Think Big,
Start Small,
Act Now:
Tackling Indicator Chaos

A report on a national summit:
Saskatoon, May 30-31, 2011
Start with the patient.
A nation-wide system for developing and disseminating health care indicators should be shaped and guided by patients’ needs, priorities, and potential benefits.

Don’t talk, act.
Success in tackling indicator chaos demands quick action on two or three pilot projects to figure out how to set priorities, build frameworks for creating indicators, and to test the validity and usefulness of the indicators we develop.

Name leaders.
Success depends on establishing a national consortium of dedicated stakeholders who will keep momentum from the summit going. Choosing the people to work together and providing a small and flexible secretariat to support them needs to be done quickly.

Create a clearing house.
Our collective failure to communicate is causing tremendous waste. Efforts are duplicated, good ideas aren’t shared, and work done nationally may never filter down to people and organizations that could use it.

Agree on priorities.
Indicator chaos comes from a lack of common priorities and coordination and the impossibility of planning without them. Always ask: Who are we measuring for? Why are we measuring this?
Indicator chaos is the result of health care’s exploding demand for accountability and quality improvement data. Organizations across the country are chasing similar data from the same people without consulting or coordinating. Countless hours of staff time go to gathering and interpreting a wide range of data. In response, on behalf of an informal network of provincial quality councils and Accreditation Canada, the Health Quality Council in Saskatchewan, the British Columbia Patient Safety and Quality Council, the Health Quality Council of Alberta and the Canadian Patient Safety Institute organized a national summit on solving indicator chaos and invited participants from across the country.

There was broad agreement at the summit that indicator chaos is a symptom of the increasing commitment to improvement and measurement from all sides—provincial systems and organizations at all levels—because of their lack of coordinated priorities and planning. Overcoming chaos, it was agreed, begins with asking some fundamental questions: Who are we measuring for? Why are we measuring this? Is anyone else in Canada working on this that we could collaborate with to avoid duplication?

The discussion paper circulated before the summit called for a structured, transparent, accessible, pan-Canadian measurement system which would coordinate work on developing and disseminating indicators. The paper stressed the need for an increased emphasis on the information needs of those focused on improving quality. Current efforts overly emphasize measurement for accountability purposes. Participants at the meeting agreed that there should be a central role of patients’ perspectives in shaping the new system. Whether it’s planning strategy, setting priorities, or developing, disseminating, and using indicators, working from the patient point of view will ground health care measurement in providing better care for patients. It would also be a way to overcome the competing agendas of all the groups involved in measurement. There was some concern that health care consumerism can drive political decisions that are not the best priorities for health care and may have unintended consequences.

Other issues discussed at the summit included our general failure to exchange ideas and experience. The meeting called for a national clearing house for sharing and disseminating everything from effective indicators, processes for developing new measures, and discussions of priorities and coordination of measurement work. There was also long debate on whether indicators should be developed on the front line, by the people who give care, or at higher levels of the health care system, where planning and policy making happen. Top-down development dominates in Canada but its information often seems irrelevant to people on the front lines of care. Several speakers worried about whether bottom-up indicators would be of high enough quality to be valid across the broader system. Others recognized that to be relevant to clinical populations and services, bottom-up
measurement would need support from experts on measurement, and should integrate a few measures vertically and horizontally throughout the system. The term used for ensuring indicators are relevant to all levels in health care was cascading; and the important question is not whether developing indicators from the top down or the bottom up is better, but whether the indicators created provide information needed for decisions at all levels. Although the summit was oriented to a discussion of performance measurement in health care broadly, the discussions at the meeting focused primarily on measurement pertaining to the quality and safety aspects of performance not financial measurement.

Participants at the summit agreed on several challenging issues:

- The goal for organizing measurement should be improving quality and delivering patient-centred care;
- Top-down and bottom-up approaches in developing indicators are both valid, but there needs to be more connection between the people developing indicators and the people who will use them to improve care;
- We need both well-established priorities and standard, coordinated methods for developing and testing indicators; and,
- We need more communication, networking and collaboration to reduce duplication and spread good ideas.

The organizations that put the summit together promised to get things moving by recruiting folks from the meeting to a pan-Canadian consortium that will oversee the rest of the tasks that need to get done, which include:

- Developing terms of reference;
- Creating a secretariat; and,
- Starting regular meetings.

