



**Report on
WHO Mission to ESTONIA
- Hospital Performance
Assessment -**

19-21 October 2005

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CONTENTS

	<i>Page</i>
Introduction: Background and purpose of the mission.....	1
Summary of discussions during the mission	2
<i>Preliminary experience from the PATH international pilot implementation.....</i>	<i>2</i>
<i>Technical considerations for hospital performance assessment (HPA) in Estonia.....</i>	<i>5</i>
<i>The view of the medical association and health care board on HPA</i>	<i>6</i>
Conclusions and recommendations for developing hospital performance assessment system in Estonia.....	8
Annex.....	10
<i>Provisional programme.....</i>	<i>10</i>
<i>List of participants</i>	<i>11</i>
<i>Presentations.....</i>	<i>12</i>

Introduction: Background and purpose of the mission

Background

During the past two years WHO supported the development of indicators to assess hospital performance in Estonia by sharing information and evidence on projects in Europe and other regions. Major milestones of this collaboration are the following:

- Meetings with stakeholders at the Ministry of Social Affairs, Estonian Health Insurance Fund (EHIF) to introduce the PATH project and performance assessment in general (Ann-Lise Guisset, June 2004);
- Continuous distribution of reports on performance assessment to WHO Country Office and meetings with stakeholders organized by WHO Country Office throughout 2004 and 2005;
- Discussions on institutionalising quality improvement, including performance assessment during expert workshop in December 2004 (financial and expert support from WHO Bruno Bouchet) and mapping current status of health system quality published in *Quality Assurance of Health Services in Estonia*, Ministry of Social Affairs Estonia, 2005;
- Seminar and meeting held to discuss evidence on performance measurement in hospital sector with participants from state agencies and hospital management boards (J Veillard & S Brown, September 2005);
- Meetings held to discuss methodological issues in external evaluation of hospital performance and provide an overview on development of international pilot implementation of PATH (O Gröne, 19-21 October 2005).

Purpose

The purpose of this mission was to present an overview on the formal adoption of strategies to measure and improve quality in health care, to discuss methodological issues in the external evaluation of health care performance and to provide an update on the progress of the international pilot implementation of the PATH project.¹

Meetings were convened with the participating hospitals in national hospital performance measurement to discuss methodology for indicator selection, issues related to data collecting methods and analysis, and further steps of national project. The possible collaboration between the developments in Estonia and with WHO at international level was discussed.

¹ Oliver Groene also attended the National Estonian Health Promoting Hospitals Conference and gave a keynote presentation on the evaluation of health promotion activities in hospitals. More information on this event can be obtained through a separate report.

Summary of discussions during the mission

Preliminary experience from the PATH international pilot implementation

PATH was developed during 2003 and pilot-implemented in various countries in 2004 and 2005. Overall, 51 hospitals from six countries participated in the piloting and have provided data for analysis. A preliminary manual for PATH implementation was prepared for the pilot project. For the final evaluation, feedback from country coordinators from pilot sites will be gathered and recommendations and amendments will be included in the final implementation manual. Two new WHO Collaborating Centres were established to take forward the work of the PATH project with the following tasks: to establish a network to compare hospital performance, set up an Internet platform for data collection and analysis and provide training to support countries in their implementation.

Indicators in PATH project include the following:

Performance dimension	Indicator
Clinical effectiveness	Primary Caesarean section delivery rate Appropriateness of prophylactic antibiotic use Rate of readmission for selected tracer conditions Rate of admission after day surgery Return to ICU for selected procedures/conditions
Safety	Mortality rates for selected tracers and procedures Formal procedure to report and analyze sentinel events Work-related injuries (percutaneous injuries)
Efficiency	Ambulatory surgery use Median length of stay for specific procedures Average inventory in stock for pharmaceuticals Wastage of blood products Operating rooms unused sessions
Patient centeredness	Cancelled surgical procedures Score on patient perception/satisfaction survey Score on interpersonal aspects Score on client orientation: information and empowerment
Responsive governance	Perceived continuity through patient survey Women breastfeeding at discharge
Staff orientation	Training expenditures on average number of FTE staff Budget dedicated to staff health promotion activities Short and long term absenteeism Staff excessive weekly working hours

Methodology for selection of indicators in PATH project

The development process of the PATH framework included reviews of the literature, workshops with international experts and an ad-hoc survey on data availability in European countries. Thirty-one experts coming from fifteen different countries (western and central European countries, Australia, South Africa and North America) and representing hospital performance projects in Australia, Canada, Europe and the USA met in four workshops. These experts built the framework based on evidence gathered in background articles and on their own experience. A conceptual model of performance was elaborated to identify dimensions and sub-dimensions of performance.

