Practical Quality Measurement

Brenda Kirtzinger, B.Comm., CHE

Objective

This case study offers a practical application in the development and implementation of an evidence-based decision making system, focusing on the quality improvement aspect of information collection and use. The study deals with the experience of Battlefords Health District (BHD), North Battleford SK, and outlines the organization's development of a quality reporting system, structure and timeframes. The staff education component is included, discussing training in the practical use of the indicators for front-line staff, middle management, senior management, and the board of directors.

Setting and population

BHD is situated in the northwestern area of Saskatchewan. The District's population is approximately 27,800 residents with the largest proportion of residents living in the City of North Battleford. Five First Nation communities are situated within the District boundaries. Several formal partnerships exist with surrounding Districts and together, the population of the service area is approximately 70,000.

Case Example Background

The need for "hands-on" tools relating to quality measurement was identified throughout the organization by front-line staff through to senior managers and board members. The development of a quality improvement team structure was initiated by implementing District Quality Improvement (QI) Teams. These teams consisted of front-line staff, managers, and board members, clients and community partners, and were applied consistently across the District as we prepared for our accreditation survey. The structure that was implemented promoted communication flow to the senior managers and board members, as well as back to front-line staff members. Issues identified by the individual QI Teams were compiled and reviewed on an organizational basis by senior managers and board members, and the themes were then communicated to the District QI Teams, allowing staff to note the common issues across the District. The system was well received, with the information sharing and the educational components being appreciated. This led to development of the *Evidence-Based Decision Making Handbook (EBDM).*

Support for Managers

Managers were increasingly stretched by day-to-day operations, spending much of their time "firefighting" and feeling they had no time for indicator monitoring. Many of the managers had risen through the ranks and had not had much planning and evaluation experience. Most managers were already tracking some indicator information (i.e., service levels, repeat clients, client satisfaction surveys), but consistency in data collection and use was lacking. Those who did try to monitor information either felt like they were fumbling trying to find the "right" data, or that the information they were reporting was not useful to the senior managers. Managers *wanted* some guidelines for monitoring, planning and evaluation.

Another of the issues that concerned already strapped managers was "What is more important - quality improvement, risk management, or utilization management?" By developing one resource for planning and evaluation, and a limited number of indicators for each of these areas, we attempted to show the relationship between quality, risk and utilization. An emphasis was placed on how accurate and consistent information can be useful for monitoring, planning and evaluation.

Support for Front-line Staff

Staff members were also stretched with heavy caseloads and uncertainty in the health system. The staff working with the clients/patients on a daily basis often noticed trends in service or patient needs, but did not know how to document this information. Staff found it very frustrating to see a pattern emerging, but not be able to prove their hypothesis without sifting through an onerous amount of paperwork. These concerns came through clearly at the QI Team meetings.

The Handbook

In order to help our staff record the information they were observing so this data could be used to improve the care we provide, the EBDM Handbook was developed. The concept of a handbook was used because it was concise and user-friendly. The components of operational planning, quality improvement, risk management, utilization management, human resources, finances, and overall program evaluation were compiled in one source. The inherent connections between these evidence-based decision making tools were identified. The handbook contains three sections a) narrative descriptions, b) examples of the tools in use and c) blank tools the managers could copy and use on their own. The primary message for managers is that data collection and use in one area (i.e., utilization data), may also be tied to program goals and objectives and used in overall program evaluation. Program evaluation is inherently tied to our budgeting process and our human resource plan. This handbook will be a guide for all of our program planning activities.

The EBDM Handbook offers a number of practical templates to:

1. Increase consistency in data collection and comparability across programs.
2. Improve the timeliness of data collection and use by managers.
3. Increase information exchange across programs to encourage strategic planning and broad operational planning.

Examples of the forms in the EBDM Handbook include:

a) A general District satisfaction survey applicable across all programs and tied to the District's Values statements;
b) A client concern tracking system template for issue identification and analysis at the program level;
c) A program evaluation template, including program goals, financial information, service level information, and a communication component.

Staff Training

A number of training opportunities were offered to middle and senior managers on topics such as operational planning and indicator development and monitoring. The presentations were conducted by the Director of Business Services, the Director of Human Resources, and the Director

of Performance and Evaluation. Managers unable to attend the sessions were provided with copies of the overheads. All managers received a copy of the Evidence-Based Decision Making Handbook. As the evidence-based decision making structure was being developed, presentations were given to members of the board of directors to keep them informed.

At numerous Quality Improvement Team meetings, a description of the quality improvement structure and process was provided. Staff were encouraged to ask questions about how these evidence-based decision making tools pertained to their specific programs, and practical examples were discussed. Again, one of the key messages in these presentations was that information used for program quality improvement will be useful in budgeting and human resource planning. Quality Improvement is more than client satisfaction surveys - QI is integral to all aspects of our programs and our organization.

Consistent use of the tools is being gradually phased in across all District programs. As mentioned, the initial training sessions dealt with program managers completing an operational plan for their program area. Indicators relating to service levels, finances, and cost per unit of service were then identified in each program. Intensity of service data or indicator data depicting the severity of the service being offered, is currently being identified in all areas. Implementation of the District Satisfaction Survey, and the Client Concerns summary sheet will be coordinated in the first half of 2002.

With a new year will come the planning associated with budgeting. Recommendations from Canadian Council on Health Services Accreditation (CCHSA) relating to our November 2001 accreditation survey, comments from our District QI Teams, suggestions from our District Concerns Handling Process, and other client comments will serve as a basis for next year's fiscal planning. An evaluation with the managers using the tools will also be conducted early in 2002 so that any recommendations for modification to the EBDM tools or training process may be incorporated.

Summary

Our experience is important in today's health care arena because it provides:

1. A template to implement a quality improvement structure across diverse District programs.
2. Links between quality in care, and quality in the use of financial and human resources.
3. Promotion of fair evaluation across diverse programs.
4. Assistance in identification of District-wide issues.
5. Improved communication among staff, from front-line staff to managers and the board of directors.

As we continue to implement the EBDM tools, we are learning what processes will best meet the needs of our clients, our staff and our community partners. Having tools to assess quality in care and service clears one hurdle. Having an adequate process to interpret and communicate the

results, implement recommendations, and re-evaluate, leaves us with another challenge as we progress toward a "Continuous Quality Improvement Culture".

About the Author

Brenda Kirtzinger, B.Comm., CHE Director CBO Contract Administration at Government of Saskatchewan