BRITISH COLUMBIA

HEALTH QUALITY MATRIX

COMPANION GUIDE

BC PATIENT SAFETY & QUALITY COUNCIL
Working Together. Accelerating Improvement.

BACKGROUND

The *BC Health Quality Matrix* (the Matrix) was first published in 2009 following dialogue with partners across British Columbia's health system. In 2019, partners were brought together again to incorporate the latest evidence in an updated version, and to ensure that our definition of quality honours the history and teachings of Indigenous peoples in BC. We embraced the opportunity to translate reconciliation into action by embedding Indigenous perspectives on health and wellness and advancing the "best of both worlds" approach of exploring what is possible when we welcome our Indigenous and non-Indigenous worldviews.

The updated Matrix goes beyond previous frameworks by incorporating new learning and a more representative understanding of quality through:

- Broadening the concept of health quality to include health and wellness, encouraging a focus on the whole person and on promoting wellness in addition to treating illness;
- Reflecting the wellness focus in each of the Areas of Care as well as adding a fifth area to account for the critical role of the early years of life;
- Strengthening the concept of care as relational, along with enhancing core values of cultural safety and humility as well as person- and family-centred care throughout;
- Broadening and strengthening each of the seven Dimensions of Quality, including renaming the Respect dimension (previously Acceptability) and expanding the Safety dimension to include fostering security and trust in addition to avoiding physical, cultural and psychological harm;
- Expanding the concept of evidence to include experiential and traditional sources of knowledge; and
- Reinforcing the notion of substantive equity along with the importance of understanding and recognizing differences in people's histories and experiences.

> The term **Indigenous** is used throughout this document to refer to First Nations, Métis and Inuit peoples. It is an inclusive and international term to describe individuals and collectives who consider themselves as being related to and/or having historical continuity with "First Peoples."[1]

1. Allan B, Smylie J. First peoples, second class treatment: the role of racism in the health and well-being of Indigenous peoples in Canada. Toronto: Wellesely Institute; 2015.

HOW TO USE THIS GUIDE

This document supports those working to improve quality. Users will be able to reflect on how they will apply the Matrix in their own setting. It contains an overview of the core components and perspectives within BC's common definition of quality, followed by case studies to illustrate some ways these can be used in planning, assessing and improving the quality of care.

Background	2
About the Matrix	4
Health and Wellness	5
Dimensions of Quality	6
Areas of Care	9
Using the Matrix	12
Case Studies	15
Acknowledgments	25
Contact Information	26

ABOUT THE MATRIX

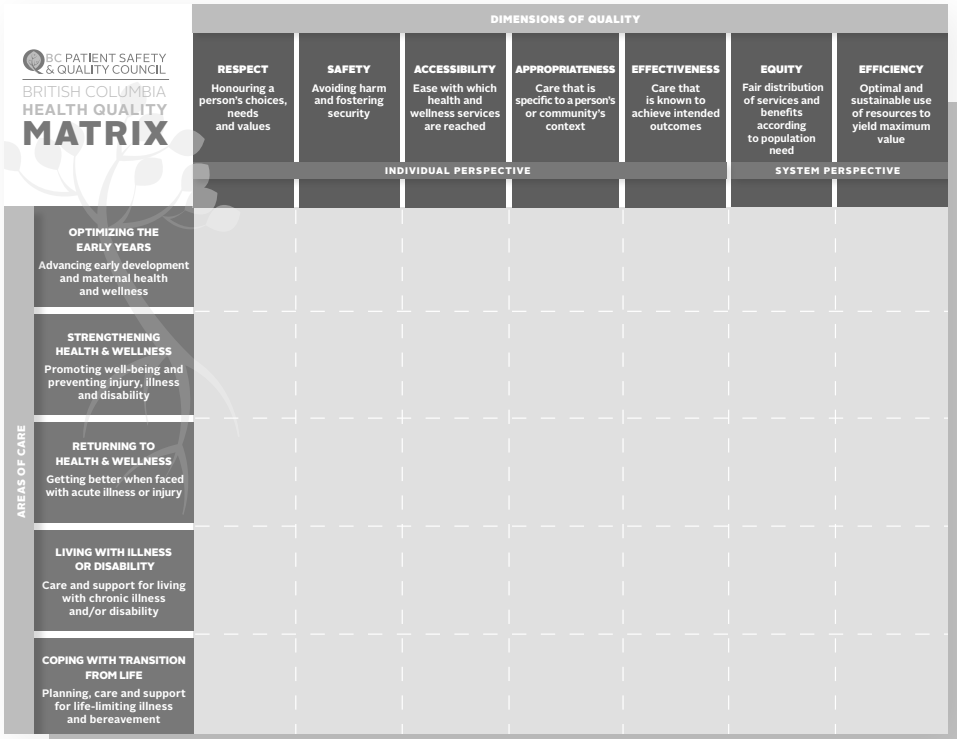
The Matrix provides a common language and understanding about quality. It answers the question: What do we mean by the "quality" of care? How we define quality ultimately translates into how well we care for people and where we place our attention.