A list of 100 hospital performance indicators was identified through a review of the literature. Indicators were assessed against a series of criteria by the experts panel through a modified nominal group technique. Indicator selection was based on evidence gathered through the previous review of the literature and on the survey on data availability. This process was iterative in the sense that even though agreement on the conceptual model preceded and guided indicator selection, analysis of the evidence on various performance indicators led to refinements of the conceptual model. Furthermore, even though the main process of indicator selection was one of progressive elimination starting from a comprehensive set to a parsimonious one limited to a range of 20-25 indicators, new indicators had to be sought and introduced throughout the process as new evidence was gathered.

The steps for selection of indicators were thus the following:

1. Conceptual model: identification of dimensions and sub-dimensions and how they relate with each other;
2. Initial screening of indicators in performance assessment systems and critical reviews;
3. Complementary indicators to fill in areas not properly covered after initial screening, based on grey and scientific literature;
4. Pre-selection of indicators based on experts' opinion and preliminary evidence;
5. Extensive research of the literature for prevalence rates and evidence of burden, reliability and validity; survey in participating countries;
6. Final selection based by experts, based on information collected at step 5., using a nominal group technique.

The review of the literature showed that some dimensions and indicators, such as on clinical effectiveness, have been well researched and build on a scientific tradition of evaluation. Yet others, such as responsive governance and efficiency are less represented in literature and tend to be based primarily on empirical evidence. It was considered acceptable to recommend measures that are based on usefulness rather than hard scientific evidence. Indicators included in the core set have been selected on the basis of best available evidence and relevance to the European hospitals context.

Indicators (e.g. sentinel events) should not be excluded merely because they require data that are inaccurate or regularly missing; on the contrary they should be used as an opportunity to identify and respond to a need for education and improvement leading to more effective information systems.

It is recommended to refine this methodology of indicator selection for further projects on assessing hospital performance. This should include establishing a clear baseline on data

availability, scientific validation of indicators and the use of DELPHI method in expert panel to reduce systematic bias and individual factors in determining indicator selection.

Discussion on developing PATH in Estonia

Discussion in various meetings demonstrated the different applications of performance assessment systems in health care, i.e. whether data is used for administrative purposes, for internal continuous quality improvement, for external reporting to purchasing agencies, to guide contracting and reimbursement of services, or to inform and guide the public in choosing the right health care provider. Since in Estonia different interests exist in parallel, a discussion on the purpose of the indicator project was paramount. It was concluded that the purpose should be agreed upon stakeholders and documented in a formal statement.

International experience from performance indicator projects shows that the burden of data collection is a major criterion for selection of indicators. Many projects have shifted their focus on routinely available data as completeness and quality of data collected alongside clinical practice has been disappointing. Routine data is also much less expensive than data collected for the particular project and puts less burden on clinical staff. A decision on indicator selection should therefore be carefully built on knowledge of data availability in any given context. This should include availability of data to adjust for case-mix (socio-economic factors, severity and co-morbidities).

It was discussed whether the project in Estonia could start with collection data on less indicators as included in the PATH project. While this was confirmed, it should be acknowledged that the idea of PATH was to guide data collection in relation to a comprehensive framework of hospital performance. Nevertheless, in relation to the six-dimensional framework of PATH, any project is likely to be incomplete at the beginning and thus focus of data collection in priority areas therefore should not be used as a reason to postpone performance assessment. It is recommended to obtain consensus among stakeholders on priority areas for performance assessment. These areas should reflect the burden of disease in Estonia, frequency and costs of hospital admissions and any national priorities or health care targets published by government.

Experience from the PATH project demonstrates the difficulties that exist in data collection. Data collection should be guided by clear indicator definitions in terms of ICD-code, inclusion and exclusion criteria, time periods for data collection and stratification details (age-bands). It is highly recommended to develop an Internet-based data collection platform to gather data in a unique format to include automated quality checks of data, to support quick data analysis and reporting. The data collection process should be designed in a way that it allows for refinement of definitions and reporting criteria, in order to continuously improve data quality.

A final discussion addressed the use of data for analysis, linking the results back to the purpose of the project. It is recommended to clarify before hand what data will be analysed in what way and how data will be handled (ownership, publication). Experience shows that, once comparative data has become available, it is very tempting to carry out comparisons. A data analysis and reporting plan should therefore be prepared and agreed upon by stakeholders. It is highly recommended that a strong weight is put on data reporting to ensure that it supports the continuous quality improvement among health care providers.

