QUALITY MATRIX REFRESH

What we Learned and Heard (Phase One)

December 16, 2022

Improving Healthcare Together

The Health Quality Council of Alberta is a provincial agency that brings together patients, families, and our partners from across healthcare and academia to inspire improvement in patient safety, person-centred care, and health service quality. We assess and study the healthcare system, identify effective practices, and engage with Albertans to gather information about their experiences. Our responsibilities are outlined in the *Health Quality Council of Alberta Act*.

Please contact the Health Quality Council of Alberta for more information: info@hqca.ca, 403.297.8162.

WHAT WE HAVE LEARNED AND HEARD SO FAR ON THE QUALITY MATRIX REFRESH (PHASE ONE) NOVEMBER 2022

I. Background

The HQCA adopted the Alberta Quality Matrix (Matrix) for Health in 2005 as a tool to guide healthcare workers and decision-makers in the pursuit of quality health services. It provides a way of organizing information and thinking around the complexity of the health system during quality improvement conversations and planning.

The tool defines six dimensions of quality: acceptability, accessibility, appropriateness, effectiveness, efficiency, and safety (across an *x* axis) and four areas of need: being healthy, getting better, living with illness or disability, and end of life (*y* axis) (see Appendix A). The Matrix enables users to think about quality across a patient's journey (areas of need). In 2021 the HQCA determined a refresh of the Matrix was needed to ensure this popular tool remains current and relevant as we look at quality in a people-centred system.[1]

II. What we have done so far (phase one)

To inform a refresh of the Matrix, a first phase of an ongoing information-gathering process began in September 2021 that included:

- A review of the academic literature (since 2017) and frameworks on health and safety (since 2015).
- An environmental scan (since 2015) of prominent health quality and safety organizations in Canada, the U.K., Australia, and New Zealand, and of Alberta-specific considerations.
- Interviews with eight non-Alberta healthcare organizations identified from the environmental scan that had innovative or recently updated health quality frameworks.[2]

[1] Person-centred care was added to the HQCA's mandate in 2019. Many healthcare organizations are responding to the World Health Organization's 2007 call to develop a people-centred system. It describes people-centred care as: "An approach to care that consciously adopts individuals', carers', families', and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that carers attain maximal function within a supportive working environment. It is organized around the health needs and expectations of people rather than diseases" (WHO, 2007). People-centred health care: A policy framework (who.int)

[2] Shared Health MB, First Nations Health Authority (B.C.), BC Patient Safety & Quality Council, Healthcare Excellence Canada, Health Standards Organization, Health Quality & Safety Commission (New Zealand), Australian Commission on Safety and Quality in Health Care, World Health Organization

- Interviews with 46 individuals and groups within Alberta, many of whom were users of the Matrix but to differing degrees.[3] Some interviewees had limited experience using the Matrix; others were unfamiliar with it but reviewed it to provide feedback. However, many interviewees were sophisticated users, applying the tool often and in innovative ways.[4]

III. What we learned from the environmental scan, literature review, and interviews with other jurisdictions

The environmental scan, academic literature review, and interviews with people and organizations outside Alberta affirmed the relevance of the quality dimensions in the Matrix but also revealed shifts in language over time.[5]

In recent years, perspectives about components of healthcare quality have evolved, with many frameworks now including content about person/people-centred care. These frameworks make connections to equity, cultural humility, cultural safety, health and wellness (not just healthcare), the social determinants of health, integration (across a patient's journey and sectors/services), the needs of communities and populations, and engagement or partnership (with individuals and communities).

In interviews with some organizations outside Alberta, we learned important context behind how they defined, and what shaped their approach to, health quality. For some jurisdictions, updates to their definition of health quality occurred as part of their commitment to reconciliation with Indigenous Peoples.[6]

IV. What we heard in interviews in Alberta

Providers we interviewed value an Alberta-specific framework and its common vocabulary for healthcare. Views varied on how much the language might need to change and how the format might be visually reconceptualized.

Some felt the tool is working well and oppose large-scale changes because other tools and plans are tied to it. Others said considerable updates are needed to align with current thinking about healthcare quality, particularly around equity, person-centredness, healthy staff/healthy

[3] To recruit participants, the HQCA reached out to those known to be familiar with the Matrix and emailed its distribution list. Participants also offered referrals from their networks. We spoke with teams and departments within Alberta Health Services (AHS) and Alberta Health, and individuals from universities, continuing care, primary care networks, regulatory colleges, and patient/family advisory groups. More than half of interviewees were from AHS.