Quality is defined through the lens of seven **Dimensions of Quality**. Five focus on individual experiences from both a person as well as a population perspective, and two focus on the performance of systems that deliver care.

The seven Dimensions of Quality span the full continuum of care, which in turn is distinguished by five interconnected **Areas of Care**. Each area represents different experiences within a person's journey to physical, mental, emotional and spiritual health and wellness.

It is important to recognize that this definition of quality is grounded in an understanding of **health and wellness** that considers the whole person and the relational nature of care.

The Matrix is useful for anyone engaged in the health system – including administrators, practitioners and patient partners – for planning, assessing, improving and teaching at the practice, program, site and system levels.



This tool on page 14 was created to guide users in applying the Matrix.

HEALTH AND WELLNESS

British Columbia's definition of quality is grounded in an understanding of health that includes wellness and considers the whole person. The phrase *health and wellness* captures the full continuum of supports for addressing people's needs while also supporting them to stay well, build on their strengths and thrive. Considering the whole person means considering their physical, mental, emotional and spiritual well- being, as well as their past and present familial, social, cultural and environmental context. These are complex and interconnected.

Relationships are at the core of any healing environment or interaction. Strong relationships are based on humility, trust and reciprocal accountabilities in order to understand and support one another. Support looks different for every person, and their needs and desires change over the course of their life. Committing to advancing cultural humility is a way to enable and support this relational nature of care at individual and organizational levels. The term *care* is used in a broad sense to capture the many connections, treatments and services that support people's health and wellness. Care can be relational within one-to-one interactions or among groups and communities.

> **Cultural humility** is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.[2]

2. First Nations Health Authority. Cultural Humility [Internet]. 2020 [cited 2020 Jan 1]. Available from: https://www.fnha.ca/wellness/cultural-humility

DIMENSIONS OF QUALITY

Quality is made up of multiple *Dimensions of Quality.*

Five dimensions focus on the individual experience from both a person and a population perspective: respect, safety, accessibility, appropriateness and effectiveness.

Two dimensions focus on the performance of the systems in which health and wellness services are delivered: equity and efficiency. This does not mean that these two dimensions are only relevant to those working at a system level. While the dimensions may not fully apply within the scope of every project or program, individuals and teams can still be thinking about their activities and changes through the lenses of equity and efficiency.

Respect	Honouring a person's choices, needs and values
Safety	Avoiding harm and fostering security
Accessibility	Ease with which health and wellness services are reached
Appropriateness	Care that is specific to a person's or community's context
Effectiveness	Care that is known to achieve intended outcomes
Equity	Fair distribution of services and benefits according to population need
Efficiency	Optimal and sustainable use of resources to yield maximum value

When considering quality...

Think about how you are accounting for the whole person, as well as the nature and strength of the existing relationships that form the foundation of care between people and communities. Key questions to ask include:

- **How are we considering the physical, mental, emotional and spiritual states of the person or community?**
- **What about this person or community's context may be impacting their health and wellness or their experience of care?**
- **What are the primary relationships involved? How are we fostering these relationships and what more can we be doing to support them?**

DIMENSIONS OF QUALITY

RESPECT: *Honouring a person's choices, needs and values*

This dimension upholds human dignity by minimizing power imbalances and creating space for people to demonstrate agency in their own health and wellness. Respect includes being responsive to and making decisions in partnership with a person, family, caregiver and/or community.

You can learn more about ways to foster respectful care here.

ACCESSIBILITY: *Ease with which health and wellness services are reached*[3]

Accessibility is the extent to which people can readily obtain care when and where they need it. This dimension aims to overcome physical, financial, cultural or psychological barriers to receiving information and care. It includes a welcoming entry and seamless transitions between and within services.

SAFETY: *Avoiding harm and fostering security*

This dimension involves processes and environments that ensure both actual and perceived physical, cultural and psychological safety. Safety is the extent to which services prevent or minimize harm that could unintentionally result from the delivery of care, and the extent to which they promote trust.

> **Cultural safety** is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.[4]

You can learn more about cultural safety and humility in the health system here.

> **Psychological safety** is broadly defined as a climate in which people are comfortable expressing and being themselves, sharing concerns and mistakes without fear of embarrassment or retribution, and asking questions when they are unsure about something. [5]

You can learn more about working on psychological safety in your workplace here.

> **Harm** exists in many different forms. Adverse outcomes for people receiving care, such as prolonged pain, suffering, medical complications and death, are examples of clinical harm. Care providers and staff may experience injury, burnout and vicarious trauma. Harm can also be inflicted by limiting a person's autonomy or subjecting them to racism, discrimination or stigma. Other examples of harm include disrupting a person, their family, their caregiver or their community through displacement or separation from supports. The effects of harm can be wide-reaching or unique to every individual, and they can limit a person's or population's engagement with health services and their benefits.

