The Readiness to Implement Quality Measurement Checklist: Development and Pilot Testing

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A Deliverable for the Continuous Enhancement of Quality Measurement in Primary Mental Health Care: Closing the Implementation Loop project

Funded by Health Canada: Primary Health Care Transition Fund

Abstract

Introduction: The majority of people seeking care for a mental health problem do so exclusively in primary care. Unfortunately, many medical practices do not have the resources to provide adequate care. Quality measurement is an important component of quality improvement; however, implementing quality measures in primary care is viewed as a very difficult task. A Canadian research team has created a practical tool to assess an organization's readiness to implement quality measurement.

Method: The results of a recent systematic literature review on the facilitators and barriers to implementing quality measurement in primary care guided the development of the checklist. The identified facilitators and barriers were developed into brief descriptive statements, sorted into theme categories and compiled in a checklist. A heterogeneous group of participants was recruited to complete the checklist and answer six pilot test questions. Participants submitted their pilot test responses via electronic mail or facsimile.

Results: Seventeen individuals completed the pilot test. Feedback included queries about the checklist purpose and suggestions regarding statement content and checklist format. Subsequent changes to the checklist included 3 new statements, 24 modified statements and 22 removed statements. The modified *Readiness to Implement Quality Measurement Checklist* has 37 statements grouped into seven categories that cover the topics of measure characteristics, promotion, implementation strategies, resources, individual level factors, organizational level factors and external factors.

Discussion: The checklist is a practical tool for an organization to identify its facilitators and barriers to implementing quality measurement. The checklist goal is to generate discussion about implementation issues within an organization and provide a structure for planning. Recommended next steps to refine the checklist are using cognitive interviewing techniques to better understand how people are completing the checklist and doing a descriptive case study of an organization applying the tool. An important research project would be to test the checklist to see if it can discriminate between an organization successfully implementing quality measurement and an organization that is not.

Conclusion: The *Readiness to Implement Quality Measurement Checklist* is an internal management tool that allows an organization to assess its position regarding implementing quality measurement. The checklist is brief but comprehensive, being based on a systematic literature review and pilot testing with a heterogeneous group of stakeholders.

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Introduction

One in five Canadians will personally experience a mental illness during their lifetime (Health Canada, 2002). The majority of those who use mental health services will likely seek mental health care in Canada's primary health care system. It has been found that 25 percent of people visiting a family doctor have a major mental health condition (Barrett et al., 1988; Tiemens et al., 1996) and in any given year over 80 percent of people accessing services for a mental health problem do so exclusively in a primary care setting (Waraich & Jones, 2003). Yet, while there is a high demand for mental health services in primary care, there are significant gaps between services currently being provided and the growing literature on effective care. Developing quality measures for primary mental health care is an important step in ensuring Canadians have access to the best primary mental health care services now and in the future.

Researchers in the United Kingdom and the United States have developed measures to be used in quality improvement efforts in primary health care (McGlynn et al., 2003; Shield et al., 2003). In Canada, the development of quality measures for primary care is less advanced, especially measures of primary care mental health. The Continuous Enhancement of Quality Measurement (CEQM) in Primary Mental Health Care: Closing the Implementation Loop project brings together a Canadian group of clinicians, decision makers, users of mental health care services, and academics who are working together to foster quality improvement through quality measurement. This group of individuals will agree upon a small set of measures that can be used both at the system level and at the practice level to foster coordinated and comprehensive quality improvement efforts.

A CEQM research team conducted a systematic review of the current knowledge on the facilitators and barriers to the uptake and implementation of quality measures in primary care and, more specifically, primary mental health care (see Appendix A for definitions of key terms). Using the systematic review results, the team created a checklist to assess an organization's readiness to implement quality measurement. This paper reports on the development and pilot testing of the checklist.