[4] Such as to ensure comprehensiveness in strategic planning so that plans and programs consider quality from multiple perspectives, and occasionally, the areas of need; inform the design and evaluation of research and quality improvement activities in clinical, planning, and teaching settings; explain the impact of a program or intervention for funding or research grants; examine the collective impact of programs across an area using standardized language; orient new employees and patients/families to understandings of quality

[5] Several terms are used in this document for which there is not yet a confirmed common understanding, or which may be used and defined differently, within Alberta. An updated Alberta Quality Matrix for Health will help provide the clarity that is currently lacking.

[6] For example, New Zealand and the BC Patient Safety & Quality Council

workforce, system constraints and population health. Some users supplement the Matrix with other frameworks so that quality is considered from some of these missing perspectives.[7]

Many questioned the Matrix's overall usefulness at the micro or clinical level, such as with individual provider and patient interactions, and whether the areas of need serve a purpose.[8] The grid format was a source of confusion for many people who consider the linear and 'either/or' design constraining and unrepresentative of patients' needs both during events and over time. Some felt the grid implies that a good project fills more boxes, as when submitting funding requests.

Users reported application of the Matrix to be difficult at times because of overlap across the dimensions and lack of clarity in the definitions. Overlaps were noted between:

- acceptability and appropriateness
- effectiveness and efficiency
- appropriateness and effectiveness
- safety and effectiveness

As such, it was suggested a review of the definitions would improve their descriptiveness, interpretability, and ease of use, and better reflect content deemed missing from the current Matrix, particularly equity. (See Appendix B for specific suggestions.)

Regarding the grid format, there was considerable support for exploring non-matrix alternatives. Some we spoke with advocated for a nonlinear visual representation that blurred boundaries and drew attention to interrelationships between the dimensions and areas of need. [9]

V. Putting it all together

Gaps in the current Matrix are evident based on updated understandings of health quality. Across our information sources, consistency was noted:

- Acceptability has been renamed respect, person-centred, client-centred, or people-centred.
- Understandings of effectiveness are less prescriptive about which knowledge system or world view defines the concept. They now consider the patient's perspective as well as other knowledge systems (e.g., Indigenous).
- Efficiency is defined broadly to urge consideration from a wide variety of perspectives, including the patient and family, and beyond cost efficiency.
- Definitions of safety have been broadened to include cultural safety.

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[7] The Institute of Medicine's Quadruple or Quintuple Aims were cited frequently.

[8] Interestingly, the environmental scan found no examples beyond Alberta or B.C. of a matrix format mapping quality dimensions against a second axis of areas of need/care. Shared Health MB references a "continuum of care" without a matrix.

[9] Suggestions included a circle/pie, 'Q', medicine wheel, a prism light, road map, tree, or heat map.

- Equity is expected and commonplace as either an additional dimension or interwoven throughout frameworks (in the definitions or explanations of other dimensions, such as appropriateness or accessibility).[10] Definitions generally discuss equity in terms of access to safe, quality care and services for everyone, regardless of individual characteristics. Some frameworks discuss equity and health equity as important, and distinct, objectives.
- Dimensions of quality not present in the Matrix are sometimes included in other frameworks, such as:
    - Community driven or partnership/engagement (with an emphasis on equity-deserving populations)
    - Population focused
    - Continuity/integrated/seamless across service providers and sectors
    - Healthy workplace culture and workforce

The importance of Indigenous voices in defining quality was another key finding from the literature review, environmental scan, and interviews. In fact, many Alberta interviewees asked us about our plans to (or suggested we) consider Indigenous perspectives. Updating this tool with Indigenous perspectives is important, so healthcare providers and decision-makers in Alberta aim to achieve quality healthcare in a way that is consistent with the preferences and expectations of Indigenous individuals, families, and communities.

Accomplishing this goal is further encouraged by the Truth and Reconciliation Commission's healthcare-related Calls to Action,[11] the United Nations Declaration on the Rights of Indigenous Peoples, and the treaty right to health.[12] In addition, in September 2022 Alberta's health minister announced five desired outcomes in healthcare: access, integration, high quality, patients as partners, and culturally safe (in particular for First Nations, Inuit, and Métis peoples).[13]

VI. Where we're going (phase two)

To date, many valuable suggestions have emerged about how to improve Alberta's understanding of health quality and the functionality of the Matrix. Considering what we have heard and learned in our first phase of engagement, the HQCA has identified key principles that will guide our second phase:

1. Continue to work with others to explore the divergent perspectives on how to update the Matrix. Many are invested in the tool and expressed a desire for continued engagement.