3. Kelley E, Hurst J. Health care quality indicators project: conceptual framework paper. OECD Health Working Papers. No. 23. Paris. Available from: www.oecd.org/dataoecd/1/36/36262363.pdf
4. First Nations Health Authority. Cultural Humility [Internet]. 2020 [cited 2020 Jan 1]. Available from: https://www.fnha.ca/wellness/cultural-humility
5. Edmondson A. The fearless organization: creating psychological safety in the workplace. Hoboken, NJ: John Wiley & Sons; 2018.

DIMENSIONS OF QUALITY

APPROPRIATENESS: *Care that is specific to a person's or community's context*

Appropriate care is informed by evidence and best practice to optimize care to achieve a specific person's health and wellness goals. It weighs the benefits and risks of interventions to prevent the overuse and underuse of treatments or services.

EFFECTIVENESS: *Care that is known to achieve intended outcomes*

Effective care is informed by evidence and best practice to achieve the best possible outcome for people's or populations' desired health and wellness. A commitment to effectiveness is demonstrated by continuously studying the results of care as well as promising new methods that may improve health and wellness for all.

> **Evidence** includes knowledge gained through formal academia and clinical research, such as randomized control trials. It also includes knowledge gained through collective expertise and lived experience, such as Indigenous knowledge and practices passed through oral tradition, as well as groups' shared stories and experiences.

EQUITY: *Fair distribution of services and benefits according to population need*

Equity involves understanding the people being served, focusing on the social determinants of health, overcoming structural barriers and eliminating systemic oppression to address gaps in experience and outcome. Equity is demonstrated when every person has the opportunity to achieve their health and wellness goals regardless of social, economic or geographic location. Equity does not mean the exact same care for everyone because individuals have different experiences, histories and needs.

You can learn more about how to promote equity-oriented health care here.

EFFICIENCY: *Optimal and sustainable use of resources to yield maximum value*

A commitment to efficiency is demonstrated by the thoughtful use of financial, environmental and human resources to deliver health and wellness services today and in the future. This includes maximizing capacity to deliver more or better services by minimizing and eliminating waste throughout health systems, such as unnecessary energy, materials and money spent.

AREAS OF CARE

The seven Dimensions of Quality span the full continuum of care, which in turn distinguishes between five interconnected Areas of Care. Each area represents different experiences within a person's or community's continual journey toward physical, mental, emotional and spiritual health and wellness.

Optimizing the Early Years	Advancing early development and maternal health and wellness
Strengthening Health & Wellness	Promoting well-being and preventing injury, illness and disability
Returning to Health & Wellness	Getting better when faced with acute illness or injury
Living with Illness or Disability	Care and support for living with chronic illness and/or disability
Coping with Transition from Life	Planning, care and support for life-limiting illness and bereavement

People's health and wellness journeys often involve flow between Areas of Care. For example, they may obtain care for acute illness and then later access community support services while living with a disability. A person may also experience multiple areas at the same time. For example, a person may receive care for a chronic condition, while also focusing on strengthening their overall health and wellness as well as accessing support for grieving the loss of a loved one.

Some may move through the Areas of Care chronologically, while others may enter and exit at any stage. People do not take this journey alone; family and community can play a role in influencing the journey and outcomes.

Some health service providers (organizations and individuals) specialize in one Area of Care, but many provide services within a few or even all five. For example, BC's health authorities provide services within each of the areas through public health programs, hospitals, rehabilitation programs, long-term care homes and palliative care programs. Using available evidence, they are increasingly adopting approaches to supporting health and wellness that span multiple areas.

When considering quality...

Organizations, care providers and individuals are encouraged to consider their role within each Area of Care and the interrelationships among services in the health system to support coordinated care. Key questions to ask include:

- **What Area(s) of Care does our work touch?**
- **How does our work impact other related Areas of Care? Or, alternatively, how do other areas impact our work?**

AREAS OF CARE

The following are examples that show how care related to substance use spans all five Areas of Care:

OPTIMIZING THE EARLY YEARS	Reducing prevalence of substance use during pregnancy and protecting children from adverse childhood experiences that may be associated with mental health and/or substance use issues later in life
STRENGTHENING HEALTH & WELLNESS	Sharing information about the potential harms associated with substance use, and prioritizing early intervention and treatment of factors contributing to substance use, such as unresolved pain or mental health concerns
RETURNING TO HEALTH & WELLNESS	Using naloxone to reverse the effects of an opioid overdose and treating substance use disorders through evidence-based pharmacological and psychosocial interventions
LIVING WITH ILLNESS OR DISABILITY	Supporting a person to reduce the harms associated with substance use by accessing harm reduction services or to reduce or stop substance use through medication (when appropriate), counselling and peer support for those who are affected by substance use issues, including their loved ones
COPING WITH TRANSITION FROM LIFE	Recognizing the specific palliative care needs of people with substance use disorders and those of their family, caregivers or communities

The ultimate aim of the Matrix is to advance health and wellness through a high-quality health system that is respectful, safe, accessible, appropriate, effective, equitable and efficient across the continuum of care.