Background

Undertaking quality measurement in primary care settings is a lengthy process that includes finding or creating suitable indicators (Shield et al, 2003), deriving the indicators in practice (McColl et al., 2000), analyzing and interpreting the data and using the results to improve practice. Due to the many competing demands on primary care physicians and staff, implementing quality measures in primary care is viewed as a very difficult task. The research on the use of clinical practice guidelines in primary care (Grimshaw et al., 2004; Conroy & Shannon, 1995; Wensing et al., 1998; Cabana et al., 1999; Davis & Taylor-Vaisey, 1997) shows that implementing innovations in primary care is challenging and not often successful. Research in other service sectors had found that the efforts of developing innovative programs and practices are small compared to the challenges and complexities of implementing those (Fixsen et al, 2005).

It is important to seek accurate information about the receptor environment and the resources available to support implementation (Grol & Grimshaw, 2003). Systems theory states that changing one part of an organization (or system) will affect the other parts of the organization. Because the various parts of an organization are

interrelated, it is vital to assess all organizational aspects, including infrastructure, activities, technology, finances and human resources, when planning for change (Rhydderch et al., 2004). To realistically assess these factors in primary care would require a brief and easy to use tool or process. The authors searched for such a tool, but found none that were suitable, although there are a few that provided some guidance to developing a new tool. Aarons (2004) developed a brief measure of mental health provider attitudes towards adoption of evidence based practices and Lehman et al. (2002) developed a comprehensive assessment of organizational functioning and readiness for change, based on a conceptual model and previous findings on transferring research into practice.

Checklist Development Method

Formulating the Checklist Statements

The results of a recent systematic review of the literature on the facilitators and barriers to implementing quality measurement in primary care (Kyle et al., 2005) guided the development of the *Readiness to Implement Quality Measurement Checklist.* The review uncovered six articles that presented research on implementing quality measures in primary care and 52 articles on implementing clinical practice guidelines and other health care innovations. The facilitators and barriers to implementing quality measurement in primary care identified in the literature were categorized into seven broad themes: *characteristics* (key attributes) of the innovation, CPG, or quality measure; *promotion* of what was being implemented; implementation *strategies*; *resources* required; and *individual*, *organizational* and *external* factors affecting implementation. The research team also listed the

facilitators and barriers to implementing CPGs and other health care innovations in primary care and used this data to validate the chosen themes.

The facilitators and barriers to implementing quality measures identified in the systematic review were developed into brief descriptive statements. Facilitators and barriers to implementing CPG's and health care innovations that were repeatedly mentioned in the reviewed articles were also developed into statements. Both sets of statements were sorted into the seven theme categories and compiled into the first draft of a checklist. Some statements were written in a positive tone and others had a negative tone, depending on whether they were presented as facilitators or barriers in the literature.

Next, two researchers with Master's Degrees independently read the statements and marked those that were redundant or less relevant to the checklist purpose. They compared lists and used consensus to reduce the total number of statements. The statements were then reviewed for clarity and relevance by a psychiatrist with expertise in performance measurement and a psychiatric epidemiologist. These experts independently reviewed the statements and gave their opinion on what statements should remain or be removed.

After two rounds of reducing the number of checklist statements, the final version of the checklist contained 52 statements: 26 specific to quality measures and 26 specific to clinical practice guidelines or broad health care innovations. The statements covered all seven themes found in the systematic review: five statements on characteristics, six statements about promotion, ten statements on implementation strategies, seven statements on resources, ten statements on individual-level factors, eleven statements on organizational-level factors, and three statements on external

factors. Although the majority of statements were written in a positive tone, the team chose to include at least one negative statement in each category so that readers would read each statement carefully.

Checklist Format and Scoring

Two scoring options were considered in the development of the tool. In the first option, completing the checklist provides practical information about an organization's readiness to do quality measurement. The outcome is not a 'readiness score', but rather a snapshot of the organization to be used as a starting point for discussion and planning. In the second option, checklist completion would require rating each statement on a Likert-type scale. The outcome would be score for each checklist category and an overall readiness score. This development option would allow the tool to be used for research purposes or for comparing the 'readiness' of clinics within a health system to implement quality measurement. The first draft of the checklist represents the first option.

