and participating in spread and scale-up	The INESSS contributes to the identification or spread of innovations as they relate to clinical technologies or medications.
Conduct policy analyses	The INESSS engagement in QI policy analyses could not be conclusively determined.

Yukon

Structural features

Yukon does not have a quality or safety council, nor does it have capacity to conduct QI initiatives to the extent that they are undertaken in larger jurisdictions. Constrained by limited human and financial resources, health system actors are nonetheless committed to integrating QI where possible.

The Yukon Hospital Corporation views its objectives through an Integrated Quality Management model with six elements: strategic planning, integrated risk management, patient and organizational safety, QI, utilization management, and ethics.[38] The corporation's board of trustees also contains a quality management council to oversee performance measurement in the territory's three hospitals.

Yukon Health and Social Services (HSS) manages all other health facilities. Within Yukon HSS, there is a small QI group that takes advantage of webinars and other short-learning opportunities, but no unit or individual throughout the organization has "quality improvement" in their title. Yukon HSS collaborates with First Nations and other governments, non-governmental organizations, and members of the public.

Mission and objectives

For its role in leading health initiatives throughout the territory, including delivering a wide range of primary healthcare services delivered in community health centres, Yukon HSS is profiled in this section.

[38] Yukon Hospitals. (2017). *Closer to Home: Year in Review 2016-17*. Whitehorse, YT. Retrieved from https://yukonhospitals.ca/sites/default/files/yhc_year_in_review_2016-2017.pdf

One of three strategic goals in the Yukon HSS 2014-2019 strategic plan is access to integrated, quality services.[39]

Table B8. QI functions of Yukon HSS at a Glance

Monitoring and evaluation	In line with its 2014-2019 strategic plan, Yukon HSS has a performance measure framework that identifies annual and five-year indicators to inform decision making.[40] Within the performance-measure framework, Yukon HSS states a desire to move from measuring outputs to outcomes. Currently, the department evaluates certain initiatives within particular service areas on an ad hoc basis.
Building capacity	Yukon HSS recognizes this as one of its greatest needs. Introductory QI training and education are needed to build capacity within Yukon's health system. Yukon HSS and the BCPSQC in British Columbia are currently developing a memorandum of understanding to allow Yukon HSS employees to access learning opportunities offered by BCPSQC.
Setting quality standards	Yukon HSS does not have the capacity to set its own quality standards. Standards from national policy and accrediting bodies are used.
Implementing QI initiatives	There is interest within Yukon HSS to implement QI initiatives, but a limited capacity to do so.
Identifying innovations in care provision and participating in spread and scale-up	Yukon HSS has a unit that completes cross-jurisdictional scans of best practices or innovations when developing policy. Otherwise, there is limited capacity to identify innovations.
Conduct policy analyses	Yukon HSS does not conduct policy analyses related to QI.

Informant opinion

Our informants emphasized that while there is great talent within Yukon's health system, there is significant need for exposure to foundational QI thinking, as well as capacity building and support to sustainably integrate QI throughout all aspects of daily practice. They expressed desire for the CFHI to actively disseminate lessons learned out of QI initiatives across the country. Collaboratives, they explained, were counterproductive for small jurisdictions that end up sidelined by others engaged in more advanced work. Support from the CFHI or other pan-Canadian organizations that is based in lessons learned and tailored to context was seen as crucial for the territories and other small jurisdictions. In the absence of such support, Yukon is exploring a relationship with the BCPSQC in order to develop QI leadership throughout executive and managerial levels.

Organizations such as the Canadian Institute for Health Information and the Canadian Agency for Drugs and Technologies in Health are essential to small jurisdictions that lack capacity to complete similar work. There is a role for the CFHI to play in conducting the same level of essential work in QI, and building supportive relationships with the small jurisdictions that most need the CFHI. Our informants cited the

[39] Health and Social Services. (2014). *Health and Social Services Strategic Plan 2014-2019*. Yukon Government. Retrieved from http://www.hss.gov.yk.ca/pdf/hss-stratplan-2014-2019.pdf

[40] Health and Social Services. (2014). *HSS Performance Measure Framework 2014-2019*. Yukon Government. Retrieved from http://www.hss.gov.yk.ca/pdf/hssperformansmeasure2014-2019.pdf

Institute for Healthcare Improvement and Healthcare Improvement Scotland as models warranting further examination. Moreover, robust collaboration among pan-Canadian organizations is necessary to leverage one another's contributions across the country.

NORTH AMERICAN
OBSERVATORY
on Health Systems and Policies

The North American Observatory on Health Systems and Policies (NAO) is a collaborative partnership of interested researchers, health organizations, and governments promoting evidence-informed health system policy decision-making. Due to the high degree of health system decentralization in the United States and Canada, the NAO is committed to focusing attention on comparing health systems and policies at the provincial and state level in federations.