USING THE MATRIX

Why use the Matrix?

The Matrix provides a common language and understanding about quality for all those who interact with, deliver, support, manage and govern health and wellness services. Having a shared definition facilitates a coordinated approach to thinking and learning about the Dimensions of Quality, how the dimensions relate to one another, and responsibilities throughout a person's journey. It also enables the development of metrics that comprehensively measure quality across the continuum of care, or for a single Area of Care, and across dimensions.

Ways to apply the Matrix

The Matrix is used to initiate, maintain and guide work throughout the life cycle of a project, program or strategy. The Matrix can be used at multiple levels, from planning the distribution of health services to evaluating a specific health service or developing a measurement plan for a local improvement project. It helps to consider quality in a comprehensive way and to account for existing assets and deficits as you engage in activities and make decisions.

The visual on page 14 was created as a tool to guide the use of the Matrix in practical ways. While all the parts of the Matrix are interconnected, considering the different dimensions and areas is a useful way to think about and measure quality.

The format prompts and enables users, at a glance, to thoughtfully and methodically consider multiple Dimensions of Quality and the full continuum of care as it pertains to a particular situation or piece of work. The lines used are intentionally dashed to represent the inherent connection and overlap between different dimensions and areas. At times the lines will not be as relevant depending on the nature of the work. For example, those working in programs that impact multiple Areas of Care, such as primary care, might ignore the horizontal dashed lines if elements apply to more than one area (see page 24 as an example). The dashed lines are intended to enable you to be creative with how you use the tool to make it most valuable for your context or purpose.

USING THE MATRIX

How the Matrix aligns with your work

The health system and the communities it serves are diverse and complex. In bringing consistency to understanding and measuring quality, the Matrix is intentionally flexible enough to be relevant across local contexts. This enables you to integrate the common understanding of quality described in the Matrix with other existing mechanisms, frameworks or tools you are currently using in order to strengthen your approach to quality.

Case studies

The case studies on the following pages illustrate some of the ways the Matrix can be used. The examples are based on work taking place in BC, though the information has been adapted to highlight key areas and is not intended to offer a complete or comprehensive examination of the activities.

- Developing quality measures for an inpatient stroke rehabilitation program (page 15)
- Leading an improvement project aimed at promoting healthy medication use (page 19)
- Planning the implementation of a Primary Care Network (page 22)

BC PATIENT SAFETY & QUALITY COUNCIL

BRITISH COLUMBIA HEALTH QUALITY MATRIX

DIMENSIONS OF QUALITY

RESPECT	SAFETY	ACCESSIBILITY	APPROPRIATENESS	EFFECTIVENESS	EQUITY	EFFICIENCY
Honouring a person's choices, needs and values	Avoiding harm and fostering security	Ease with which health and wellness services are reached	Care that is specific to a person's or community's context	Care that is known to achieve intended outcomes	Fair distribution of services and benefits according to population need	Optimal and sustainable use of resources to yield maximum value
INDIVIDUAL PERSPECTIVE					SYSTEM PERSPECTIVE	

AREAS OF CARE

OPTIMIZING THE EARLY YEARS
Advancing early development and maternal health and wellness

STRENGTHENING HEALTH & WELLNESS
Promoting well-being and preventing injury, illness and disability

RETURNING TO HEALTH & WELLNESS
Getting better when faced with acute illness or injury

LIVING WITH ILLNESS OR DISABILITY
Care and support for living with chronic illness and/or disability

COPING WITH TRANSITION FROM LIFE
Planning, care and support for life-limiting illness and bereavement

CASE STUDY #1:

Developing quality measures for an inpatient stroke rehabilitation program

This case examines the inpatient stroke rehabilitation program at a local hospital as an example of how a team can apply the Matrix to develop a balanced set of indicators to measure the quality.[6] Using the Matrix enables us to reflect on all the Dimensions of Quality and set up a comprehensive measurement plan to monitor quality of care and whether gains within one dimension are translating into unforeseen or unwanted consequences within another.

Description of the program:

The stroke rehabilitation program considered in this case study provides care for older adults aged 55 and over who have suffered a stroke. It is located within a large referral rehabilitation hospital in BC that mainly serves the Lower Mainland and local communities. Rehabilitation is based on an interdisciplinary team approach to maximizing people's quality of life.

Applying the Matrix to develop a balanced set of indicators:

Identifying a balanced set of indicators to measure quality begins by reflecting on what high-quality care looks like in the stroke rehabilitation program within each of the Dimensions of Quality.