The Pilot Test

A pilot test will point out things that were not recognized or even considered during the construction of the tool. Noticing errors at this stage allows modifications to be made to the tool before committing major resources to implement it (Dalys, 1997: 176). Convenience sampling, a non-probabilistic sampling method, was used to recruit participants for this pilot test (Dalys, 1997: 136-137). Heterogeneity was sought by recruiting 2-3 participants from the following stakeholder groups: clinicians, service provider managers, decision makers and academics. The resulting sample (n=17) was heterogeneous with one psychiatrist, one manager of the Alberta Medical Association project *Toward Optimized Practice,* seven family physicians,

four academic researchers, one user advocate/researcher, one decision maker and two service provider managers.

The pilot test package (see Appendix B) consisted of a cover page explaining the CEQM project, the checklist and one page of open-ended pilot test questions. Pilot test participants were recruited by the research coordinator via electronic mail. When invitees agreed to participate, the three page document was sent to them via electronic mail. The participants were instructed to complete the checklist and answer the pilot test questions, focusing their feedback on checklist content, clarity and relevance. Participants were invited to submit their pilot test responses via electronic mail or by fax. They were also offered the option of sharing their feedback with the research coordinator over the telephone.

The participant responses were compiled and sorted by pilot test question. The feedback on the content of statements was organized by checklist category. The research coordinator read the compiled data numerous times, searching for commonalities and differences within the data and then wrote a data summary sheet. Using the summary sheet as a guide, the coordinator modified the checklist by rewording, removing and adding some statements. The data summary sheet and the modified checklist were then reviewed by two team members, a psychiatrist with expertise in mental health services performance measurement and a psychiatric epidemiologist, The checklist was modified a second time, incorporating the additional insights and suggestions.

Results

Participants commented on a lack of clarity for eight checklist statements, gave options for rewording thirteen statements, suggested nine additional statements, and recommended the removal of ten statements. The justifications for removal included that the identified statements were vague, unclear, confusing, offensive, dealt with sensitive topics, addressed the same issue as another statement, or were not relevant to study goals. Only nine of the seventeen participants responded to the question: 'Are the checklist statements relevant to your organization?' and six of the nine participants answered maybe or yes and did not elaborate.

Feedback about checklist format touched on three themes. First, the checklist format was considered to limit the data collection. . One participant suggested that there needs to be an option to answer N/A (not applicable). Another cautioned that checking only statements that are true may lead to social desirability bias; for example, some managers may not want to admit that morale is low. Several participants suggested using a Likert scale to allow for graded responses. To guide the decision about how to structure the response options, a participant recommended testing the checklist using cognitive interviewing techniques.

Second, the presence of a small number of negative statements among mostly positive statements was raised as an issue. One participant pointed out that statements about staff were positive but statements about physicians and patients were negative. Another person wrote "putting the odd negative statement in can be missed by some raters … and if that question produces different results, one is never sure if the results are 'real' or if the question was just misinterpreted by a number of respondents".

While several advocated for unidirectional statements, one participant raised the importance of considering the pros and cons of having unidirectional responses.

Third, there were questions about the purpose of the checklist and whose perspective it is to represent. One participant questioned whether the checklist was a organizational management tool or a research tool. Another pointed out that 'physicians' is plural in the checklist and wondered how a respondent is to answer when some think a certain way and others a different way. Another inquired "is it recommended to be an individual or group process and, if there is disagreement, whose perspective prevails?"

In response to the question about the checklist being user-friendly, several participants commented that the checklist was easy to follow. However, there were complaints that the checklist included too many questions and that the font was very small. One participant stated that he would prefer to do a web-based survey.

Discussion

Responding to the Pilot Test Feedback

The revised checklist is in Appendix C. The following changes were made to the checklist statements based on pilot test feedback: three new statements were added, 24 statements were modified to improve clarity and/or rewritten in a positive tone, and 22 statements were removed. During the pilot testing period, the research coordinator discovered an additional article that reported on quality measurement research that had previously been screened out of the systematic review. Three additional statements were added to the checklist based on the facilitators and barriers mentioned in this article (Wilkinson et al., 2000). That only six new statements were added to the checklist shows that the systematic review was thorough. Finally, a screening category with five statements was added to the top of the checklist. Its purpose is to ascertain an organization's experience with quality measurement and the state of its current plans to implement measures.

