

PERFORMANCE ASSESSMENT & QUALITY IMPROVEMENT

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EDITORIAL

In the last couple of months, PATH-II was completed with data analysis and reports produced at the international level, while PATH'09 was recently developed and now unfolds with the recruitment of new countries and hospitals. At this intersection between PATH-II and PATH'09, we are pleased to present you with this Newsletter which including results and recent activities in PATH-II

countries and the main orientations for PATH'09. We are especially honoured to present and have the opportunity to welcome newcomers to PATH. Please take some time to review the PATH IV Newsletter.

By now all hospitals have received their reports and Country Coordinators are initiating or continuing local meetings focusing on interpretation of the results to identify potential for improvement and share best practices.

This Newsletter owes much to the hospitals and Country Coordinators who present experiences related to data collection and analysis, and to implementation of actions for improvement, starting with two indicators: c-sections and antibiotic prophylaxis. Their description of the situation is balanced, sometimes critical as they do not hesitate to expose some controversial results. But they not only highlight the need for improvement in a noteworthy effort of transparency; they also indicate ways forward and achievements. In the description from different countries, we note important variations and the crucial role of an "enabling environment" to sustain improvement activities.

PATH'09 was redeveloped to build on the lessons learnt in PATH-II and on the numerous ongoing activities in the field of quality measurement in Europe.

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The set of indicators for 2009 was reviewed and includes some new indicators while others were discarded. The new orientations as well as the indicators are presented in this Newsletter and will be discussed during the kick-off international coordination workshop in Ljubljana, 12 - 13 March to discuss and learn more about the details. You will find more information about this event as you read. Invitations and registration forms will be sent to the respective Country Coordinators.

We are very honoured to welcome the new enthusiasts of performance measurement who have decided to work with PATH'09. You will find below their profiles and contact details. Their presence adds much to the multicultural climate in the PATH community. This enhanced interest in PATH confirms the new orientations defined in PATH'09 with a reiterated focus on responsiveness to hospitals and local capacity building, with a strengthened role for the Country Coordinator to bring data analysis closer to data collection, as well as using PATH as a channel for dialogue between stakeholders and to make explicit some strategic priorities on quality. This keen interest is also generated by an increased awareness throughout Europe of the need not only to collect data but to use them, building a culture of measurement and providing incentives for continuous improvement. PATH derives from and contributes to this increased awareness. These values and actions are made explicit in the Vienna Statement on Performance Assessment in Hospitals, to be endorsed by members of the PATH com-

munity. And with the signature of the Tallinn Charter on Health and Wealth all 53 WHO Member States committed to accountability and transparency, performance measurement, cost-effectiveness, high quality and safety. This trend is here to stay and to grow further, the train is on track, so pack your bags (with PATH tools) and..... enjoy the trip!

This Newsletter is a tool for communication among all members of the PATH community. It is your tool. So please do not hesitate to send us your reactions, experiences, comments, and suggestions. We look forward to hearing from you, and hope you enjoy reading further.

Editors

PATH LOGO



WHO Performance Assessment Tool for Quality Improvement in Hospitals.

A project of the WHO Regional Office for Europe.

All PATH hospitals are allowed to use this logo (complying with the criteria as specified in the letter of understanding).

REPORT ON INTERNATIONAL PATH CONFERENCE IN VIENNA

The Vienna Conference on Performance Assessment in Hospitals

was held on July 3rd and 4th 2008 and attended by 150 participants from 30 countries. It was organized by WHO Europe, WHO CC Krakow, IQMS and the University of Vienna, the latter two of whom were indeed grand hosts. The event was an excellent opportunity for the PATH community gathering, which welcomed many newcomers who expressed their interest in the model.



The Vienna PATH conference provided a forum for exchange among experts, academicians, and PATH users and to present PATH to potential interested parties. The most valued participants were country and hospital coordinators, who came forward to share and learn from their experiences and reflections. The relations and interactions initiated in Vienna will hopefully translate into sustainable commitment to performance measurement for improvement with PATH or any other available model.

The speakers and presenters highlighted the issues of complexity of performance measurement, the challenges ahead and the variety of solutions proposed in the different settings. They also discussed how to move forward and develop creative and custom-made solutions, assure accountability and transparency, define the scope of use of indicators, incentives for improvement, roles and responsibilities of the different stakeholders in performance, and, most of all, the future of PATH.

We shared and reflected on PATH developments in the past; Jeremy Veillard and Ann-Lise Guisset from the WHO Regional Office for Europe provided an overview of what PATH might look like in the future.

Thus, PATH'09 will take on the role of intensive in-country work with a modified set of indicators, data collection and analysis on the national level. It will carefully plan and implement improvement activities. With the new countries involved, it will be exciting to see

how PATH can contribute to performance management and quality improvement in different hospitals in a country. PATH'09 will be positioned to fit one's own national context.

All the above may be found in the final conference document, and the Vienna Statement on Performance Assessment which is included in this Newsletter.

Presentations from the PATH Vienna conference are available at www.pathqualityproject.eu.



VIENNA STATEMENT ON HOSPITAL PERFORMANCE ASSESSMENT

2nd International WHO Conference on PATH, 4 July 2008, Vienna

Health systems in the European region are under growing pressure to optimize their performance so as to meet the health needs of the populations increasingly calling for more accountability and transparency. Functions carried out by hospitals are an integral part of and contribute to the performance of health systems. Incentive mechanisms encourage health care providers to improve their contribution to population health and to the quality of services delivered to patients. Monitoring and evaluation mechanisms such as external assessment, economic incentives, public reporting and internal continuous quality improvement tools are increasingly used to support quality improvement, accountability and transparency in hospitals. In this context, hospitals strive to continuously improve the quality and efficiency of their services and thereby contribute to strengthening health systems.

We, the members of the PATH network,

Recognize that equity, solidarity, and participation are core values of WHO Member States as stated in the Tallinn Charter on Health Systems, Health and

Wealth, and that accountability and transparency are essential to promote these. In particular, we recall the commitment made by the Member States of the WHO European Region through the Tallinn Charter on Health Systems, Health and Wealth to promote transparency and to be accountable for health system performance to achieve measurable results.

Endorse these values and commitments and encourage the evolution towards more hospital accountability.

Recognize that a comprehensive and holistic view of hospital performance which goes beyond traditional concepts of single performance dimensions is necessary to adequately respond to the needs of the population; that patients are central to all health care processes and that as such they must be empowered to contribute to hospital performance improvement processes; and that mechanisms should be developed to involve, motivate and enable professionals to function in teams and maximize their contribution.