Respect:

- Involving the person receiving care, and their family and/or caregivers, if desired, in care decisions from admission through to discharge and connection with community services.
- Getting to know the person, including their beliefs, traditions and values, to ensure that their care is consistent with what matters most to them throughout their care journey – from admission to discharge.

Safety:

- Planning processes to reduce the risk for adverse physical outcomes from falls, urinary tract infections, bedsores, aspiration and pneumonia, which can be more common for people in stroke rehabilitation.
- Maintaining an environment in which patients, caregivers and family members, as well as providers and staff, feel confident and encouraged to speak up or ask questions without experiencing stigma or retribution.

6. Arione, A. Quality framework - Focus: Inpatient stroke rehabilitation program [master's assignment]. Vancouver (BC): University of British Columbia; 2016.

CASE STUDY #1

Accessibility:

- Creating a straightforward referral and admission process that can be readily completed in a timely manner and connecting the person, their family and/or their caregiver(s) with beneficial services in the community following discharge.
- Designing mechanisms to overcome potential geographic or financial barriers to receiving rehabilitation, such as reducing unnecessary displacement and incorporating telehealth when possible.

Appropriateness:

- Developing tailored care plans to acknowledge that each person comes with a unique background, including comorbidities, family and community history, genetic makeup, level and motivation for exercise, eating habits and coping mechanisms.
- Supporting people in weighing the anticipated risks and benefits of care to make decisions around treatment options for their personal circumstances, such as encouraging Botox injections for people experiencing spasticity or electro-physical agents for those who present with motor issues.

Effectiveness:

- Ensuring all disciplines within the care team use evidence to inform care planning and stay current on best practices such as the intensity, duration and timing of therapy.
- Analyzing the results of care within stroke rehabilitation in order to make any changes necessary to improve the care provided within the program.

Equity:

- Offering translation and interpretation services to people who do not speak English so that neither their rehabilitation nor experience in the program are unfairly compromised by language barriers.
- Examining how experiences and outcomes of care vary, if at all, across groups of people receiving care in the program, including those from different physical locations and social and economic backgrounds.

Efficiency:

- Helping to ensure that people attend scheduled appointments.
- Leveraging central scheduling to ensure that therapist time does not go unused.
- Being mindful of the high volume of equipment used in rehabilitation and reducing waste both in terms of unnecessary materials as well as staff time spent looking for and gathering items.

CASE STUDY #1

Following a reflection on what high-quality care looks like across the Dimensions of Quality, we can start to identify potential indicators to measure those aspects of quality. The Matrix visual aid on the next page has been filled in with sample potential measures. From there, we can prioritize and select a balanced set of indicators to ensure that we are monitoring significant factors while not inadvertently advancing one dimension at the expense of another.

At times, a quality measure or activity may fall under two or more Dimensions of Quality. For example, offering translation services leads to care that is more respectful and accessible for a person, and more equitably delivered. In those cases, we might choose to only mention it once under the dimension where it has the biggest impact; repeat it under multiple dimensions; or draw across the borders of the squares.

Though rehabilitation focuses on *Returning to Health & Wellness*, it is worthwhile to note that activities within other Areas of Care are also impacted. For example, certain people are predisposed to having a stroke due to genetic or lifestyle factors (*Optimizing the Early Years* and *Strengthening Health & Wellnes*s). At the same time, the quality of care people receive within the rehabilitation program will influence how they live with any long-lasting effects of their stroke following discharge *(Living with Illness or Disability)*.

CASE STUDY #1

Developing Quality Measures

DIMENSIONS OF QUALITY

	RESPECT Honouring a person's choices, needs and values	SAFETY Avoiding harm and fostering security	ACCESSIBILITY Ease with which health and wellness services are reached	APPROPRIATENESS Care that is specific to a person's or community's context	EFFECTIVENESS Care that is known to achieve intended outcomes	EQUITY Fair distribution of services and benefits according to population need	EFFICIENCY Optimal and sustainable use of resources to yield maximum value
	INDIVIDUAL PERSPECTIVE					SYSTEM PERSPECTIVE	
AREAS OF CARE							
OPTIMIZING THE EARLY YEARS							
STRENGTHENING HEALTH & WELLNESS							
RETURNING TO HEALTH & WELLNESS **Getting better when faced with acute illness or injury**	Average rating on stroke patients' experience survey Median patient satisfaction scores with the initial "family meeting" Percentage of people who feel their preferences for care were respected	Number and type of adverse outcomes Percentage of patients screened for risk of falls on their first day of admission Percentage of patients with a falls-prevention strategy implemented Percentage of patients who have a documented swallowing screen on the first day of admission that do not have a record of one being completed in acute care	Median wait time from referral to admission to a stroke rehabilitation program Number of patients provided stroke rehabilitation through tele-rehab Percentage of patients' referrals on hold due to pending diagnostics	Percentage of patients who receive evidence-based care that meets their individual needs Rate of Botox use with patients who have spasticity Rate of neuromuscular electrical stimulation use with patients who have foot drop	Percentage of patients who reach their goals Number of re-admissions back to acute care Percentage of patients who receive care that is based on best practice Percentage of staff who participate in training modules for evidence-based stroke rehabilitation	Number of patients who require and use translation and interpretation technology Number of patients provided stroke rehabilitation through tele-rehab Median patient/family experience scores for non-English speaking patients and families	Median time (in days) from admission to initial treatment session by each discipline Number of scheduled therapy sessions unattended Median time that staff in each discipline spend gathering equipment per day
LIVING WITH ILLNESS OR DISABILITY							
COPING WITH TRANSITION FROM LIFE							