The new consortium will start on some longer-term tasks:

- Preparing a business case on a pan-Canadian measurement approach;
- Asking the USA’s National Quality Forum about its work;
- Setting priorities for the consortium;
- Choosing a joint pilot project;
- Creating a clearing house for indicator information;
- Developing a communication plan for sharing and gathering information; and,
- Meeting in a year to evaluate success.
THE ORIGINS OF CHAOS

Measurement and the data it produces are essential for improving the quality of health care. Demand for information for accountability and to improve practice is surging, with multiple stakeholders chasing similar data from the same people in an uncoordinated way. That’s led Canada into “indicator chaos,” the result of local, provincial, and national measurement initiatives on overlapping issues all running at the same time. Countless hours of staff time can be drained away by chaos, because of often slight differences in the types and range of data required, or in how they are collected, analysed, and responded to.

“The impact of chaos is both to frustrate those who need measurement most and to frustrate those of us who try to provide information,” said Gary Teare in his opening remarks to the Summit on Solving Indicator Chaos, held in Saskatoon on May 30 and 31, 2011. Teare, director of quality measurement and analysis at the Health Quality Council, told participants the stress of too many demands for information weighs heavily on organizations. Middle managers and front-line workers usually bear the brunt of gathering data, and organizations may lack the time or expertise to develop the measures, conduct the analysis, and interpret the information from it. As well, not enough of what is gathered is readily applicable to improving the quality of care.

Calls have been growing for health care measurement to be organized into a more efficient system, so it’s less of a drag on health care workers and would provide more effective results, more relevant to people actually delivering care. There’s also pressure for measures to be standardized, so the quality of care across the country could be compared and innovations tested and spread more quickly. But there’s a patchwork of jurisdictions and interest groups seeking similar information, often for different reasons, which causes duplication and waste. There is more emphasis on using data for monitoring and accountability than for improving quality of care, which is what patients need, and there’s a lack of pan-Canadian coordination. All have combined to prevent progress and contribute to the chaos.

In response, Saskatchewan’s Health Quality Council, the British Columbia Patient Safety and Quality Council, the Health Quality Council of Alberta, and the Canadian Patient Safety Institute organized the summit and invited some 75 people from across the country who are interested in health care quality and performance measurement. Participants came from ministries of health, regions, quality councils, and national agencies including Accreditation Canada, the Canadian Institute for Health Information (CIHI), the Canadian Institutes for Health Research (CIHR), Statistics Canada, and the Health Council of Canada (HCC). There were also researchers from several universities. Everyone was asked to bring their different perspectives together to identify opportunities a pan-Canadian measurement consortium could start working on in the next six to eight months, with the long-term goal of establishing processes and connections across the country to make health care measurement work better.

TACKLING INDICATOR CHAOS

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THE ROUTE OUT OF CHAOS

The summit mixed presentations with small group discussions and plenary sessions to explore participants’ perspectives. There was broad agreement that indicator chaos is a symptom of a health care system committed to measuring but lacking coordinated priorities and planning. Overcoming chaos, it was agreed, begins with asking two questions: Who are we measuring for? Why are we measuring this? Hugh MacLeod, CEO of the Canadian Patient Safety Institute, told participants that when he worked at the Ontario Ministry of Health and Long Term Care, various parts of it were measuring a total of 1,168 indicators. As an associate deputy minister, he knew neither he nor the deputy minister looked at all of them; in fact, they rarely used them. “For whom were we creating this? It accomplished what?” he asked. In discussion later, Melanie Rathgeber of the British Columbia Patient Safety and Quality Council said “Just ask who looks at this and what do you use it for, and if you can’t find the answer pretty quickly, ask if you should be there [measuring that].”

There was a sense too much measurement is out of touch with the needs of the people most directly affected by health care—patients and providers. Much of it is for accountability, although as Cy Frank (executive director of Alberta’s Bone and Joint Health Institute) pointed out, using measurement to blame and shame professionals and organizations has been shown not to work. Measures, he said, should be for educating, not punishing.

“Chaos isn’t all bad. It shows there’s activity.”

Bill Ghali, University of Calgary
THE BEST APPROACH—TOP DOWN OR BOTTOM UP?

Front-line, or from above? The question of the most effective approach for developing indicators for improving health care was brought up in the discussion paper and extensively discussed at the summit. According to the paper, top-down indicator development starts from high-level summary measures; users have to drill down to uncover information about underlying processes to make these measures useful. Developing indicators from a bottom-up perspective, on the other hand, starts from measurement of care processes and outcomes that matter most to patients and those providing their care and must be aggregated for relevance at higher levels of decision making. The top-down approach seems to dominate in Canada, but providers complain the information it provides often seems irrelevant to their jobs. Several speakers were worried about the efficiency of basing measurement on bottom-up indicators. To be valid, measures must be drawn from high-quality data that have been carefully and consistently collected and interpreted. There was concern that ensuring high standards for data and its interpretation might not be realistic with front-line information collected across the country. “I get concerned if there isn’t agreement on a common framework,” said Wendy Nicklin, president and CEO of Accreditation Canada. “Will the floor of the house and the roof connect?” She said the hazard of bottom-up data is that it might not build to a common useful point. Others said the most important thing was that everyone at all levels of health care feels the measurement system is relevant to their jobs.