Declare that we are committed to quality. Quality is a high level of performance which assumes a state of functioning that corresponds to societal, patient, and professional norms. It should be based on professional competences in applying existing knowledge, maximizing the use of available technologies and resources, increasing efficient use of resources, minimizing risk to patients, promoting patient centeredness and working towards optimal health outcomes. Within the health care environment, hospitals should be responsive to community

needs and demands, integrate services in the overall delivery system and commit to health promotion. Hospital performance should be assessed in relation to the availability of hospital services to all patients irrespective of cultural, demographic, economic, physical and social barriers.

Believe that performance assessment is a cornerstone to quality improvement processes and that while there are variations in the way performance measurement is currently used for performance improvement in European hospitals, it is important that performance assessment tools be adapted to the diversity of needs across the Region. It must be aligned to the strategic orientations of each hospital and should be embedded in its local context, thereby helping to test and revise the hospital's strategies.

Believe that quality improvement is further facilitated by learning from other hospitals, countries and professions. We support a collegial and constructive dialogue and believe that the PATH network is an appropriate mutual learning environment to identify international best practices.

Assume that the effort by hospitals towards continuous quality improvement is recognized and financially supported and that appropriate information systems are in place.

Understand that hospitals are only one of many actors in complex health systems and that they need to coordinate their efforts with other stakeholders and sectors.

PATH II ONGOING ACTIVITIES, RESULTS AND LESSONS LEARNT

A look at the PATH-II indicators results and lessons learnt

Introduction

With data analysis completed at the international level and PATH-II final reports sent to the country coordinators, this article reflects on the main results and lessons learnt from this exercise. We take a critical look at the data to build on its limitations as well as on its success. Indeed, those results raise a number of issues in terms of data collection as well as data analysis. This is a natural learning process that has been described in national systems for monitoring quality and that should not undermine the value of PATH. What remains essential in PATH is also its potential for raising awareness and for actions. Those have been demonstrated in a number of instances, even before any international data analysis were brought to the countries and hospitals.

Two indicators –c-section and antibiophylaxis– are the focus of the Newsletter. In this article, we describe and discuss the main results for both of them in more detail. Both provide a good illustration of many of the limitations and achievements in PATH-II. For ease of reference, the definition, rationale, limits and strengths of the indicators and support to interpretation are provided in figures 1 and 2.

Overview of indicators collected

International analysis and reports were provided for 12 of the 17 core indicators. No reports were made available for the remaining 5 indicators because of either their nature (qualitative responses –often in the local language– regarding surgical theatre use and absenteeism), either wide differences in operational definitions or tools for data collection or reporting format (results on patient surveys, training expenditures, excessive working hours). For these indicators, it is advisable to have results synthesized and discussed at a national level. This national approach supposes the active role of the national PATH Country Coordinator and hence direct access to the raw data provided by the hospitals. The analysis of the qualitative indicators is especially problematic. As it seems the questions were not sufficiently specific, responses diverged greatly in their nature, even within a country.

→ **Lessons learnt:** *Restrict PATH'09 indicators to quantitative indicators. Qualitative questionnaires might be provided in addition, as a support to interpretation of results, to give added meaning to the results, or to describe the structure and process and initiate benchmarking also on structures and procedures.*

Table 1 summarizes the sample size (number of participating countries, number of hospitals, and number of observations) for all 12 “international” indicators in the core set. It is notable that only two indicators (C3 mortality and C8 length of stay) were reported by a minimum $\frac{3}{4}$ of the sample. This observation

undermines the assumption that core indicators “are relevant to all contexts and represent a low burden of data collection” and are expected to be collected by all participating hospitals.

→ **Lessons learnt:** *The distinction between core and tailored indicators does not hold in practice. Have a single list of indicators for PATH'09, with proper descriptive sheets for all of them and advocate for countries/hospitals to use a balanced set of indicators with at least one indicator in each dimension and to have data collection both prospective (ad hoc) and retrospective (from readily available administrative databases).*

In some countries, it was centrally agreed at PATH-II inception not to measure some indicators because of the burden/timeliness of data collection or the lack of relevance to the local context. When excluding such countries from the analysis (table 1), two additional indicators were computed by more than $\frac{3}{4}$ of the PATH hospitals: antibiotic prophylaxis and discharge preparation. Both indicators created probably the higher burden of data collection, as they required respectively audit of medical records or patient survey.

→ **Lesson learnt:** *With appropriate support and motivation at the country coordination level, the burden of prospective data collection can be compensated by expected usefulness. Indeed, experience in both PATH-pilot and PATH-II suggest that monitoring the compliance with antibiophylaxis guidelines had a great impact in terms of raising awareness and resulted in concrete actions for improvement such as the development or revision or dissemination of guidelines.*

Table 1. Description of the sample for 12 core indicators

Indicator code and name	# of participating countries	Total # of hospitals in participating countries	# of hospitals providing data on the indicator	# of hospitals meeting the min threshold to compute the indicator	# of observations at denominator	Mean	Median	St.dev.
C3 mortality*	8	155	120	108	23455	9.5%	7.1%	8.0%
C8 length of stay (median)***	7	154	116	105	20166	12.1	11.5	3.2
C1 c-section	8	155	84	84	<i>unknown(1)</i>	23.2%	21.4%	10.5%
C2 prophylactic antibiotic*	6	101	78	78	6292	87.7%	100.0 %	24.3%
C4 readmission*	6	108	75	67	8407	3.8%	2.8%	4.1%
C13 needle injuries	8	154	67	67	59648	4.7%	3.9%	3.5%
C5 day surgery**	5	100	63	60	21325	82%	99%	24%
C14 staff smoking	6	105	52	50	35680	32%	30%	15%
C7 Readmission to ICU	6	105	48	48	20865	1.08%	0.98%	0.91%
C16 score on CTM3 (discharge preparation)	5	55	47	47	15995	81.9	82.3	6.2
C15 exclusive breastfeeding	6	105	46	46	6686	82.6%	89.3%	17.2%
C6 admission after day surgery**	5	100	23	22	13821	no rate computed because rare event, average rate on sample 0.3%, max 8 admissions (each case to be analyzed individually)		

* Hip replacement

** curretage of the uterus

*** hip fracture

(1) some hospitals provided rate without including details on number of deliveries