Technical considerations for hospital performance assessment (HPA) in Estonia

Estonia has had discussions with all four central hospitals to develop hospital performance measurement tool where PATH indicators are considered as starting point. During the last months two regional hospitals have also joined the network. The Estonian Health Insurance Fund facilitated meetings among hospitals to assess feasibility of data collection. In preparation of the mission, the Estonian working group prepared a list of questions that was sent to WHO. The following section summarizes the discussions on these issues.

Availability of data

Four of the PATH indicators require a standardized measure on patient satisfaction/experience. As no validated common measure is available in Estonia (as in many other countries) it was discussed to use or develop proxy measures. One possibility would be to introduce a question to patients at discharge (“Would you recommend this hospital to your family?”). This question to assess patient satisfaction was evaluated in the literature and, provided that a clear procedure exist for data collection (timing of question), it has been found valid.

Another discussion point was the availability of clinical data, which is in electronic format in some hospitals and in paper format in others. While indicators can be computer based on electronic data bases, in hospitals with paper based records a clinical audit on a sample of records can be carried out to obtain the same information (e.g. a random sample of 200 patients discharged in the last three months for a clearly defined condition and identification of vital status at discharge by a trained nurse).

Indicator definition for performance assessment in Estonia

Meetings among hospital representatives have taken place to discuss indicator specification. A problem that was discussed was the use of ICD codes, as Estonia uses ICD-10 since 1997 while the PATH pilot implementation uses ICD-9. A particular question was raised regarding clear ICD codes for stroke indicators, which are in the PATH project codes 430, 431, 432, 433, 434 and 436. That means that transient ischaemic attacks and brain tumours are excluded. For the mortality tracer indicator included in PATH, the following ICD codes are recommended:

Tracer	ICD 9 code
Stroke	431, 433 (5 th digit = 1), 434 (5 th digit = 1), 436
Acute myocardial infarction	410
Hip fracture	820
Community acquired pneumonia	480 - 486) (incl. patients in ICU)
Coronary artery bypass graft	36.1
Total hip replacement	81.51

- These codes can be converted from ICD 9 to 10 (or reverse) and software exists to facilitate this process. It is also envisaged to include both ICD-9 and 10 codes in the next

version of the PATH manual for easy identification.² Indicator definition based on ICD codes will be made available to Estonia after the revision of pilot experiences.

Funding and human resource issues

Resources required within each hospital for coordination and data collection would be: one person half a week during the continuous period of data collection, some resources for printing and meeting facilities and minor travel expenses to participate in joint meetings. It is expected that one third of the data is easily available from routine data sources, but two thirds will require additional work.

The view of the medical association and health care board on HPA

After sharing experience from international level as well discussing details of all indicators a separate meeting was held to discuss further steps as well the views of different public agencies as Health Insurance Fund, Health Care Board and Ministry of Social Affairs about such development in Estonia. It was felt that the development has been good and quite fast, where Estonian Health Insurance Fund has the role to support the movement and hospitals are taking the leading role.

From WHO side the international experience will be shared with Estonian network; especially after summary is available from international network meeting in November in Barcelona. The six hospitals interested in the development will be used to pilot the tools that can be adapted into Estonian setting. The plan is to collect data from six hospitals in 2006. The following extension to other hospitals and providers will be decided later in 2007. (In addition in primary health care level a separate quality bonus system will be implemented from 2006).

The Ministry expressed their strong support for the project that developed during the last year. It was also discussed that - even though for this project the collection of data and all work is independent from Ministry - it is recommendable that in mid-term hospitals could share publicly the results. This would also allow the public to see some measures on hospital quality in addition to financial performance. In the short term and for this project in 2006 in particular the focus will be on supporting hospitals to use performance data for internal quality improvement.

The Health Care Board expressed the need to define more clearly the purpose of the project and use of data. During the discussions it revealed that HCB has only limited possibilities to control quality in hospitals, which is limited to licensing and other areas which are mainly related to input where as process and outcome are usually not monitored. It was mentioned that introduction of accreditation system (providers and doctors) might be one of the further steps to monitor but also support quality development.

There is need to develop an environment for quality improvement and to learn from each other, without providing negative incentives to those participating. On data collection burden it was

² For example see the following link for downward conversion:
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=RC_64_E

discussed that the data available from Health Insurance Fund can be used even now to share some of the results with participating hospitals.