Tom Briggs, executive director of performance measurement and reporting at Alberta Health Services had a term for ensuring indicators developed top down are relevant to all levels in health care—“cascading.” He feels the issue is not whether one approach is better than the other. What matters is whether the data gathered are useful for making decisions at all levels, in line with strategic directions. If frontline measures show diabetes incidence has climbed 6 per cent per year for eight years, it’s pretty clear some strategic decisions need to be made. At the same time, he said, we aren’t making good enough use of top-down measures we have, such as CIHI data.

“Indicators must have value for local users. Seeing an indicator that has nothing to do with what I do just wastes my time.”
— Rick Birtwhistle, Canadian Primary Care Sentinel Surveillance Network
FROM CHAOS TO COMMUNITY

Frustration with the burden of measurement was the driving force behind the summit but there was a second concern as well. People all over the country are doing good work on improving clinical care, but there isn’t nearly enough exchange of ideas and experience, or awareness of similar efforts and opportunities to collaborate. Looking for ways to create a community of those involved where they could share information (perhaps virtually, through some kind of clearing house, or through regular meetings) was an important subtext of the Saskatoon session.

You didn’t have to look far to see evidence of where better communication and sharing of information would benefit everyone interested in improving care. There were representatives from all the national agencies concerned with health indicators: Statscan, CIHI, and Accreditation Canada, (CIHR, which funds indicator research, was also represented). The agencies meet twice a year, and all regularly consult with users and generators of data across the country, but they were told some summit participants knew little about what they did and others felt it wasn’t relevant or flexible enough to serve all the provinces and territories.

“I smooth operating is not a product of isolated actions. It’s from orchestrating interactions.”
— Hugh MacLeod, CPSI

Indicator development—a collaborative effort: some CIHI examples

• Canadian Hospital Reporting Project: 23 clinical and 10 financial indicators.
• Collaborating for Excellence in Health care Quality: 11 teaching hospitals have agreed on 16 comparable indicators so far.
• Cardiac Care Indicators: 10 cardiac care indicators were agreed to for a pilot project.
• Primary Health Care Indicators: Electronic medical records used to provide feedback to physicians; the indicators are being updated.

Bruce Harries, of Improvement Associates (at the meeting to talk about his quality improvement work with a national organization of intensive care physicians) was speaking on behalf of a breakout group on using expertise when he said we need an infrastructure that would let people involved in measurement share improvement ideas. But the group cautioned that we must also build up expertise in how to use data to make improvements. Other breakout groups called for an environmental scan, to establish what is being done across the country.
THE POINT OF VIEW THAT MATTERS MOST

The discussion paper that was sent to participants before the summit offered a vision that was widely supported at the meeting. It called for a structured, transparent, accessible, pan-Canadian measurement system focused on improving quality rather than accountability, which would coordinate work on developing and disseminating indicators. The system would have shared priorities, a standardized format for documenting indicators, transparent governance, and would ensure value to local users. But the vision underwent one profound modification during the meeting. Its original focus was the frustrated users and providers of information Gary Teare referred to in his opening remarks. An important addition that came from the meeting was the determination that the system should be shaped and guided by considering care from the patients’ perspectives. Whether it’s planning strategy, setting priorities, or developing, disseminating, and using indicators, patient-centred care will be the guiding light.

Working from “the patient point of view” would constantly ground health care measurement, taking it back to its ultimate goal: providing better care, for patients. One breakout group noted we’re generally much more comfortable talking about finding another $30 million for the emergency department than discussing a patient’s journey through it. But focusing on patient-centred care would overcome the competing agendas of all the groups involved in measurement.

Focusing on patients’ needs to guide measurement decisions would also acknowledge the growing reality of the “health care consumer,” according to Hugh MacLeod of the CPSI. “Eighty million U.S. health care consumers share their health care experiences on-line through social media,” he told the meeting, adding that we need to remember that consumers own the system—which will become more obvious as the activists of the 1960s increasingly turn their attention to health care.