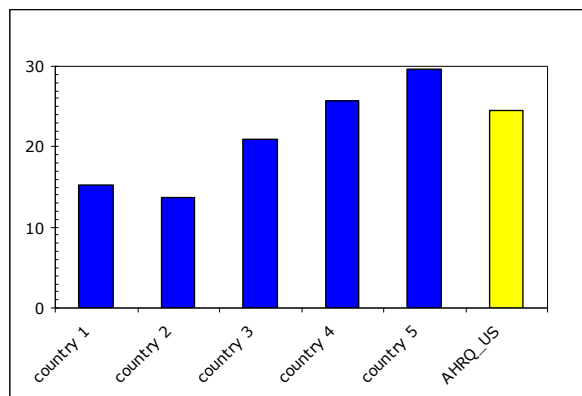
On the contrary, less than half of the participating hospitals have reported on the number of needle injuries for all staff excluding students). This low participation rate is troubling as the definition was general to accommodate any source of data and hence the expected burden of data collection was supposed to be very low. It might mean that a large number of hospitals have no central monitoring system in place to report needle injuries for all staff categories and hence lack opportunities to identify and eliminate the main causes for such incidents.

→ **Lessons learnt:** *The number of participating hospitals might be a useful element to consider in the process of redevelopment of the PATH'09 set of indicators but it will not guide this process. For indicators such as "needle injuries" or "staff smoking" – reported by only 52 hospitals – one might argue that this low participation calls for more advocacy and raising awareness on hospitals' role in promoting health, including preventing incidents and in supporting its staff to quit smoking. Hence, the PATH'09 descriptive sheet on staff smoking will also refer to an auto-audit questionnaire for each hospital to identify areas needing further attention and to provide a guide for smoking policy development.*

C1: C-section rate

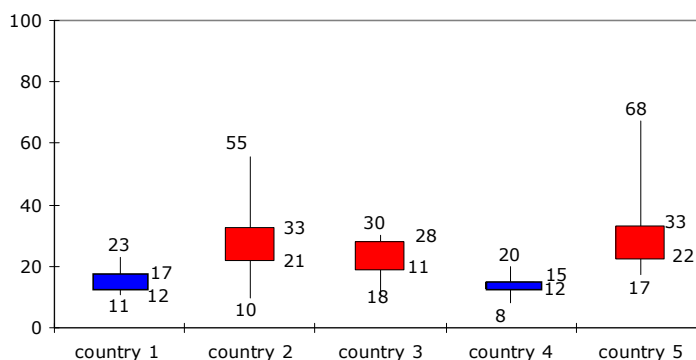
The core indicator on c-section relies on the AHRQ definition that concentrates on low risk deliveries. Complicated deliveries (e.g. fetal death, breech procedure, pre-term within 37 weeks or less of pregnancy) are excluded with the aim of having a more homogeneous population to enable comparisons.

Figure 3: International comparison on average c-section rate within country



In two out of five participating countries, the average rate was higher than in the United States (using AHRQ definition, 2003 data) where it is commonly believed that c-section is a procedure generally over-used (figure 4). There is no agreement on a "gold standard" for c-section rate but rates between 15% and 25% are generally accepted; while WHO targets a rate of 10-15%. Those reference rates include all deliveries and should be slightly revised downwards if applied to the AHRQ definition as it excludes complicated deliveries.

Figure 4: International comparison on average c-section rate within country



Therefore, globally (figure 3) as well as at the level of individual hospitals (figure 4), results tend to indicate an over-use of C-section in all countries, even if caution in interpretation should be exercised, as the appropriateness has not been assessed.

Seldom do hospitals present c-section rates below 10%. Countries 2, 3, and 5 (figure 4, red) tend to have a higher rate (median and mean) as well as a wider dispersion (inter-quartile and standard deviation) compared to countries 1 and 4 (figure 4, blue). This might signal generally better practices in countries 1 and 4 with more homogeneity in the process around a more accepted median or mean rate. If socio-cultural factors (demand induced-c-section) can contribute to higher rates in some countries, it does not explain wider variations in those countries. However, it might also result from more homogeneous patient populations in countries 1 and 4 and consequently question the reliability of coding exclusion criteria in countries 2, 3, and 5.

For c-section, the core indicator –described above– is complemented with two tailored indicators: primary c-section deliveries and repeat c-section after previous delivery. These indicators could not be collected based on discharge abstracts or other administrative databases and hence required ad-hoc prospective data collection. Thus, the period of observation for the core and tailored indicators did not correspond. The proper understanding of the indicator on primary c-section was questioned after it was observed that some hospitals had higher numbers of primary deliveries than of deliveries in the same day. For such hospitals, the mistake was obvious and they were excluded from further analysis for tailored indicator. But for other hospitals, without this “obvious mistake” the question of how they understood the definition remains. Such misunderstandings might be eliminated with more explicit procedures for data collection (e.g. with algorithms) and training. The prompt analysis and feedback to hospitals is also crucial and will be greatly facilitated if done at the country level. Such quality controls of data are crucial to ensure that the efforts for data collection are rewarded, and that comparisons are not spoiled by a few hospitals entering misleading data.

C2: Compliance with anti-biophylaxis guidelines

When taking into account all observations and computing a global rate, between 62% and 80% of patients received antibiotics in compliance with the guidelines (figure 5). These seemingly good results (high rate of compliance) can be disputed for several reasons. First, how to justify that around 1/3rd to 1/4th of the patients receive sub-optimal antibiophylaxis? Second, global rates hide wide variations between hospitals (figure 6) and the rate of compliance is strikingly low in a number of hospitals.