Measuring performance in Europe to improve health care quality is developed with different speed and countries are in different stages (see presentations in Annex 3). The discussion followed the presentations showed that hospitals are interested to measure their performance and compare to other similar providers (in Estonia but also internationally). Even the time was considered to be ready it was mentioned that the start of the measurement should be voluntary as it has been now, but then there is need to have similar framework for measurement to ensure comparability. It was mentioned also that there is need for an independent organisation who could lead such performance measurement, but during the past five years such organisation is not developed in Estonian environment. Providers felt this to be important as all Government agencies could have their interest to use results to award/... good/bad performers. Currently the project is facilitated by Health Insurance Fund that has developed an environment, but in next steps it should be commonly agreed what is the organisational structure for performance measurement in Estonia to ensure sustainability of the project. The PATH framework was considered to be good for start and when first results are available in coming years then further steps could be discussed. In addition it was mentioned that the hospitals are ready for such measurement at hospital level, but how to explain this inside organisations and how to measure each individual doctor's work is more difficult. In this area there is need to learn how to use available statistics in more useful way to give feedback at hospital but also individual doctors level inside hospitals. In addition the relationship between clinical guidelines (developed by specialists with the support from EHIF) and performance measurement and how these areas are related was discussed and found as one area that needs further development.

Conclusions and recommendations for developing hospital performance assessment system in Estonia

It was concluded to continue the performance assessment project in Estonia with the aim to establish a baseline on hospital performance. The project will address comparisons of performance of Estonian hospitals with the level of performance in peer groups of hospitals in Estonia and internationally. The main objective will be the identification of potentials for quality improvement in a systematic manner and it is not to release data to purchasers or the public. Data is owned by the hospital and can be released to the public and other stakeholders if it decides so.

Specific steps towards implementing the performance assessment project include improved understanding and then training on the use of indicators for quality improvement. A training plan should be prepared to address the whole process from indicator definition, over data collection, to analysis, interpretation and implementation.

With regard to the selection of performance indicators for the project in Estonia it was agreed to identify what information is routinely available to construct indicators and match this information with the indicators suggested in the PATH project. The working group would then take a decision on the selection of indicators and would develop a common methodology for data gathering (if not available routinely). It was also suggested to agree on a minimum set of indicators for comparisons between Estonian hospitals and internationally. Individual hospitals may collect additional indicators to carry out further comparisons. The minimum set of indicators should reflect care processes or clinical conditions for which each of the participating hospitals provide care.

Five hospitals so far confirmed their participation in the project, although one additional hospital will be allowed to join to project (given contribution and participation is provided). The Estonian Health Insurance Fund will support the project, address possible conflict of interests and, while keeping an independent position, it will identify possibilities to financially support the issues around information technology to support data collection. WHO will support the project through sharing of working documents on performance indicator selection, definition and data gathering methodology and consultations with the Estonian working group. The Ministry of Social Affairs, though not directly involved in any steps of this project, will be kept informed about the main orientations and directions of the project. It was found that in later stage of the project the professional associations as Hospital Association, but also health care workers associations and specialist groups should be included in discussions.

The participants agreed on the following task to follow up:

Task	Responsible	Timeframe
Report on meeting	EHIF/WHO	November 2005
Circulation of full PATH materials	Report of November !! EHIF/WHO	December 2005
Identify routine data available	All hospitals: report (table) which indicator, data source, issues, for each indicator	After Barcelona workshop and based on final list of indicators – January 2006
Developing methodology for indicator selection for Estonian pilot	WHO: share framework for selection (table with criteria for each indicator)	Until end of year 2005
Next EST working group meeting: planning of subgroup for health care quality within Estonian Association for Quality (AQE)	All hospitals	November 2005
Address patient satisfaction measure	All hospitals	December 2005
Reflect on Barcelona workshop results and make operational plan for data collection	All hospitals	January 2006
Prepare implementation manual for indicators and instructions how to use them	WHO / Estonian working group to adapt and translate	From March 2006
Develop It solution for data collection	All hospitals/EHIF	First quarter 2006

Annex

Provisional programme

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA



ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ
ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

WHO mission on hospital performance assessment Estonia 19-21 October 2005

1) Wednesday 19.10.2005, Time: 15.00 - 17.00

Venue: Estonian Health Insurance Fund (1st floor meeting room)

Participants: EHIF, MoSA, WHO, pilot hospitals participating in initiative in Estonia, selected specialists
Topics

Presentation "Formal adoption of strategies to measure and improve quality

In health care in Europe", Oliver Gröne

Presentation "External comparisons in health care delivery: current approaches and methodological challenges", Oliver Gröne

Discussion PATH project, both international experience and local development

2) Thursday (20.10), Venue: Institute for Health Development

Time: 10.00 - 17.00
Topic: National Health Promoting Hospitals conference

3) Friday (21.10)

Time: 9.00 - 12.00
Venue: Estonian Health Insurance Fund (1st floor meeting room)

