



Alignment of Health Quality Measurement

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Measurement and “Quality”

Alberta Quality Matrix for Health

Dimensions of Quality



Areas of Need

Being Healthy

Achieving health and preventing occurrence of injuries, illness, chronic conditions and resulting disabilities.

Getting Better

Care related to acute illness or injury.

Living with Illness or Disability

Care and support related to chronic or recurrent illness or disability.

End of Life

Care and support that aims to relieve suffering and improve quality of living with or dying from advanced illness or bereavement.

Acceptability

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

Accessibility

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

Appropriateness

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

Effectiveness

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

Efficiency

Resources are optimally used in achieving desired outcomes.

Safety

Mitigate risks to avoid unintended or harmful results.



Shotgun Representation?

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	Acceptability	Accessibility	Appropriateness	Effectiveness	Efficiency	Safety
Being Healthy						
Getting Better						
Living with Illness or Disability						
End of Life						

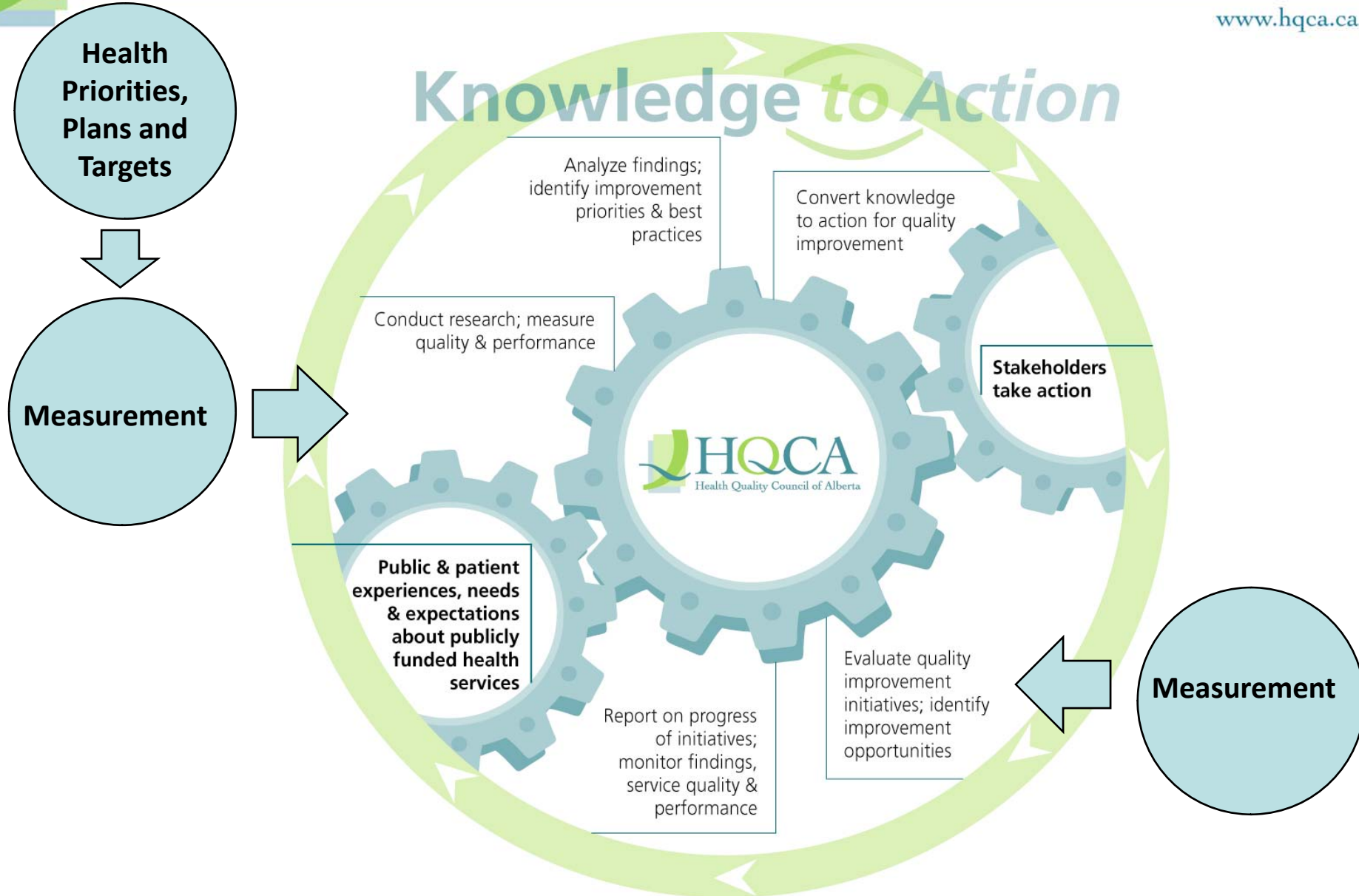


Premise

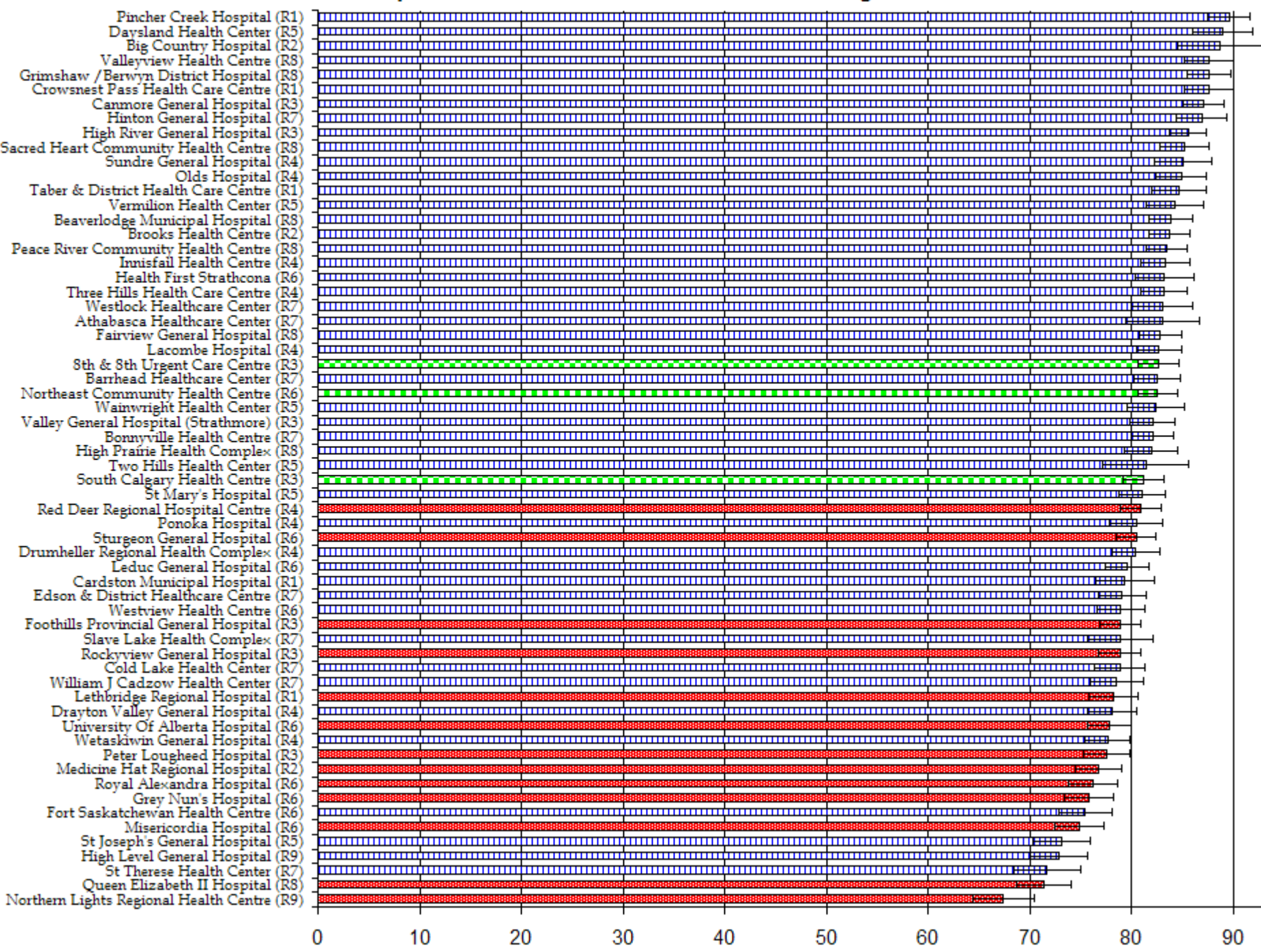
Without an effective measurement *system* for healthcare quality there cannot be:

- effective self-evaluation
- information needed to identify improvement opportunities
- information to assess intervention results
- information required for accountability
- meaningful cascade of measures up to system level

From Priorities to Measurement to Action to Improved Performance



Composite: Staff care and communication - average score





Alignment . . .