Figure 5: Percentage of patient with appropriate, under-use, over-use or other inappropriate use of antibiophylaxis in the international sample

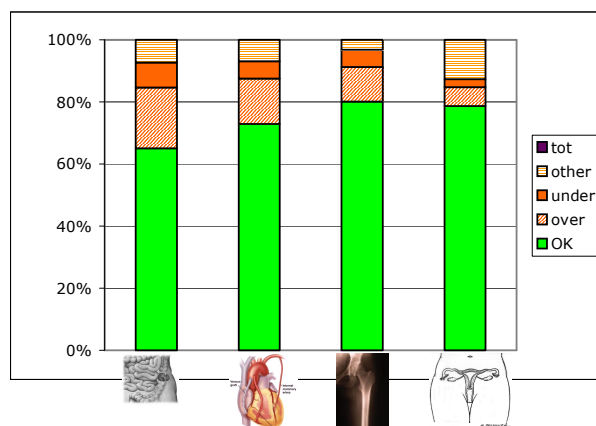
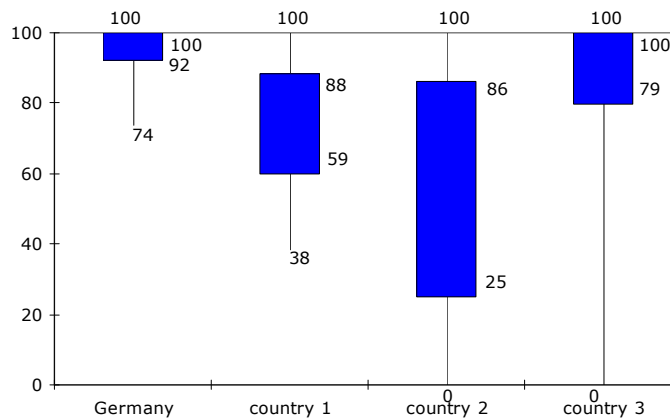


Figure 6: Inter- and within-country distribution of % of patients receiving antibiophylaxis in compliance with local guidelines for hysterectomy (minimum, 1st quartile, 3rd quartile, maximum)



Third, analysis of the tailored indicators suggests that the degree of compliance with antibiophylaxis guidelines is over-estimated by the core indicator or that guidelines do not include instructions on timing of the first and last dose and hence allow for sub-optimal care. Indeed, 19, 44, 47, and 39 patients, representing respectively 8%, 22%, 12%, and 25% of the total number of patients for which the tailored indicator on the timing of last dose was computed, received antibiophylaxis for more than 24 hours after surgery but nevertheless were considered as having received appropriate antibiophylaxis. This contradicts the general understanding that antibiophylaxis should be stopped within 24 hours of the surgical intervention. The quality of the reference guidelines was not assessed as part of PATH-II data collection. Subsequently, country coordinators indicated that a number of hospitals/countries did not have any guideline and called for wider dissemination of international and national guidelines. This indicator opened a window of opportunity to discuss the development, revision and dissemination of guidelines in line with internationally accepted standards.

Conclusion

If a single lesson is to be learnt from this exercise, it is the crucial role of national coordinators, including training of the PATH hospital coordinators to build a common understanding of the operational definition and to standardize data collection, data

analysis and feedback to hospitals. In PATH-II, they were extremely supportive in linking with hospitals to understand (and correct or eliminate) some irregular results. Unfortunately, the delays between data collection and feedback and request for correction to hospitals was very long, because of a delay at the international level. This made it very difficult to go back to the data for some of the indicators. Delays in analysis created great difficulties and limited the impact of reporting. This has to be corrected for PATH'09. Additional standardization, to go beyond the operational definition and extend to uniform data collection tools, is also crucial. More emphasis will be placed on this standardization for PATH'09 but it is certain that data quality will grow as data are used and "gaps" in definitions are informed by experience. The intelligence gathered during PATH-II will provide a great input for PATH'09.

The difficulties related to data should not overshadow the potential for improvement generated by PATH-II. Some preliminary findings on inter-country variations (e.g. c-section rate) need to be further scrutinized and will provide important insights for improvement. A substantial potential for improvement of some indicators (e.g. antibiophylaxis) was also highlighted and hopefully will help raise awareness of the issue and lead to improvement (e.g. with the development of new guidelines). But also the discovery of a lack of reliable data –e.g. on needle injuries– is major information in itself and potentially a strong driver for raising awareness.

These conclusions can be expanded to the other indicators. In the next Newsletter, we will describe in more detail results on additional indicators and also propose a transversal approach to indicator analysis. Indeed, the assumption that indicators cannot be interpreted in isolation is central to the PATH system. The theoretical relationship between indicators/tracers has been highlighted and will be empirically addressed in the "PATH-II results" section of the next Newsletter.

Ann-Lise Guisset, WHO Regional Office for Europe

A country coordinator's reflection upon PATH-II data collection, analysis and impact on quality improvement initiatives

Data collection is finalized. Reports have been produced and sent to hospitals (and discussed in the above article). It is now time to bring figures to life, to understand what it really means and learn from others' experience in bringing changes. In the following sections, the country coordinators tell us the story behind the numbers, with a focus on two indicators: C-section (C1) and antibiophylaxis (C2). This crucial information was gathered through a questionnaire sent to all hospitals. It included questions on hospital/country experience in terms of data collection, dissemination of results, as well as the questions and issues raised by the indicators, quality improvement activities implemented or planned for the near future.

The presentation of c-section and antibiophylaxis in this context will be followed by a similar presentation for other indicators in the Newsletters to follow. We are eager to hear about the changes implemented as a result of PATH. So, as you read this article, you are welcome also to share your experience on the use of indicators in your hospital. If you wish to do so kindly contact your country coordinator to ask for support to write a "case study" for the next edition of this Newsletter. This forum is also open to put "questions to the PATH community" as you strive to understand your results or how to improve them.

PATH in Poland in 2008 – our national experience, exchange, networking, communication for improvement

Last year, PL country coordinators held two national meetings for Polish hospital coordinators.

We presented PATH and discussed the project at the annual conference "Quality in Healthcare", organized in Krakow by NCQA and Polish Society for Quality Promotion since 1995.

One conference session was devoted entirely to PATH and we hosted Dr Ann-Lise Guisset from the WHO Regional Office for Europe, who leads PATH within WHO. Dr Guisset highlighted the role and the importance of performance measurement for quality management and presented the PATH system as an international initiative which originated with WHO.



Ann-Lise outlined PATH's underlying principles (internal management use, voluntary participation, confidentiality, self-determination, methodical restrictions, impact on hospital care, limited burden of data collection), its objectives (serve as a managerial tool to support hospitals in questioning their achievements and join an international benchmarking network) and its unique aspects (multidimensional, custom-made focus on improvement, independent, international, WHO "seal").

There was also a workshop we organized in June 2008 at the Ministry of Health in Warsaw, where we presented the first results – our Polish indicators compared to international ones. We discussed the structure of reports, the difference between global rate and mean rate for the country.

Based on the chosen examples, the measures of location (mean, median), dispersion (standard deviation, quartile range) and the graphical presentation of results (how to "read" box-plots) were discussed.