The authors consulted with each other and the project's advisory committee about the feedback regarding the purpose and perspective of the checklist. The majority agreed that the checklist is a practical, easy to use tool for organizations. The goal of completing the checklist is to generate discussion within an organization rather than to generate a 'score'. Identifying the facilitators and barriers to quality measurement within an organization is a great launching pad for planning discussions. It was suggested that the checklist would be especially helpful if it was accompanied by a workbook that would lead an organization through the assessment, interpretation and response to the results. The checklist is to be filled out by individuals and answered according to the perspective of the person completing it.

The responses can prompt communication about implementation issues and guide discussions and planning.

Once the purpose of the checklist was clear, it was easy to choose how to respond to the remaining feedback regarding checklist format. Scoring using a Likert-type scale would not be necessary in a practical management tool. At the same time, checking only true statements might give incomplete information. The checklist was changed to accommodate answers of yes, no and not applicable. Cognitive interviewing to assess how people responded to the statements would be a useful next step.

The team decided against having statements written in a positive and negative manner. It was thought that having unidirectional statements would reduce the likelihood of people misinterpreting a statement. Because the checklist is primarily a management tool versus a research tool, the team decided that all of the statements would be written from a positive slant. To make the checklist more user friendly, the number of statements was reduced and the font size was increased.

Checklist Development

The pilot testing of the checklist provided useful information about the checklist purpose, content, and format. Five of the six pilot test questions were informative. The question that did not elicit helpful information was question five: ‘are the checklist statements relevant to your organization?’ Just over half of the participants responded and they gave one word answers such as yes, no, maybe and most. This question would need to be reworded in future pilot testing to stimulate answers with more depth. Possible questions include: ‘how would the use of this

checklist benefit your organization?' or 'would your organization use this checklist if it was available? Why or why not?'

Recommendations for Future Work

1. Use cognitive interviewing techniques to better understand the process people use to respond to the checklist statements.
2. Develop a workbook to that would lead an organization through using the checklist, interpreting and responding to the results.
3. Do a descriptive case study of an organization that uses the tool in planning for quality measurement.
4. Validate the checklist: test the checklist to see if it could discriminate between an organization that is successfully doing quality measurement and an organization that is not.

Conclusion

The CEQM Research Subproject team created a checklist that is a practical tool for assessing an organization's readiness to implement quality measurement. While the checklist is short and easy to use, the content is comprehensive, being based on a systematic review and pilot testing with a heterogeneous group of seventeen stakeholders. The checklist is an internal management tool that allows an organization to assess its position regarding quality measurement and to guide discussions and planning for implementing quality measures.

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Appendix A: Key Definitions

Quality measures (or quality indicators) are norms, criteria, standards, and other direct qualitative and quantitative measures used in determining the quality of health care (MeSH term, 1998).

> **Examples of measures** could include items such as ‘percentage of clinicians with appropriate skills in cognitive behavioral therapy’ and ‘percentage of patients being treated for depression receiving the appropriate dosage and duration of treatment for antidepressants’.

Primary health care is care which provides integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (JAMA 1995;273(3):192).

> **Examples of primary health care** could include ‘a regular check-up with a family physician’, ‘a phone call to a health information line’, ‘a visit from a public health nurse’, or ‘advice given by a pharmacist’.

Appendix B: Pilot Test Package

Continuous Enhancement of Quality Measurement
In Primary Mental Health Care

Readiness to Implement Quality Measurement Checklist

Background:

The Continuous Enhancement of Quality Measurement (CEQM) project aims to develop a small set of quality improvement measures that can be used at the practice level in primary mental health care. Quality measures (also referred to as indicators) describe specific features or outcomes of health care practices that may be amenable to improvement. Clinicians, decision makers, people who use mental health care services and academics across Canada are participating in a series of three surveys to help identify a final set of quality measures for primary mental health care services. The CEQM project is funded by Health Canada's Primary Health Care Transition Fund.