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[10] Alberta stakeholders were divided on whether equity should be a standalone dimension or span all dimensions.

[11] For example, but not only, Calls to Action 13 (language rights), 19 (health outcome gaps), 22 (valuing Indigenous healing practices), and 55(iv) (progress toward Reconciliation)

[12] https://www.nccih.ca/Publications/Lists/Publications/Attachments/10361/Treaty-Right-to-Health_EN_Web_2021-02-02.pdf

[13] Announced Sept. 23, 2022 as part of the Modernizing Alberta's Primary Health Care System (MAPS) initiative

2. Prioritize relationship-building with Indigenous health peers and seek guidance on how best to advance understandings of health quality in a way that honours the histories and teachings of Indigenous Peoples in Alberta and aligns with their preferences and expectations. An inclusive process better positions healthcare providers and decision-makers in Alberta to act and assess progress on the TRC's Calls to Action.
   Our efforts at present are focused on connecting with Indigenous peers to determine how and with whom we should work to answer the questions:

   - How is healthcare quality defined by Indigenous patients, families, and communities?
   - What is important to consider from an Indigenous lens as we refresh this resource to describe healthcare quality in a people-centred system?
   - How can we better understand and respect data and information sovereignty needs (e.g., First Nations Principles of ownership, control, access, and possession (OCAP©[14]) in developing a resource like this?
   - How do we create a resource(s) that resonates for Indigenous and non-Indigenous healthcare users?

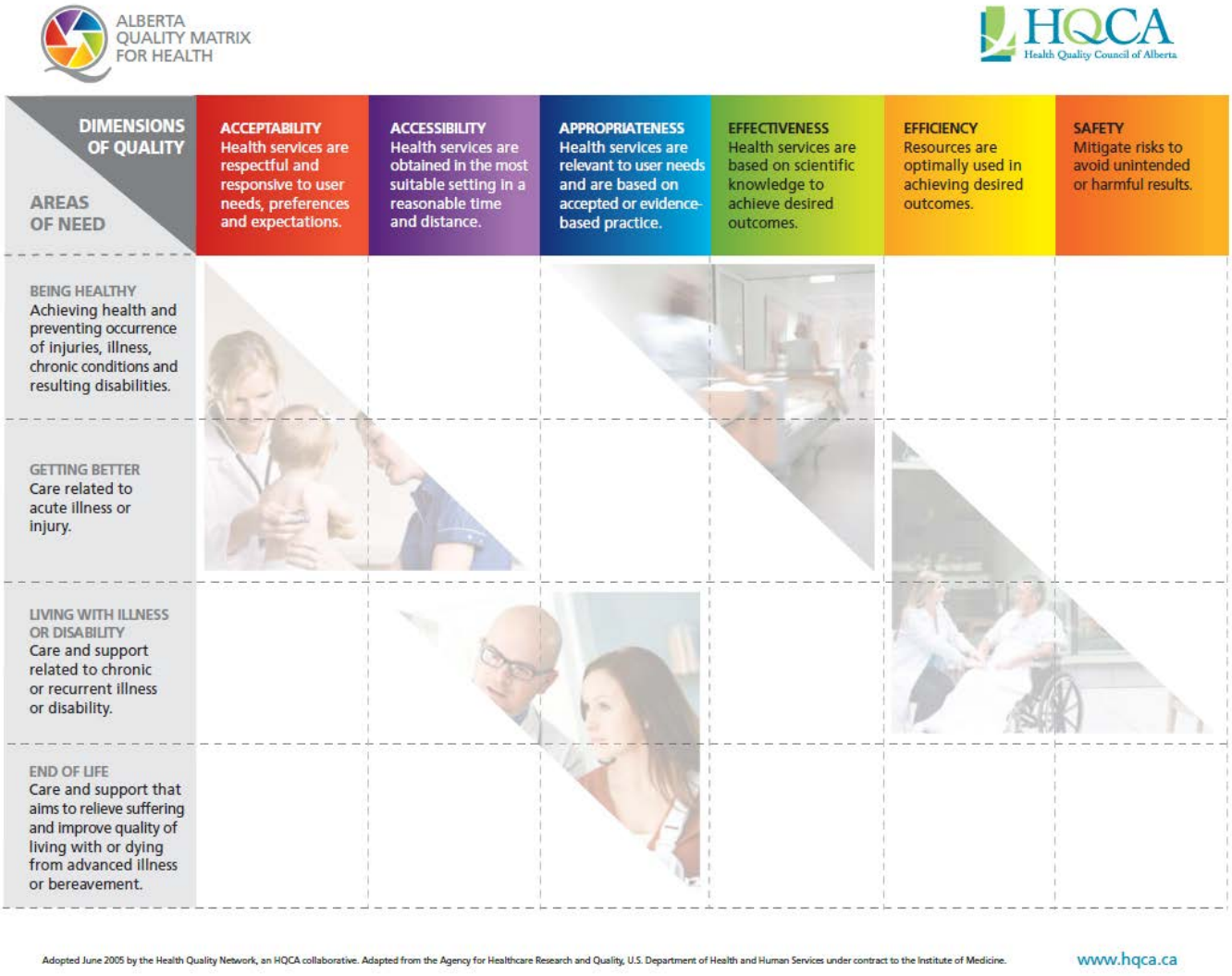
3. Identify and seek out missing perspectives and bring an equity lens to our engagement plan. In phase one, our recruitment strategy identified mainly people familiar with the Matrix. However, our sample to date does not include many perspectives of those with an interest in how quality is defined and understood in Alberta, but who are less familiar/or unfamiliar with the Matrix yet involved in the provision of care and services to Albertans. For instance, we have not heard from frontline care providers, or representatives from specific sectors of the health system (e.g., mental health, substance abuse/addictions/recovery), where much development is taking place in Alberta. There are also some areas of the healthcare system (i.e., primary care, continuing care) and perspectives (i.e., urban/rural, disability, ethnicity, and sexual orientation and gender identity) where feedback has not been sufficiently captured. More conversations are needed with all of these stakeholders.