Both meetings provided a good occasion for exchange, discussion and sharing, especially the difficulties in data collection and

the correct interpretation of data.

We also provided hospitals with assisting instructions on how to read their individual reports and interpret the results.

Polish experience in data collection for C-sections (C1) and perioperative antibiotic prophylaxis (C2) in PATH II

C1 – Caesarean section

Core indicator: the percentage of Caesarean sections of the total deliveries.

For the core indicator, the year 2006 has been agreed as the retrospective data collection period.

Optional/tailored indicators:

- a) Number of primary Caesarean sections over number of primary deliveries
- b) Vaginal deliveries over all deliveries with a previous Caesarean section.

For tailored indicators a data collection period has been agreed prospectively for 1 month (May 2007); where there are under 30 deliveries in that period, the data collection time should be prolonged (be more than a month).

Data source: deliveries register; registry of obstetrical OR; documentation of obstetrical ward; patients' records.

Tab. Description of Polish C1 sample

Core indicator: c-section rate for deliveries with low-risk of c-section	Poland (29 hospitals in PATH 2007)
Number of hospitals	19
Number of deliveries included in denominator	14607
Global rate on the Polish sample	25.7

In response to the request to share the experience of data collection in PATH II, 8 hospitals out of 19 having collected and sent their data and received PATH reports have provided their input regarding C1.

Time of data collection and mode (prospective / retrospective) for C1 indicator varied.

The majority (5) collected data for core indicator retrospectively for 2006 and 4 of them covered one month (May 2007) for optional indicators. Other hospitals' data collection periods were: 39 days, 10 months and 2 years.

The results seem reliable and as expected. The numbers correspond to hospital average statistics and reflect the general tendency of C-sections growth.

The increase in numbers of C-sections is ascribed to the increase in number of births, number of pathology pregnancies and neonates with unusually high birth weight.

All hospitals conduct regular monitoring of C-sections and report their statistics to the regional consultant on Obstetrics and Gynecology and regional Institutes of Public Health.

In a group of 8 hospitals, 6 provide the data on deliveries with regard to the inclusion/exclusion criteria (patient with abnormal presentation, preterm, fetal death, multiple gestation, breech procedure, delivery within 37 weeks or less of pregnancy). Only 2 hospitals identified those exclusion criteria from the administrative databases. 4 rely on other sources such as the ward medical documents (Book of Deliveries or Neonatal Unit Book). This illustrates the difficulties and need for improvement regarding the hospital administrative database and options' selection. Facing these difficulties, 2 hospitals increased the possibilities of their administrative database for the PATH project.

Only 3 out of 8 hospitals introduced an internal process to review C-sections.

The improvement undertaken as a result of PATH measurement included:

- Introduction of local regulation to perform C-sections only when clinically indicated
- Initiate proper monitoring of C-sections in hospital administrative database, allowing for registration of the inclusion/exclusion criteria, starting January 2008
- Critical evaluation of C-section indication by specialists other than Ob-Gyn.
- Promotion of natural deliveries
- Eliminating C-sections upon request
- Introducing software module that enables monitoring and analysis of C-sections
- Introducing focused monitoring of C-sections in rela-

tion to the number of births.

- Increase the use of epidural anesthesia free of charge.

C2 – Prophylactic antibiotic use (over and under use)

Hospitals evaluate antibiotic prophylaxis due to the local guidelines accepted in a hospital (meaning a hospital has adopted the antibiotic prophylaxis; defined the medicines used in therapeutic procedures included in PATH project; declared the lack of antagonism with SPC/the manufacturer's indications; provided reference to national guidelines (where these are available). Local information on the hospital model of prophylactic antibiotic use was sent to the WHO CC Krakow.

In Poland, hospitals were not expected to collect data for tailored indicators, i.e. the type of antibiotic (including the chemical drug content).

8 hospitals out of 17 in case of colorectal cancer surgery, 20 in case of hip replacement and 19 in case of hysterectomy having collected and sent their data and received PATH reports, provided their input regarding C2. None of Polish hospital have collected and sent data regarding use of prophylactic antibiotics for CABG.

Hospitals' contributions reveal data were collected for different tracers but it is not always possible to identify which ones and whether to link them to separate improvement activities. Sometimes data collection periods were the same for all tracers, sometimes one cannot specify this.

Data sources were mainly patient medical records; registry of antibiotic use; hospital computer database.

The results again were considered reliable and met expectations. Some hospitals claim that the results' reliability is high as data was collected personally by heads of surgical departments.

Five hospitals do not monitor antibiotic prophylaxis on a regular basis.

In hospitals that do, the analysis goes to heads of surgical units and medical directors.

Trends observed in the prophylactic antibiotic therapy vary: decrease, increase or no significant change. However such observations are not supported by data.

Increase of indicator is explained as the result of more rigorous monitoring and following the adopted definition of antibiotic prophylaxis.

The decrease is the result of limiting antibiotic prophylaxis in "clean" surgeries.

All 8 hospitals have adopted definitions of antibiotic prophylaxis and developed the local scheme, including antibiotics identified for prophylaxis (narrow spectrum), timing and administration principles. These have been defined and based upon:

- Opinion of Therapeutic Committee
- Opinion of hospital epidemiologist and microbiologist
- Opinion of the Hospital Infection Committee
- SPC
- Quality Director

The exact time of the first dose of prophylaxis administration and of the last dose administration is reflected in patient medi-

cal record only in 3 respondent hospitals.

Improvement activities undertaken:

- Detailed analysis of each case of prophylaxis by head of the department
- Reducing prophylaxis in “clean” surgeries
- Establishing Hospital Antibiotic Committee
- Initiate systematic monitoring of antibiotic prophylaxis
- Initiate local analysis of perioperative prophylaxis

The contributions from hospitals indicate that PATH has played a vital role in prompting local reflections on very clinical aspects of care. The improvements planned or already implemented contribute significantly to the quality of patient care.

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A national indicator in prospect The French experience

Among 17 indicators of the French PATH project, surgical antibiotic prophylaxis is particularly interesting for exploring two dimensions: clinical effectiveness and safety. France, like most of the developed countries, is in search of reliable indicators to estimate quality and safety in healthcare.