The Calgary Research Team, led by Dr. Donald Addington, is studying the facilitators and barriers to implementing quality measurement in primary mental health care. The team has created a tool called the ***Readiness to Implement Quality Measurement Checklist***. We invite you to complete the checklist, which will help to determine how ready your organization is to implement quality measurement. For more information on the Calgary project or the national project please contact Tania Kyle at 944-2477 or tania.kyle@calgaryhealthregion.ca

Pilot test

Thank you for agreeing to pilot test the checklist. We are requesting feedback on checklist content, clarity and relevance. Factor analysis and scoring will be addressed in the next stage of checklist development. If you have any questions, please call Tania Kyle at 403 944-2477.

Please return your pilot test feedback to Tania Kyle by email or fax.

Email: tania.kyle@calgaryhealthregion.ca
Fax: (403) 270-3451

Please place a checkmark next to each statement that is TRUE.

A. What are the characteristics of the Quality Measures you wish to implement?	
A1. Have well recognized definitions	
A2. Can be used to demonstrate clinical competence	
A3. Are evidence based	
A4. Do not reflect psychosocial and behavioural aspects of health and illness	
A5. Are related to improved quality of care	
B. How are the Quality Measures being promoted?	
B1. Use of measures is linked to incentives	
B2. Championed by a medical leader	
B3. Adapted locally	
B4. Endorsed by a credible source	
B5. Published in a respected source	
B6. Documentation method is the same across organizations	
C. What implementation strategies or tools are available to your organization?	
C1. Collecting measure information is part of documenting care	
C2. A common documentation language is used	
C3. Measures are selected sparingly	
C4. Use of an audit tool	
C5. There is a multidisciplinary health care improvement team/committee	
C6. Implementation strategy was preplanned	
C7. Academic detailing by a trained nurse	
C8. External lectures about the measures	
C9. Practice based learning in peer groups	
C10. Telephone support is available following training	
D. Which statements best describe your organization's resources?	
D1. Practice computer system is current	
D2. Documented information is computer ready	
D3. Office has internet access	
D4. There is a budget for quality improvement activities	
D5. Office has sufficient number of staff to implement quality measures	
D6. Office has ability to hire more staff if needed	
D7. Physicians do not have time to devote to quality measurement	
E. Which of these statements best describe the individuals in your organization?	
E1. Staff are compliant in current documentation method	
E2. Staff have excellent communication skills	
E3. Staff have limited computer skills	
E4. Physicians lack familiarity with measures	
E5. Physicians have poor adherence to practice protocols	
E6. Quality measures are not seen as credible by physicians	
E7. Physicians view measures as a threat to their autonomy	
E8. Physicians think measures are a tool used to penalize bad performance	
E9. Patients are resistant to mental health diagnosis or treatment	
E10. Patients do not comply with mental health visits	
F. Which of these factors best describe the current operation of your organization?	
F1. Morale is low	
F2. There is a respectful work environment	
F3. Stakeholders are involved in implementing innovations	
F4. Enthusiasm and creativity is nurtured by managers	
F5. Office staff have a high workload	
F6. High staff turnover	
F7. Clear leadership in the organization	
F8. Recent leadership changes	
F9. Decision making authority is unclear	
F10. Barriers exist between professional groups	
F11. Organization personnel are team players	
G. Which of these external factors affect your organization?	
G1. There is a lack of specialists for referrals	
G2. Physicians have minimal access to new diagnostic technology	
G3. Political environment is open to new healthcare innovations	

Readiness to Implement Quality Measurement Checklist
Pilot Test Questions for Version 1.0

Tip: Use the letter/number codes, e.g. B2 or E7, to refer to specific statements.

1. Are the checklist statements clear? (If not, which statements are unclear? Could you suggest a better way to word them?)

2. Are there any statements you would remove from the checklist? (List which statements and why)

3. Are there any factors or statements that are missing from the checklist? What factors or statements would you add? (Please name the missing factor and, if possible, write a descriptive statement for it.)

4. Please comment on the checklist format. (e.g. Is it easy to understand? Is it user-friendly?)

5. Are the checklist statements relevant to your organization? (If not, please indicate which statements are not relevant and why.)