CASE STUDY #2:

Leading an improvement project aimed at promoting healthy medication use

The creation of the "Coyote's Food Medicines" story offers an example of how the Matrix may be used within an improvement project.[7] Improving the quality of care starts with having a deep understanding of what we are trying to change. The Matrix enables us to examine a situation in terms of how it relates to the multiple Dimensions of Quality, the people we are seeking to support and the relationships that form the foundation of care. This helps us to plan and execute a tailored strategy for improving care.

Description of the improvement project:

The First Nations Health Authority, Shared Care Committee (a partnership of Doctors of BC and the BC government) and the Aboriginal Health team at Interior Health, supported the creation and dissemination of the "Coyote's Food Medicines" story in 2018 in response to the risks that Indigenous peoples in Canada face concerning the concurrent use of multiple medications, which is referred to as polypharmacy. The story was developed by Elders from the Secwepemc Nation as a means of promoting healthy medication use through shared understanding and conversation among health care providers and Indigenous people, and through regular medication reviews to ensure people are taking the right medication at the right dose and time. The story, along with its accompanying illustrations and video, has been disseminated across communities and made available in both online digital and hard-copy formats.

7. Shared Care Committee. Coyote's food medicines [Internet]. 2018. Available from: https://www.coyotestory.ca

Using the Matrix to develop a strategy for improvement:

An opportunity was identified to improve the way in which healthy medication use is supported within Indigenous communities. The development of the "Coyote's Food Medicines" story as a response can be understood through the Matrix.

The healthy use of medication involves a person only taking the medications they need, at the right dose and at the right time, to ensure that the benefits of medication use continue to outweigh the risks for harm. In many cases, medications are the most effective treatment for a disease. However, medications are not always the most appropriate treatment for an individual when considered in light of other factors related to their overall health and wellness. The more medications a person uses at the same time, the higher the chance of those medications interacting with one another in unexpected or harmful ways. Some of the potential risks include a person falling, not taking each medication correctly, or needing to go to a hospital and losing independence in daily activities as a result.

CASE STUDY #2:

All people are vulnerable to polypharmacy risks. Indigenous people may be exposed to polypharmacy risks stemming from historical and systemic reasons, which are additional and unique to them. These include the fact that Indigenous people experience higher rates of many chronic diseases, such as diabetes and dementia, which are commonly treated with medication. Care guidelines often recommend treatment related to a single condition, which means extra vigilance is required when a person is accessing care for multiple conditions. Individuals might have different goals of care that are influenced by their culture or worldview and differ from traditional care guidelines. Encouraging people to ask questions regularly and conducting annual medication reviews are important ways to help support people's health and wellness. However, many Indigenous people do not feel safe questioning health care providers about their prescriptions. For some, it would also be considered disrespectful within their culture to ask questions. Historical and present-day colonizing policies and practices have led to the mistrust of institutions among many Indigenous people.

- The Matrix visual aid on the next page has been filled in to illustrate ways that the Dimensions of Quality are impacted, as described above. While healthy medication use can be relevant across all five Areas of Care, this work is focused primarily on the use of medications to get better and for the ongoing management of chronic diseases. It is therefore situated within the *Returning to Health & Wellness* and *Living with Illness or Disability* Areas of Care.

To further inform a response, the improvement team spoke with members of the target communities to better understand the circumstances surrounding medication use. Supporting people's health and wellness requires considering their physical, mental, emotional and spiritual wellbeing, as well as their past and present contexts. From what the team heard, a unique relationship-based strategy was developed to start conversations and bridge connections between Indigenous people and health care providers. The "Coyote's Food Medicines" story was born out of this learning. The story encourages people to be active and informed within their own care by letting them know about the potential risks of taking multiple medications and encouraging them to ask questions about what they are prescribed. At the same time, it supports health care providers in communicating with Indigenous people about their medication use in a way that develops mutual understanding and helps to build trust.