Appropriate antibiotics prescription is a crucial public health issue, because antimicrobial use is the major determi-

nant of antibiotic resistance. Over the last decades most Western countries have developed clinical guidelines for surgical antimicrobial prophylaxis. Although the principles of prophylaxis have been defined, there is still widespread misuse. Studies assessing the current practice of prophylaxis throughout the world have shown that over-consumption and inappropriate timing remain a problem. In France the guidelines published in 1992 by the Societe Française d'Anesthésie Réanimation (SFAR), were updated in 1999 (1). Claude Martin has shown in 1998 that written guidelines were posted in the operating theatre in only 48% of cases (2). The current French practice of prophylaxis for total hip replacement complied with the national guidelines in respectively 66.9 and 53.0% in 2004 (3,4).

In the frame of PATH, our aims when looking specifically at antibiotic prophylaxis were to assess the compliance of anaesthetic practices with the national French guidelines of 1999, to investigate the causes of non-compliance, and to suggest ways for improvement.

Study design

The definition of the indicator was in line with the French experience of PATH 2004. The WHO criteria were discussed in a multiprofessional workgroup and adapted to be operational.

The 4 surgical tracers procedures were: total hip replacement (THR), hysterectomy (HYS), colorectal cancer (CRC) and coronary artery bypass graft (CABG).

The sample was constituted by 50 procedures of each tracer in each hospital.

The exclusions were: history of surgical site infection, betalactam allergy, endocarditis risk, Methicillin-resistant Staphylococcus aureus carriage.

The national coordination team worked in close collaboration with its regional correspondents in Aquitaine, Auvergne and Pays de Loire.

Variables studied

Core set : appropriate use = global compliance, over-use (too long, too strong, too high), under-use (no antibiotic, too low, too short)

Tailored : timing of first administration conform to the guideline

Evaluation criteria

Global compliance or appropriate use was defined with five essential criteria derived from the SFAR consensus statement :

- Antibiotic use
- Antibiotic choice
- Dose of first injection
- Timing of first injection
- Duration of prophylaxis (perioperative reinjection if necessary, no useless postoperative injection)

Results

Among the 47 voluntary hospitals for PATH 2007, 26 participated in the data collection concerning the prophylactic antibiotic for one to four surgical procedures. 2628 surgical procedures were reviewed, and 2344 were included. Systematic review of anesthetic records was easy. Inclusion of 50 surgical records in each hospital was difficult only for colorectal cancer. Only 3 hospitals participated for coronary artery bypass graft.

The appropriate use varied between 39.8% and 76.8% respec-

tively for HYS and THR. The timing of first injection was adequate for 76% of HYS and CRC, and 89.4% for THR. Over-consumption is defined as “prolonged duration of SAP and/or large broad-spectrum antibiotic”, and “first injection after skin incision”. These are the 2 major difficulties to comply with national guidelines.

Discussion

Inappropriate use of antibiotics is still a problem in current French prophylactic antibiotic practices with global compliance <50% for clean-contaminated surgery (CRC, HYS). On the other hand, compliance for THR is > 75%; surgical site infection is indeed a daily concern for surgeons & anesthetists.

Simple guidelines are not enough to improve practices, indeed only one antibiotic (cefazoline) is recommended for HYS, an inappropriate agent is used in 30%. The choice of Amoxicillin-clavulanate is associated with useless injection suggesting confusion between prophylactic & curative use for clean-contaminated surgery.

Conclusion

The generalization of prophylactic antibiotic indicator requires prior revision of some criteria with the SFAR to lead to a stabilized version:

- To clarify the surgical acts to be included for CRC (appropriate codes of the French procedural terminology “CCAM”),
- To clarify the timing of first injection : strictly within the 60 min before skin incision, or within 30 and 60 min before skin incision.

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Acknowledgments

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PATH French coordination team,
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PATH in Slovenia

The PATH project has attracted quite a lot of attention in Slovenia during the last year. Participation of one of our general hospitals in the PATH 2007 pilot project was found to stimulate other stakeholders to increase their interest in quality control in hospitals. On behalf of the Slovenian Ministry of Health and of the WHO country office, the National Institute of Public Health accepted the PATH coordination role in the country.

The National Institute of Public Health (NIPH) is a leading national institute and major research centre in epidemiology, disease prevention and health promotion, environmental health, health services, systems and policies research. Public health activities in Slovenia have a long-standing tradition. The creation of the Institute was one of the achievements of Dr. Andrija Štampar who was the first president of the World Health Organization.

Rade Pribakovic Brinovec, MD, a researcher in health services at the NIPH, became national PATH coordinator.

Our approach in the preparations for the kick-off was to involve all major stakeholders in a steering committee. These stakeholders were the Ministry of Health (the leader), the National Health Insurance Fund, the Association of Health Institutions of Slovenia, the WHO country office and NIPH. All partners have strongly committed themselves to the success of the project. The Ministry of Health found PATH to be an opportunity for implementation

of quality indicators in all hospitals around the country. The Ministry will also contribute to necessary investments in ICT. We believe that these incentives are a strong signal to the providers of health care to join the PATH community. Having on board the Association of Health Institutions of Slovenia which involves all hospitals in the country adds value to our endeavor.

At the moment, we are planning steering committee activities for this year. During the next months we expect to have several presentations of the project to the hospitals. We are looking forward to our future cooperation.

Rade Pribakovic Brinovec, Country Coordinator

PATH in Estonia

The PATH Estonia group (6 hospitals) had a feedback meeting end of 2008.

We hosted Dr Ann-Lise Guisset from WHO Europe, Copenhagen as the PATH coordinator, who gave an overview of the data collection process and the results on the country level. The main interest of Estonian hospitals was to initiate comparison in international peer groups which turned out to be impossible for technical reasons. It was very interesting to hear about the “painful” data analyzing process and the reasons for this as we had the same experiences here in Estonia!

It took our group of only six hospitals many hours to understand the definition of indicator

in the same way and to agree upon the necessary details to enable data comparisons among our hospitals. But this process is helpful in understanding the aim and the benefit to the hospital. It has also shown how useful the existing IT systems in hospitals are and how valuable are the systematically collected data.

The main value of our workshop in November was the discussion with Ann-Lise Guisset about the interpretation of indicators, learning how to find and use the information behind the numbers, following the estimated hypothesis.

The main challenge we have identified is how to attract physicians to participate in the process more actively. Until now, we have good experiences with this regarding indicators C2 and C9.

Jane Alop, Country Coordinator, Estonia

PATH'09 STRATEGIC ORIENTATION

The cornerstones for implementation of PATH'09 are local ownership, clear positioning of PATH in relation to a national (or regional) strategy for quality improvement and/or for increased accountability, and development of local capacities. Harmonization and building synergies are additional features of PATH'09, which is being improved in partnership with leading international organizations in hospital performance measurement.