Some participants, however, expressed concern that the issues raised by patients would not necessarily lead to the right improvement initiatives. Health care consumerism, one breakout group observed, often drives political decisions that are not the best priorities for health care and may have unintended consequences. There were suggestions that patient education programs would be needed.

“Bring in the patient voice. We need to think about the patient community. The people being served have a very important perspective.”
— Kimberlyn McGrail, UBC
“Even if we get one good idea, wouldn’t that be great? Right now within each of our jurisdictions we are spinning our wheels in terms of getting some thoughtful way forward on measurement.”

— John Cowell, Health Quality Council of Alberta

THINK BIG, START SMALL, ACT NOW

Getting a roomful of people seeking answers to agree on the importance of an issue is not hard; acting on solutions is. Alberta’s Cy Frank told the group everyone must be on the same page to find solutions — and it can take years to get different interests to compromise enough to take action. “In my mind, it must be project driven; talking philosophy won’t make it happen…I think if you pick three areas to collaborate on nationally it will be feasible,” he said.

Philosophizing had certainly been done. Participants had agreed on several challenging issues: that strategy and goals for organizing measurement should be patient focused, and that top-down and bottom-up measures are both valid, but there needs to be more connection between people developing indicators and people using them and more dependence on people at the front line of care to guide development. We need both well-established priorities and standard methods for developing and testing indicators and more communication and better sharing of information is needed to reduce duplication and spread good ideas. The national agencies were urged to work more closely with quality councils and other users of indicators.

Facilitator Catherine Delaney had built in opportunities to acknowledge issues that weren’t being discussed. They included some “elephant in the room” topics, such as the fact many organizations (and individuals) present compete in different ways and would have to be prepared, as Hugh MacLeod put it, to park their egos if a national measurement consortium were to succeed. Also, the goal of shared quality indicators does not allow for people who are happy with their own indicators and won’t welcome interference or cooperation. Other issues:

- Privacy around medical records is always an issue for indicator development;
- Support funding is going to be hard to find and,
- Provinces and territories may resist moves toward centralization.

There was no question in the room that it was time for action, but you could sense concern that, faced with the reality of the chaos outside the meeting, nothing solid would come of it. Someone urged a moratorium on new indicators until a national system was in place to set standards and disseminated them; someone else said it won’t be possible to stop people developing new indicators until the system is ready, but we could suggest a “one in, one out” rule in the interim. Someone else warned against developing indicators on spec, then searching for a use for it. There were cautions against getting bogged down in structure, and encouragement to start with small steps that would have visible results. There was fear the momentum from the meeting would dissipate.
To counter that, the four sponsors of the meeting—the Health Quality Councils of Saskatchewan and Alberta, the British Columbia Patient Safety and Quality Council, and the Canadian Patient Safety Institute promised to act on the first few steps called for at the summit, immediately issuing a memo about what the summit had achieved and promising to recruit folks from the meeting to be the core members of a pan-Canadian consortium that will then oversee the rest of the tasks that need to get done, which include:

- Creating a secretariat;
- Identifying who should be involved but wasn’t at the summit;
- Consulting the National Quality Forum about its structure and processes;
- Developing terms of reference;
- Starting regular meetings; and,
- Writing a briefing note (for various audiences) that describes what we will do and how we will work together.

The new consortium will start on these longer-term tasks:

- Building on the discussion paper, including information on ‘C group’ (CIHI, Statscan, and Accreditation Canada) projects around health care quality indicators;
- Preparing a business case to show the value of a pan-Canadian measurement approach and the risks of not doing this work;
- Asking the National Quality Forum about the impact of its work;
- Developing a list of irrefutable facts about the measurement situation in Canada;
- Setting priorities for the consortium;
- Choosing a joint pilot project;
- Exploring partnership opportunities with CIHR to promote research on indicators;
- Creating a clearing house for indicator information;
- Developing a communication plan for sharing and gathering information; and,
- Meeting in a year to evaluate success.

Since the summit, the host organizations have planned a meeting in September 2011, to initiate some of the “next steps” work recommended by participants at the Saskatoon meeting in May. A key step envisioned will be to convene a meeting of all health quality councils, related provincial organizations, and other health organizations keenly interested in measurement (e.g., Accreditation Canada, CPSI, CIHI, Health Council of Canada, Statistics Canada, etc) to agree on a common framework to describe health care quality, to reduce the confusion brought about by our organizations having different ways of talking about and categorizing the same things. Finally, a number of conversations between some of the summit host organizations and CIHI have occurred, since the meeting, to engage that important national health measurement organization early on in a consortium that will carry out the next steps suggested by the summit participants.
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