6. Other comments or suggestions?

Appendix C: Revised Checklist

Readiness to Implement Quality Measurement Checklist

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Completing the checklist will provide practical information about your organization's readiness to do quality measurement. The outcome is not a 'readiness score', but rather a starting point for discussion and planning. The checklist statements are organized into categories that prompt you to assess your organization in terms of its stage of planning for quality measurement, the characteristics and promotion of the quality measures, implementation strategies, available resources, staff readiness, operational readiness and external factors.

Quality measures (or quality indicators) are norms, criteria, standards, and other direct qualitative and quantitative measures used in determining the quality of health care. Examples include: 'the percentage of mental health clinicians with appropriate skills in cognitive behavioral therapy' and 'the percentage of patients being treated for depression receiving the appropriate dosage and duration of treatment for antidepressants'.

Instructions: Read each statement and indicate your response with a check mark. Complete the checklist based on your perspective in the organization. Try to respond to every statement with an answer of yes, no, or N/A (not applicable).

What are your organization's plans regarding quality measurement?	**Yes**	**No**	**N/A**
1. Has no plans to implement quality measurement			
2. Intends to implement quality measurement in the next 6 months			
3. Intends to implement quality measurement in the next 30 days			
4. Has been using quality measures for a short time (less than 6 months)			
5. Has been using quality measures for 6 months or longer			
If you checked YES for statements 2 or 3, please complete the remainder of the checklist. Otherwise, you may stop now.			
What are the characteristics of the Quality Measures you wish to implement?			
A1. The measures are evidence based.			
A2. The terms comprising the measures have recognized definitions.			
A3. The measures have recognized norms/benchmarks.			
How are the Quality Measures being promoted?			
B1. The measures are published in a respected source.			
B2. The measures are endorsed by a credible source, such as physician licensing body or professional association.			
B3. Measures are promoted as an efficient solution to quality assurance.			
B4. Quality measurement is promoted through the use of incentives.			
B5. The measures are championed by a leader.			
B6. Local stakeholders participated in adapting measures to local circumstances.			
What implementation strategies are available to your organization?			
C1. Collecting measurement data is part of documenting care.			
C2. The measures are kept to the minimum number necessary.			
C3. There is an implementation plan to follow.			
C4. Academic detailing/outreach by a trained professional			
C5. Practice based group learning with a facilitator and a specialist			
C6. A consultant is available to help the staff to implement the measures.			

Readiness to Implement Quality Measurement Checklist

Continued …

Which statements BEST describe your organization's resources?	Yes	No	N/A
D1. The office has internet access.			
D2. The office computer system can support an Electronic Health Record.			
D3. Documentation is compatible with the Electronic Health Record.			
D4. There is a budget for quality improvement activities.			
D5. There is a staff member with quality measurement skills.			
D6. Using quality measures does not add extra time or work load to staff.			
Which statements BEST describe the individuals in your organization?			
E1. Staff comply with the current documentation method			
E2. Staff have good computer skills			
E3. Physicians adhere to practice protocols			
E4. Physicians think measures could be used to monitor and reward good performance			
E5. Physicians believe implementing measures will lead to improved practice.			
E6. Quality measurement is a personal interest of a staff member or physician.			
Which statements BEST describe the current operation of your organization?			
F1. There is positive leadership in the organization			
F2. The decision making authority is clear.			
F3. Organization leaders understand the impact of their decisions on patient care.			
F4. Clinicians from different professional groups work as a team			
F5. Physicians are able to allocate time for quality measurement activities.			
F6. Frontline staff are involved in planning for change or innovation			
F7. There is team agreement on the purpose and benefits of quality measures			
F8. There is a staff member who is responsible for data entry			
Which of these external factors affect your organization?			
G1. There is a shortage of specialists for timely mental health referrals			
G2. The political environment is open to new healthcare innovations			

Acknowledgements:
The authors developed the checklist as a part of the *Continuous Enhancement of Quality Measurement: Closing the Implementation Loop* project, which is funded by Health Canada's Primary Health Care Transition Fund. The checklist content is based on the results of the authors' recent systematic literature review (Kyle, Desai, Wang & Addington, 2006).

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