PATH provides hospitals with four major features: a conceptual framework for performance assessment, a toolbox, individual reports and a national (or regional) network. The first two components are generic. They are proposed by the WHO Regional Office for Europe and freely available to all. The last two components are to be integrated into the national context.

PATH is built on a comprehensive framework for performance assessment which includes six dimensions of performance and fosters a culture of measurement and evidence-based management, cross-department dialogue, and integration of databases. It raises awareness of the strategic role of hospital top management to components of performance which are sometimes overlooked, such as responsive governance or staff orientation, in order to promote a broad approach to sustainable hospital performance improvement.

The toolbox includes a single set of evidence-based performance indicators including clear definitions of each indicator, a review of the current literature and suggestions on how to position these indicators in the global perspective of hospital performance improvement. These indicators are harmonized with best practices and are developed in collaboration with leading partner organizations in each respective domain of expertise. PATH also provides hospitals with data collection tools (e.g. survey questionnaires).

The responsibilities for data analysis, reporting of individual results to hospitals, and enhancing networking among hospitals, lie at the country¹ coordinator level. Suggested mechanisms for national or regional networking include for instance a newsletter, a forum on the website, twinning, working groups, workshops or international or national conferences. Some country coordinators might develop partnerships to exchange results to enable international comparisons on some indicators or to establish common tools for international networking among their hospitals. We believe such "regional networks" or "thematic networks" will emerge and will serve as a basis for building an international association of hospitals (on a model similar to the "Health

¹ "Country coordinator" is a generic term that we use for ease of reading. As PATH can be implemented in single provinces or regions, there might be regional or provincial coordinators in those contexts.

Promoting Hospitals" network²) in the future.

PATH'09: The next steps

The second wave of data collection (2007-2008) has brought preliminary lessons to the countries and hospitals participating in PATH:

- (1) Good quality data are key and data quality is best ensured at national level ;
- (2) Efforts in collecting performance indicators should not distract hospitals from having a multidimensional perspective on hospital performance;
- (3) There should be a better balance between retrospective data collection (such as readmission rates) and prospective data collection tools (such as prophylactic antibiotic use);
- (4) The performance measurement tools used should be as standardized as possible but interpretation is local and should be related to hospital strategies;
- (5) Hospitals value sharing experiences with other peer hospitals and therefore more should be done to promote the PATH network as an opportunity for exchange.

Building on these lessons, the scientific committee of the PATH network met at the ISQUA conference on the 21st of October 2008 to discuss the next steps to improve PATH

² For further information see <http://www.euro.who.int/healthpromohosp>.

and strengthen its sustainability. A number of steps are being taken to ensure that the data collection can start in spring 2009 and that in the meantime the PATH system can be improved to reach a high standard of quality and sustainability by the end of 2009.

First, the set of performance indicators has been reviewed in its entirety and suggestions made to: improve its face validity (so that all performance dimensions are truly covered); further standardize performance indicators in light of the work of other organizations (such as WHO, the OECD); better balance of prospective and retrospective data collection tools; and plan the steps to refine the descriptive sheets and data collection and data quality check tools for national coordinators.

Second, a thorough evaluation of the second wave of data collection will be undertaken in early 2009, in order to incorporate the lessons learned in the final set of performance indicators to be calculated by hospitals in 2009. This evaluation is led by the scientific committee. Results should be available in late April 2009.

Third, the recruitment of the countries interested in participating in PATH for 2009 is currently underway. A number of new countries have committed to participate in PATH'09, PATH country coordinators have been appointed and a few more are currently assessing the opportunity. Please visit the section "Welcome" for the new faces in the "PATH community".

Fourth, a two days workshop will gather national coordinators and one hospital representative per country to initiate or strengthen international networking, share a common understanding of indicator definitions and data collection procedures, review the tasks to be performed as national coordinator and find ways to build synergies between countries. Hospital representatives are also invited to attend to serve as "feasibility check" on data collection and to make sure that the focus remains on final users. Their role is crucial and their participation will allow them to establish personal contacts with their counterparts across Europe.

Fifth, the PATH website will be drastically revised with the objective of hosting a forum for PATH participants, and newsletters and tools such as a performance improvement guidebook developed in 2009 for participating hospitals. This redevelopment will take place in two phases to develop as PATH'09 is being implemented.

The data collection procedure is separated into two phases, to recognize different degrees of complexity or readiness for data collection. Some indicators need further refinement, or translation and validation in the national language, or setting up ad-hoc procedures for data collection, or some training. Other indicators already have extremely specific definitions, are built on international indicator systems and are extracted from readily available databases. Also, we suggest splitting data collection to 1) have rapid results on at least a few indicators and

build on the momentum immediately following on recruitment of participating hospitals and 2) distribute the burden of data collection over a longer period.

The following table clarifies the steps which are going to take place in the next few months. No doubt the deadlines are challenging and it will be a busy period for the PATH participating hospitals and national coordinators, who are interpreting the data and in the meantime preparing the implementation of PATH'09. Your experiences will be very useful to improve PATH. WHO Europe and the WHO Collaborating Centre in Krakow will attempt to share them through the website and our newsletter.

Steps	Timeline	Responsibilities
Finalize re-selection of performance indicators and contact partners for development of descriptive sheets and data collection tools.	On-going	WHO EURO with scientific committee and WHO CC Krakow
Web-site "facelift"	By Mid-March	WHO CC Krakow
Commitment of participating countries and hospitals – list closed – PATH coordinators in hospitals appointed	By end March 09	Country coordinators
Finalize data collection tools for 1 st phase indicators	By end March 09	WHO EURO, WHO CC Krakow, with external partners
Organize locally to facilitate national networking	Dec 08 - April 09	Country coordinator
Two days workshop with country coordinators and one hospital representative per participating country (see invitation)	March 09	WHO EURO
National workshop with participating hospitals to share a common understanding on data collection procedure and initiate networking	April 09	Country coordinators and hospital coordinators
Collection of data for 1 st phase indicators	Report to country coordinators by July 09	Hospitals with support from national coordinators
New website with forum and other interactive modalities opened	By July 09	WHO CC Krakow with support from external consultant
Finalize data collection tool for 2 nd phase indicators	By July 09	EURO, CC, with external partners
Second international workshop with country coordinators and one hospital representative to discuss data collection procedure for first phase, share reporting tools and learn from experience in first phase, plan "the way forward" for international networking, and prepare for next phase of data collection	September 09	WHO CC Krakow
Results for 1 st phase indicators available	By October 09	Country coordinators with external support if needed (modalities to be defined – maybe workshop with all Country Coordinators)
Collect data for 2 nd phase (and repeat data collection for indicators in 1 st phase, if relevant)	September- November 09	Hospitals with support from national coordinators