Participants: EHIF, MoSA, WHO, pilot hospitals participating in initiative in Estonia, selected specialists

- overview of PATH indicators - Oliver Gröne

- local development - Jane Alop

- discussion PATH indicators

Time: 13.30 - 15.00
Venue: Estonian Health Insurance Fund (1st floor meeting room)

Participants: EHIF, MoSA, Health Care Board, WHO

Topic: Discuss current developments on performance evaluation in hospital sector and what are the plans (incl PATH project)

List of participants

19 October 2005 (15.00 - 17.00)		
Topic: Using performance indicators to drive quality and international experience		
Tiia Arro	Ministry of Social Affairs	Analyst
Liis Rooväli	Ministry of Social Affairs	Head of health statistics unit
Evi Lindmäe	Health Care Board	Head of bureau of registers
Katrin Maiste	Health Insurance Fund	Health care specialist
Jane Alop	Health Insurance Fund	Health care specialist
Tõnis Allik	North Estonian Regional Hospital	Head of management board
Marina Kaarna	North Estonian Regional Hospital	Head quality department
Reet Malbe	North Estonian Regional Hospital	Deputy head of quality department
Kelly Podoshviljev	East Tallinn Central Hospital	Quality manager
Andrus Mäesalu	East Tallinn Central Hospital	Head of surgical Clinic
Jarno Habicht	World Health Organization	Head of Office
Oliver Gröne	World Health Organization	Technical Officer
21. October 2005 (9.00 - 12.00)		
Topic: PATH indicators		
Jaak Lind	East Viru Central Hospital	Head of surgical Clinic
Olga Feldman	East Viru Central Hospital	Quality manager
Imbi Moks	West Tallinn Central Hospital	Quality manager
Kelli Podoshviljev	East Tallinn Central Hospital	Quality manager
Andrus Mäesalu	East Tallinn Central Hospital	Head of surgical Clinic
Annely Viikmaa	Pärnu Hospital	Chief specialist in IT
Väino Zelinski	Pärnu Hospital	Analyst
Jane Alop	Health Insurance Fund	Health care specialist
Jarno Habicht	World Health Organization	Head of Office
Oliver Gröne	World Health Organization	Technical Officer
21. October 2005 (13.30 - 15.00)		
Topic: Next steps to support implementation of performance indicators in hospital sector		
Tiia Arro	Ministry of Social Affairs	Analyst
Peeter Mardna	Health Care Board	Head of Supervision Unit
Heino Levald	Estonian Quality Association	Member of board
Arvi Vask	Health Insurance Fund	Member of management board
Helvi Tarien	Health Insurance Fund	Head of health care department
Jane Alop	Health Insurance Fund	Health care specialist
Jarno Habicht	World Health Organization	Head of Office
Oliver Gröne	World Health Organization	Technical Officer

Presentation: Strategies to measure and improve quality of care in European countries

Slide 1



Strategies to measure and improve quality of care in European countries

Oliver Gröne
Technical Officer, Hospitals Programme
WHO Regional Office for Europe

1

Slide 2



What are strategies to measure and improve quality in Europe?

(key elements for quality improvement proposed by the European Commission (1998)).

Practice guidelines: Guidelines should be developed systematically, disseminated effectively to professionals as well as the public, and their effects monitored.

Technology assessment and quality improvement: Health care should be improved by applying methods of evidence-based medicine and utilising the results of technology assessment in decision making, directing appropriate attention to laboratory quality assurance.

2

Slide 3



What are strategies to measure and improve quality in Europe?

Quality indicators and information system: Health care information systems should be set up using relevant care and process quality indicators and allow for timely production, feedback and reliable comparisons of health care data.

The patients' perspective: Information on the needs, priorities and experiences of patients at all levels of care provision should be gathered through appropriate methods, ensuring the active participation of patients.

Managing change: Quality improvement systems should include effective mechanisms and strategies for achieving necessary changes in a planned and managed way and for involving all the players in care processes and decision making, in particular patients.

3

Slide 4




EC funded research projects on quality in health care (DG Research)
 MARQUIS, E4P, Health Basket

Why is the EC interested in health care?

- Cross border patients (tourists E111, residents, care tourism E112, shared capacities, provider referral)
- Do cross-border patients receive the same quality of care?
- Should there be common quality standards for health care in the EC?