CASE STUDY #2

Leading an Improvement Project

AREAS OF CARE	DIMENSIONS OF QUALITY						
	RESPECT Honouring a person's choices, needs and values	**SAFETY** Avoiding harm and fostering security	**ACCESSIBILITY** Ease with which health and wellness services are reached	**APPROPRIATENESS** Care that is specific to a person's or community's context	**EFFECTIVENESS** Care that is known to achieve intended outcomes	**EQUITY** Fair distribution of services and benefits according to population need	**EFFICIENCY** Optimal and sustainable use of resources to yield maximum value
	INDIVIDUAL PERSPECTIVE					SYSTEM PERSPECTIVE	
OPTIMIZING THE EARLY YEARS							
STRENGTHENING HEALTH & WELLNESS Promoting well-being and preventing injury, illness and disability	Being informed about the risks and benefits of medications						
RETURNING TO HEALTH & WELLNESS Getting better when faced with acute illness or injury **LIVING WITH ILLNESS OR DISABILITY** Care and support for living with chronic illness and/or disability	Maintaining independence in daily activities Identifying and being guided by the individual's goals of care	Reducing risk of falls Minimizing adverse drug events Considering the impact of mistrust of institutions due to colonizing practices and policies Increasing level of comfort with questioning health care providers	Making information available through different mediums (e.g., oral narrative/stories, electronically, hard-copy)	Using medications only when the benefits outweigh the potential risks Considering complex co-morbidities rather than a single condition	Reducing risk of hospitalization Increasing medication adherence	Recognizing the higher prevalence of many chronic conditions experienced by Indigenous people Addressing stigma and systemic racism that impacts people's and systems' ability and awareness to provide culturally safe and humble care	Reducing unscheduled emergency room visits and hospital stays
COPING WITH TRANSITION FROM LIFE							

CASE STUDY #3:

Planning for a Primary Care Network

Primary Care Networks (PCNs) are an example of how the Matrix can be used when planning changes to transform models of service delivery in communities. Using the Matrix enables us to identify the main Dimensions of Quality and Areas of Care that will be impacted by planned changes, while also considering opportunities for integration with other initiatives or potential unintended impacts.

Description of the initiative:

The development of an integrated system of primary and community care through Primary Care Networks (PCNs) offers an innovative approach to delivering services aimed at advancing the quality of care. They involve shifts to interprofessional and collaborative team-based care to ensure comprehensive person- and family-centred continuity of care.[8]

These networks collaborate with other primary care services delivered in the community by community-based health and social service organizations. A PCN team could be made up of physicians, nurse practitioners, Elders and traditional healers, and other allied health providers such as pharmacists, social workers, mental health and substance use supports, physiotherapists and occupational therapists. Team-based care is a care delivery model in which providers work together in a coordinated and integrated manner with people to enhance and maintain health and wellness.

8. College of Family Physicians of Canada. 2011. Available from: www.cfpc.ca/uploadedFiles/.../PMH_A_Vision_for_Canada.pdf

CASE STUDY #3

Using the Matrix in planning implementation of the initiative:

The lens of the Matrix enables us to see how the PCN can be integrated across all Dimensions of Quality and Areas of Care, and to account for the relationships that are at the core of its design.

A PCN is developed based on the unique needs and strengths of each community to provide timely, comprehensive and coordinated team-based care. The following are eight core attributes of the PCN framework:

1. Access and attachment to quality primary care
2. Extended hours
3. Same-day access to urgent care
4. Advice and information
5. Comprehensive primary care
6. Culturally safe care
7. Coordinated care
8. Clear communication[9]

Additionally, PCNs are aligned with an enhanced primary care program (developed by the General Practice Services Committee) to provide comprehensive coordination and care with a set of core services. Examples of these core services are represented in the Matrix visual aid below.[10]

While advancing the accessibility of care within communities is a primary driver of the transformation, the Matrix shows how the PCN impacts all seven Dimensions of Quality across the continuum of care. In particular, the two system-focused dimensions provide the foundation for the implementation of the PCN with the intention of ensuring equity – a fair distribution of services and benefits according to population needs within the PCN communities – and efficiency – the optimal and sustainable use of resources to yield long-term value for the effort.

9. General Practice Services Committee. Primary care networks. 2019. Available from: http://www.gpscbc.ca/what-we-do/system-change/primary-care-networks

10. General Practice Services Committee. Primary care network planning and implementation guide. July 2019. Version 1.0. Available from: https://www.divisionsbc.ca/provincial/news-and-events/news-and-notes/pcn-implementation-guide-now-available