   We have had limited engagement with equity-deserving and underrepresented voices. This must be addressed, given we have heard Alberta's updated understanding of quality needs to reflect equity. And so, we will we involve equity-deserving voices, as well as community-based supports and services that provide care and services to these groups.

[14] Ownership, control, access, and possession principles of the First Nations Information and Governance Centre

APPENDICES

Appendix A: Alberta Quality Matrix for Health



The Alberta Quality Matrix for Health User Guide assists with understanding and using the Quality Matrix.

Appendix B: Matrix Dimensions

Alberta stakeholders consulted thus far suggested a review of the dimensions and their definitions to improve their descriptiveness, interpretability, and ease of use.

Matrix dimension	Suggestions
Acceptability: Health services are respectful and responsive to user needs, preferences, and expectations.	▪ Rename the dimension "respect"[15] or "person-centred" to better reflect the intention of the dimension. *("Acceptable sounds like the lowest common denominator, [but] is that what we want?")*
Accessibility: Health services are obtained in the most suitable setting in a reasonable time and distance.	▪ Go beyond access to health services in the definition to include access to cultural safety/competency in the delivery of services. ▪ Consider the patient's perspective on accessibility, such as access to financial/socio-economic resources that impact health.
Appropriateness: Health services are relevant to user needs and are based on accepted or evidence-based practice.	▪ New interpretations of appropriateness exist today because of the de-adoption movement to reduce use of low-value services, thus use of the term "right care" in the description may limit overlap with other interpretations of appropriateness. ▪ The term appropriate implies judgment and begs the question, from whose perspective this dimension is being considered.
Effectiveness: Health services are based on scientific knowledge to achieve desired outcomes.	▪ May need to broaden the definition to include more strongly the perspective of value for money and evidence of impact on the patient. ▪ Definition privileges scientific knowledge and needs to consider traditional/cultural health practices and perspectives, which are needed for some patients/populations to achieve desired outcomes.
Efficiency: Resources are optimally used in achieving desired outcomes.	▪ Definition is unclear about what efficiency refers to (time, materials, cost?). ▪ Name of the definition highlights the system/provider's view, but efficiency may be experienced and described differently by patients. For instance, patients may prioritize time (i.e., amount of time waiting for a service), and affordability. ▪ Consider renaming the dimension affordability, which captures better the interests of both the system and patients.
Safety: Mitigate risks to avoid unintended or harmful results.	▪ Must be more comprehensively interpreted to include physical, emotional, psychological, and cultural safety.

[15] This was also a suggestion of the BC Patient Safety & Quality Council.

210, 811 – 14 Street NW
Calgary, Alberta, Canada T2N 2A4
T: 403.297.8162 F: 403.297.8258
E: info@hqca.ca **www.hqca.ca**