4

Slide 5



EC funded research project on "Assessing response to quality improvement strategies in health care (MARQUIS)"


Literature review
 Analysis framework
 Questionnaire design
 Recruitment of key experts

Contacts	Agreed	Declined	Not replied	Questionnaire returns
166	99 (60%)	18 (11%)	49 (29%)	62 (63% of 99 distributed)

Data analysis
 (Eileen Spencer & Kieran Walshe, Manchester Business School)

5

Slide 6



National/Regional policy development

Policy development	Responses % (n) n=62 respondents	Member states n = 22 member states
National level	47 (29)	10
National and / or regional level	53 (33)	12

6

Slide 7




Regional variations in quality improvement:

Different:

- approaches to measuring and evaluating quality (12)
- priorities for QI , between regions / between national and regional levels (8)
- interpretations and implementation of national QI policies at regional level (7)
- organisational approaches to QI within regions (4)
- levels of professional motivation, training and competence (3)
- levels of resources (3).

7

Slide 8




What influences the development of QI policy? (n=62 respondents)

<i>INFLUENCE ON THE DEVELOPMENT OF QI POLICIES AND STRATEGIES</i>	<i>'very/fairly important'</i>
Policies and priorities of government	80 (49)
Professional organisations	77 (48)
Media coverage	71 (44)
National or regional quality task force	68 (42)
Provider organisations	64 (40)
Public opinion	63 (39)
Development of QI policy in other EU member states	58 (36)
Patient and service user organisations	52 (32)
Policies and initiatives of the EC	32 (20)
Activities of ISQua	32 (20)

8

Slide 9

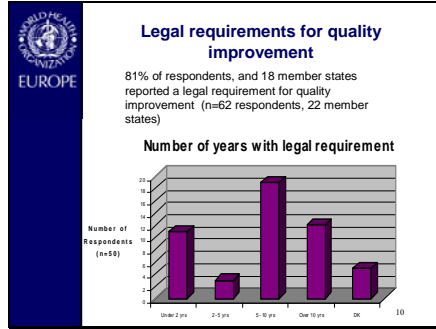


Topics included in policy documents

Topic is included	% (n) n=42 respondents
Systems for monitoring and measuring the progress of QI	84 (35)
Definition of terms	79 (33)
Setting national standards for quality	74 (31)
Setting national targets for QI	74 (31)
Seeking patient's views on quality	72 (30)
Dealing with adverse events, problems, complaints	67 (28)
Professional regulation, monitoring professional performance	55 (23)
Professional education and training	52 (22)
Provision of training and support for organisations	43 (18)
Provision of resources for QI	38 (16)

9

Slide 10



Slide 11

What does the legal requirements apply to?

Organisation / sector	% (n) n=50 respondents
Hospital	100 (50)
Primary Care	78 (39)
Mental Health	72 (36)
Public sector	92 (46)
Private sector	70 (35)
Not-for profit sector	62 (31)


Slide 12

Who is setting quality standards?

82% of respondents, and 18 member states reported defined quality standards for their health care system (n=62 respondents, 22 member states)

ORGANISATION SETTING STANDARDS	% (n) n = 51 respondents
Ministry of Health	86 (44)
Professional organisations	39 (20)
Non-governmental organisations	37 (19)
Provider organisations	20 (10)
Other organisations	8 (4)

Slide 13




What are quality standards related to?

Areas of the health care system	% (n) n= 51 respondents
Hospital services	98 (50)
Mental health services	72 (37)
Primary care services	71 (36)
Other services	49 (25)

13

Slide 14




Targets for quality improvement

69% of respondents, and 15 member states reported that targets for QI were set within their health care system (n=62 respondents, 22 member states)

TARGETS FOR QUALITY IMPROVEMENT	% (n) n = 43 respondents
Control of hospital infection rates	77 (33)
Access times for elective surgery	58 (25)
Patient satisfaction	53 (23)
Waiting times in accident departments	42 (18)
Use of clinically effective therapies	37 (16)
Reducing adverse events	37 (16)

14

Slide 15



Requirements to have QI strategies
% (n) n=62

QI STRATEGY	REQUIRED HOSPITALS	REQUIRED P.CARE	REQUIRED M.HEALTH
Monitoring patient's views	55 (34)	29 (18)	36 (22)
Performance indicators	50 (31)	23 (14)	29 (18)
Patient safety systems	47 (29)	29 (18)	34 (21)
Clinical guidelines	43 (27)	26 (16)	26 (16)
Accreditation	28 (17)	20 (12)	24 (15)
Audit of standards	28 (17)	16 (10)	18 (11)
QM	24 (15)	10 (6)	14 (9)

15

Slide 22



Three categories of adoption of quality improvement strategies in the European Union

- Member States that have not implemented explicit legislation or national quality policies in health care
- Member States that have recently started to implement legislation or national quality policies in health care
- Member States that have a long tradition in enacting legislation or implementing quality strategies in health care