CASE STUDY #3

Planning for Primary Care

AREAS OF CARE	DIMENSIONS OF QUALITY						
	RESPECT Honouring a person's choices, needs and values	**SAFETY** Avoiding harm and fostering security	**ACCESSIBILITY** Ease with which health and wellness services are reached	**APPROPRIATENESS** Care that is specific to a person's or community's context	**EFFECTIVENESS** Care that is known to achieve intended outcomes	**EQUITY** Fair distribution of services and benefits according to population need	**EFFICIENCY** Optimal and sustainable use of resources to yield maximum value
	INDIVIDUAL PERSPECTIVE					**SYSTEM PERSPECTIVE**	
OPTIMIZING THE EARLY YEARS Advancing early development and maternal health and wellness	Ongoing relationship between people and providers who get to know their unique circumstances Inclusion of people, their families and their caregivers as partners within the interdisciplinary team to ground care in what matters most to them Supporting people with services that improve health literacy, self-care, self-management and patient activation	Provision of harm reduction resources and services Home support for people with mild to moderate complex conditions and frailty Ongoing health monitoring including medication review	Improved access to primary care Care that is geographically based within communities Referrals to speciality services with follow-up Rapid access to crisis intervention services Linkages to community-based resources, including peer and group support Access to individual, group and online counselling	Provision of outpatient diagnostic imaging, laboratory services and local surgical services as appropriate based on the person's context and goals Provision of nutrition education and counselling according to established guidelines and the person's context and goals Reproductive care according to established guidelines and the person's context and goals	Diagnosis, assessment and treatment services for acute illness Screening, assessment and management for people with mild to moderate mental health conditions/ disorders Early detection, intervention and education Guideline-based chronic disease and pain management services	Networks that provide primary care services for the local population and build capacity within the community Services and activities focused on improving population health status Coordination of care and services to better address social determinants of health Community involvement in decision-making processes to ensure health services are designed and delivered in a way that reduces health inequity Increased access to care Teams that provide expanded support and network access for complex care addressing the needs and goals of vulnerable populations	Maximization of health care roles and resources by having professionals working to the top of their scope Reduced hospital visits Services that are clinically effective, cost-effective and have a positive impact on population health Support for care provided in hospitals and long-term care facilities
STRENGTHENING HEALTH & WELLNESS Promoting well-being and preventing injury, illness and disability							
RETURNING TO HEALTH & WELLNESS Getting better when faced with acute illness or injury							
LIVING WITH ILLNESS OR DISABILITY Care and support for living with chronic illness and/or disability							
COPING WITH TRANSITION FROM LIFE Planning, care and support for life-limiting illness and bereavement							

ACKNOWLEDGMENTS

We acknowledge that the *BC Health Quality Matrix* was published in Coast Salish territories – xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), səl̓ilwətaʔɬ (Tsleil-Waututh) – with support from communities across British Columbia.

The BC Patient Safety & Quality Council wishes to acknowledge and thank the many members of the province's health system and communities who provided their valuable insights into the development of BC's definition of quality.

We are grateful to the First Nations Health Authority for their leadership in ensuring that our thinking on quality embraces the history of Indigenous peoples in BC. This work highlights the strength of collaboration and connection across our partners, including the BC Academic Health Science Network, the BC Association of Aboriginal Friendship Centres, the BC College of Nursing Professionals, the BC Medical Quality Initiative, BC Patient Safety & Learning System, the Canadian Foundation for Healthcare Improvement, Doctors of BC, the First Nations Health Authority and its Quality Improvement and Safety (QIS) Network, the First Nations Health Directors Association, Fraser Health, the Government of Yukon's Department of Health & Social Services, Health Standards Organization, Interior Health, Island Health, the Joint Collaborative Committees, knowledge keepers Syex̱wáliya Ann Whonnock and Te'ta-in Shane Pointe, Métis Nation BC, the Ministry of Health, the Ministry of Mental Health & Addictions, Northern Health, patient partners, Providence Health Care, the Provincial Health Services Authority and Vancouver Coastal Health.

BC PATIENT SAFETY & QUALITY COUNCIL

Working Together. Accelerating Improvement.

The BC Patient Safety & Quality Council is a driving force for high-quality health care in British Columbia. We deliver the latest knowledge from home and abroad to champion and support the best care possible for every person in our province.

System-wide impact requires creativity and innovative thinking. Using evidence-informed strategies, we shift culture, improve clinical practice and advance person- and family-centred care.

We understand that meaningful change comes from working together. We are uniquely positioned to build strong relationships with patients, care providers, health leaders, policymakers, senior executives, academics and others. These connections enable us to nurture networks, recognize the needs of our health care system and build capacity where it is needed the most.

If you want to improve BC's health care system, visit BCPSQC.ca to access programs and resources that can help you start today.

INFO@BCPSQC.CA @BCPSQC BCPSQC.CA
201-750 West Pender Street | Vancouver, BC V6C 2T8
T: 604.668.8210 | F: 604.668.8220 | Toll-Free: 1.877.282.1919

How to cite this document:

BC Patient Safety & Quality Council. BC Health Quality Matrix Companion Guide [Internet]. 2020. Available from: https://bcpsqc.ca/matrix