- Coordination and collaboration to optimize effort, resources, and impact

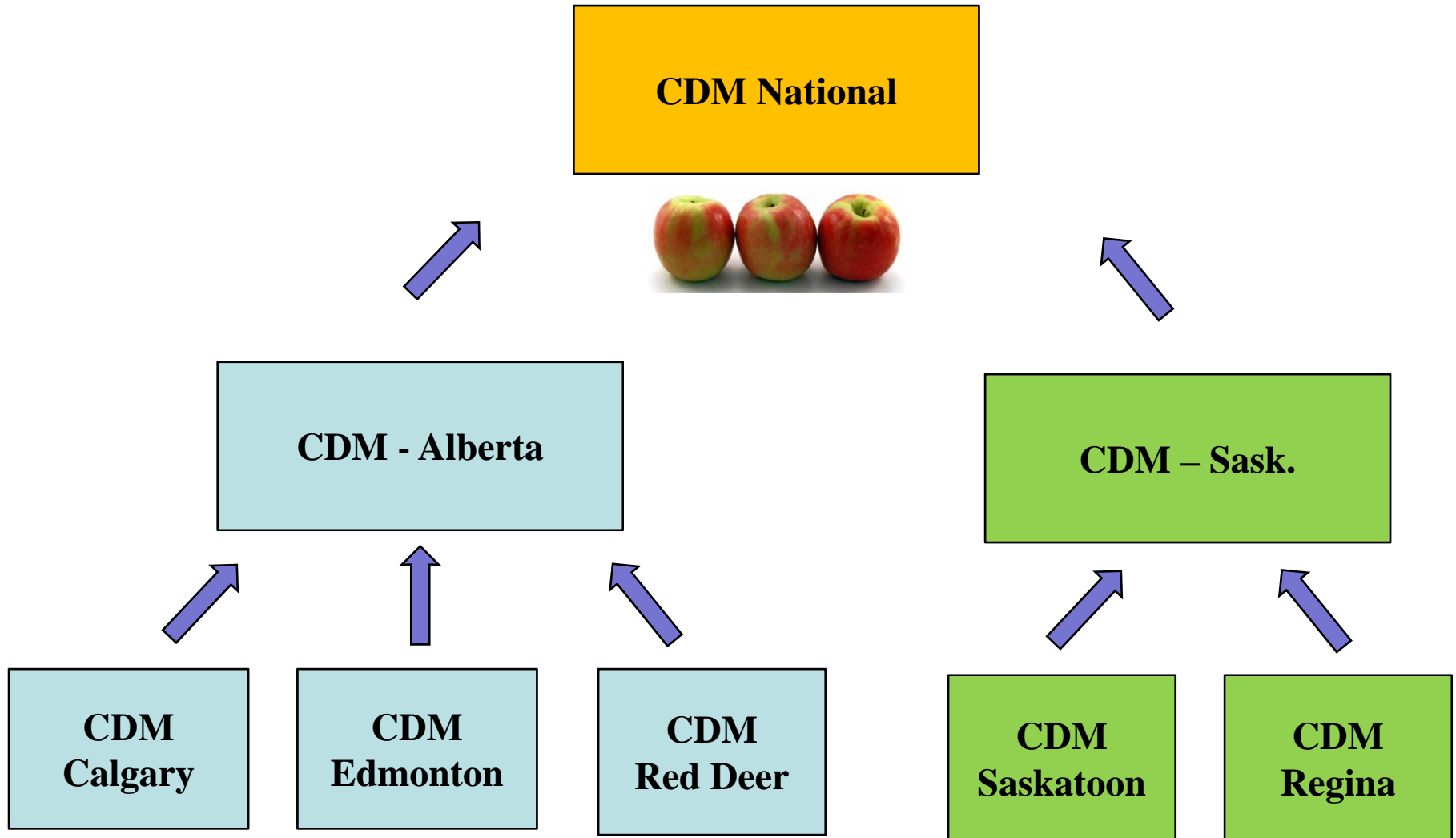


- long Term movement towards common measures at granular level (bottom up)





Indicator Networks / Consortia





- Admin data linked at patient level
(Registry, Inpatient, Ambulatory, Claims, Vital Stats)
- Using CRG software and/or linked data to examine
 - Chronic Disease Groups
 - Specific Chronic Diseases
 - Disease State Transitions
 - Compare Alternative Primary Care Models
 - Prevalence
 - Utilization and Costs for these groups
 - Break down by programs
- Potential for more comprehensive system level measures (not shotgun sample)

Examples (system)

- Proportion of patients within a single or simple chronic CRG who evolve to more complex Category within 3 years.
- Proportion of uncomplicated diabetics who transition to a more complex disease state within 3 years
- Proportion of patient level GP visits to the same provider or clinic
- Proportion of ED visits with diagnosis category having $< 3\%$ probability of admission

Clinical Risk Groups

Health State (2005/06)	Population	%
Healthy / No Important Diagnoses or Treatments	1,893,931	62.5%
Significant Acute	228,873	7.6%
Single Minor Chronic	328,272	10.8%
Multiple Minor Chronic	49,597	1.6%
Single Dominant or Moderate Chronic	400,150	13.2%
Pairs - Multiple Dominant and / or Moderate Chronic	111,004	3.7%
Triples - Multiple Dominant Chronic	6,660	0.2%
Malignancies - Metastatic, Complicated or Dominant	6,465	0.2%
Catastrophic	3,504	0.1%
Overall	3,028,456	100%



to More Complex C.D.

- Base population: Albertans within “uncomplicated” diabetes CRG, as diagnosed over 3 years
- Proportion who remain in “uncomplicated” category after 3 additional years

62.6%



Priorities

- Communicate > Share > Compare > Collaborate
- Common measures for specific clinical areas and diseases (gradually via networks not by prescription from above)
- Common core sets of patient experience measures
- Common patient level HRQOL (outcomes) and patient level costing
- System measures based on linked patient level data sets and analysis by patient need (disease)