22

Slide 23



Three categories of adoption of quality improvement strategies in the European Union

- Member States that have not implemented explicit legislation or national quality policies in health care:
Cyprus, Greece, Malta, Portugal, Luxembourg, Latvia, Slovakia

23

Slide 24



Three categories of adoption of quality improvement strategies in the European Union

- Member States that have recently started to implement legislation or national quality policies in health care:
Czech Republic, Estonia, Hungary, Lithuania, Slovenia, Ireland

24

Slide 25



Three categories of adoption of quality improvement strategies in the European Union

- Member States that have a **long tradition** in enacting legislation or implementing quality strategies in health care:
Austria, Belgium, Denmark, France, Finland, Germany, Italy, Netherlands, Spain, Sweden and United Kingdom.

25

Slide 26



Conclusion

- Quality improvement strategies are diverse in Europe (within/between countries)
- Policy and professional organizations are main drivers – EC so far little impact
- Policy papers are little operational (\$\$\$)
- Quality strategies are mostly related to hospital care
- There is strong focus on clinical/laboratory standards, little attention on organization management and leadership.

26

Slide 27



Contact

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27

Presentation: External comparisons in health care delivery: current approaches and methodological challenges

Slide 1




External comparisons in health care delivery: current approaches and methodological challenges

Oliver Gröne, Technical Officer, Hospitals Programme
WHO Regional Office for Europe

1


Slide 2



Performance assessment

Performance assessment can be defined as a comparison of what has been achieved with what the system should be able to accomplish – that is, the best that could be achieved with the same resources.
Performance is achievement relative to resources.
(World Health Report 2000)

Should the concept of relative performance be applied to health care delivery?



2

Slide 3



What influences performance?

The Hospital is a **human-service organization**:

- "Raw-material" human-beings, require direct contact between professional and patient
- Uno-actu principle: production and consumption simultaneously
- Long-term perspective of results (intervention, discharge, HRQoL)
- Patient co-producer, contributes through expectations, compliance, lifestyle to long-term results.

Limitations for planning, standardization, and evaluation → industrial sector management systems not sufficient.

3

Slide 4

**International experiences
Germany**
www.bqs-qualitaetsreport.de

4

Slide 5

**International experiences
Germany**
Postoperative complications after apendicitis

5

Slide 6

**International experiences
United Kingdom**
South east London: **Queen Mary's Sidcup acute trust**
Key Performance Targets

Overall, this trust has received a performance rating of 1 star. This means your trust is showing some cause for concern regarding particular key targets, or across many balanced scorecard indicators.

The trust **achieved** on 7 out of 9 key targets (e.g.):

- All cancers: 2 weeks wait
- Outpatient and elective booking
- Total time in A&E: 4 hours or less [...]

The trust **underachieved** in 1 out of 9 key targets:


- hospital cleanliness

The trust **significantly underachieved** in 1 out of 9:

- financial management

6

Slide 19




Conclusion

- Hospital performance tools - differences with regard to:
 - Quality dimensions assessed and indicators selected
 - Regulations for participation (compulsory, voluntary)
 - Frequency of assessment (bi-annually, quarter-annually)
 - Risk adjustment (age, sex, case-mix)
 - Use and application of results (provider feedback, public disclosure)

19

Slide 20



Conclusion

- Hospital performance comparisons can be misleading!
 - Ranking changes with case-mix adjustment (every variable more may change ranking)
 - Performance evaluation so far has paid little attention on time-dependent data (measurements at different points in time lead to different rankings)

20

Slide 21



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21

Presentation: Indicators in the PATH project: the idea ... and the truth ...

Slide 1




Indicators in the PATH project
- the idea ... and the truth ...

Estonia, October 2005

Oliver Gröne, Technical Officer, Hospitals Programme
WHO Regional Office for Europe

1


Slide 2



What are performance indicators?


"Performance measure: a quantitative tool (for example, rate, ratio, index, percentage) that provides an indication of an organization's performance in relation to a specified process or outcome"

JCAHO, USA



2

Slide 3



Classification of indicators

Purpose:
e.g. internal quality improvement, external monitoring, accreditation assessment, public accountability, consumer and purchaser choice

Developer:
e.g. government, academic, commercial, accrediting agency

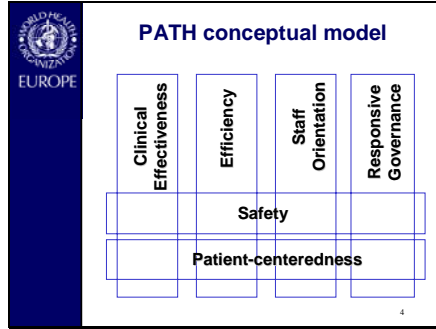
Level:
e.g. population, provider network, hospital, specialty, clinical condition

Orientation:
e.g. vertical (provider group, technology), transverse (natural history of disease, care pathway, patient experience, continuity)

Focus:
e.g. access/equity, effectiveness, efficiency, patient experience, staff experience

3

Slide 4



Slide 5

Set of performance indicators

Patient centeredness
 Cancelled surgical procedures
 Score on patient perception/satisfaction survey
 Score on interpersonal aspects
 Score on client orientation: information and empowerment

Responsive governance
 Perceived continuity through patient survey
 Women breastfeeding at discharge

Staff orientation
 Training expenditures on average number of FTE staff
 Budget dedicated to staff health promotion activities
 Short and long term absenteeism
 Percutaneous injuries on average number of FTE staff
 Staff excessive weekly working hours

5

Slide 6

Set of performance indicators


Clinical effectiveness
 Primary Caesarean section delivery rate
 Appropriateness of prophylactic antibiotic use
 Rate of readmission for selected tracer conditions
 Rate of admission after day surgery
 Return to ICU for selected procedures/conditions

Safety
 Mortality rates for selected tracers and procedures
 Formal procedure to report and analyze sentinel events
 Work-related injuries (percutaneous injuries)

Efficiency
 Ambulatory surgery use
 Median length of stay for specific procedures
 Average inventory in stock for pharmaceuticals
 Wastage of blood products
 Operating rooms unused sessions

6

Slide 7




Different examples of attributes for indicator selection: Australia (1/2)

Definable	Can the indicator be clearly defined?
Clear Intent	Is the intent of the indicator easily understood and interpretable by all users?
Relevant	Does the indicator measure aspects of care which are relevant and significant?
Accessible	Are data easily accessible?
Reliable	Is there demonstrated reliability (reproducibility) of data?
Valid	Does the indicator measure what is intended and point to issues of quality?
Event Identified	Can events be readily identified through diagnoses and/or frequency of occurrence ?

7

Slide 8




Different examples of attributes for indicator selection: Australia (2/2)

Useful	Does the indicator provide useful information to inform quality programmes and stakeholders?
Practical Benefit	Does the indicator have a strong cost utility ratio?
Responsive	Is the indicator responsive with a potential for action and quality improvement?

8

Slide 9



PATH framework for selecting performance indicators


Level 1 : Indicator
Importance & Usefulness

Level 2 : Tools of measurement
2.1. If available : Reliability, validity, causation
2.2. If not available : Burden of development

Level 3 : Data Collection
Burden of data measurement

9

Slide 10




So, what we did is ...

1. Literature review
2. Summarize strengths of the evidence
Main limits and forces
3. Provide a global recommendation (modified nominal group technique):
 - not appropriate
 - more evidence to be collected/ requires adaptation
 - very strong evidence suggest appropriate

10

Slide 11




What we did not do is ...

1. Use DELPHI method (much better to reduce systematic bias and individual factors),
2. Establish clear baseline on data availability in hospitals (some sort of survey was done ...),
3. Scientifically validate indicators (validity, reliability).

11

Slide 12




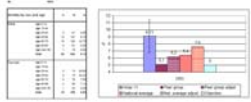
Experience from the pilot implementation ... to be honest ...

1. Only 51 hospitals out of 68 continued (6 instead of 8 countries),
2. None of the hospitals provided the full dataset,
3. Few of the hospitals used the data grid
4. Data to adjust for case-mix (SES, severity, co-morbidity) is missing,
5. Lack of use of standardized patient assessment measure makes comparisons for across two dimensions (four indicators) impossible.

12

Slide 13

 **Despite limitations, dashboards will be computed**




1. One page overall performance
2. One page composite performance index
3. One page for each indicator

→ 57 page report

13

Slide 14

 **What are we comparing?**

It is not the purpose of PATH to compare:


- Countries
- Hospitals

It is the purpose of PATH to compare:

- Peer groups of hospitals, which are constructed based on:
 - Interest of participating hospitals
 - Size
 - Specialization
 - Availability of hospital quality structures and processes (questionnaire)

14

Slide 15

 **Conclusion for Estonia**

1. Clarify purpose of indicator project,
2. Carefully review what data is available in routine data sets (incl. case-mix),
3. Identify main priorities for quality improvement,
4. Obtain agreement among stakeholders on these areas,
5. Standardize data collection procedure (Internet platform?),
6. Clarify before hand what will be analyzed and what will be done with data.

15

Slide 16



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16