Jeremy Veillard
WHO Regional Office for Europe

PATH'09 indicators

Indicator	Dimension	Definition	Level of aggregation or disaggregation for reporting and interpretation	Source of data	Phase (tentative end date for data collection)	Previous PATH experience
C-section rate	Clinical effectiveness Safety	C-section rate for deliveries at low risk of c-section. Based on AHRQ definition.	Global rate	Retrospective Admin. database	Phase 1 (fill July 09)	PATH-pilot and PATH-II: yes.
Case fatalities for AMI and stroke	Clinical effectiveness Safety	Fraction of patients with tracer condition dying in hospital within 30 days of hospital admission (AMI, stroke) – OECD definition	Global rate Rate by tracer condition	Retrospective Admin. database	Phase 1 (fill July 09)	PATH-pilot and PATH-II. Definition slightly revised. Limited number of tracers to align to OECD definition
Post-operative pulmonary embolism	Clinical effectiveness Safety	Rate of patients with post-operative pulmonary embolism (OECD patient safety indicators definition)	Global rate	Retrospective Admin. database	Phase 1 (fill July 09)	NEW indicator.
Length of stay	Efficiency Safety	Median length of stay for tracer procedures	Global rate	Retrospective	Phase 1 (fill July 09)	PATH pilot and PATH-II. Definition slightly revised (review some tracers, further specify inclusion and exclusion criteria)
Day surgery	Efficiency Patient centeredness	Percent of patients undergoing day surgery for selected tracer procedures	Rate for specific tracer conditions or procedure	Admin. database		score to summarize performance on several tracers
Educational level of nurses	Staff orientation Safety Patient centeredness	Percentage of staff with the highest level available in the country compared to the total number of nurses	Global Rate for specific departments	Retrospective Admin. database	Phase 1 (fill July. 09) Prerequisite: agree on definition, inclusion and exclusion criteria for "nurse" and compare nursing diplomas (at international and then national level)	NEW indicator

Staff smoking	Responsive governance Staff orientation	Percent of staff smoking Score on ENSH self audit questionnaire http://www.ensh.eu/	Global rate Global rate, adjusted for age and sex Rate per staff categories or department Score on ENSH audit questionnaire	Prospective Staff survey Self-audit	Phase 1. (till July 09)	PATH-pilot: no PATH-II: yes, from various sources of data (occupational medicine database or survey). Staff survey from ENSH provided as a reference but used by very few hospitals
Exclusive breastfeeding at discharge	Responsive governance Patient centeredness	Percentage of babies exclusively breastfed at discharge (monitored during one pre-specified month of observation) Refers to the definition of exclusive breastfeeding at discharge of the UNICEF/WHO Baby Friendly Initiative (BFHI)	Global rate Rate stratified for length of stay (1 day or less, 2 to 5 days, more than 5 days) and for gestation age or weight at birth (conform with BFHI tools and reporting)	Prospective Audit of record	Phase 1. (till July 09) or 2 (till Nov. 09) Data collection in June or October 2009, to be decided Prerequisite: Adopt reporting tool Inform and train staff for proper recording of any supplement given	PATH-pilot and PATH-II used for both retrospective and prospective data collection and variations on how supplements given were reported
Prophylactic antibiotic use	Clinical effectiveness Safety	Percent of patients undergoing tracer procedure which received antibioprohylaxis in full compliance with national or international guidelines in terms of timing, dosage, molecule	Global rate Rate by tracer procedure Rate by cause of non compliance (dose, timing, molecule, etc.)	Retrospective Audit of record	Phase 2 (till Nov. 09): <u>Prerequisite:</u> agree on guidelines to serve as national reference, disseminate it, and train for audit of records	PATH-pilot and PATH-II. Further refined to include national and international guidelines

Pressure ulcer prevalence	Clinical effectiveness Safety	One-day prevalence study , in population at risk (all patients to be assessed and only observed if at least one risk factor)	Risk-adjusted rate Rate for specific tracer conditions or procedure	Prospective Direct observation on one specific day or week	Phase 2 (fill Nov. 09) Prerequisite: Define protocol (at national and international level), and training of nurses	NEW indicator.
Staff experience and working environment	Staff orientation Safety Patient centeredness	Results on a staff survey . A questionnaire will be provided free of fee. Several questionnaires are now being assessed for their use in PATH and final choice of questionnaire and dimensions is still pending.	One score on each dimension. Could be then stratified per staff category or department.	Prospective Survey	Phase 2 (fill Nov. 09) Prerequisite: translate and validate translation of tool, inform staff, organize distribution of survey and encoding of results, etc.	NEW indicator.
Needle injuries	Staff orientation Safety	Prevalence of needle injuries over one pre-specified month of observation	Global rate, adjusted for staff mix Rate for departments, per staff categories	Prospective Staff survey or common reporting tool	Phase 2 (fill Nov. 09) Prerequisite: agree on tool (at international level) and inform staff (at local hospital level)	PATH-pilot and PATH-II, source: occupational medicine database. Retrospective vs. prospective for PATH'09 (to increase awareness and reliability)
Discharge preparation	Responsive governance	The indicator definition is not specified yet. Two alternatives are being considered: audit of patient records or patient surveys to assess the quality of discharge preparation	To be defined.	Prospective. Ad-hoc data collection	Phase 2 . (fill Nov. 09). No agreement reached yet on an international level as to the tool to be used for assessing discharge preparation.	PATH-pilot: no PATH-II: Results on Care Transition Measure (CTM3) patient survey – little discriminating
Patient experience and patient satisfaction	Patient centeredness	Results on a staff survey. A questionnaire will be provided free of fee. Several questionnaires are being assessed and final choice of tool is still pending.	To be defined	Prospective. Ad-hoc data collection	Phase 2 .	PATH-Pilot and PATH-II: included but no common tool provided and no comparison on results

Whom to contact if you wish to join PATH?

1. Your Country Coordinator
2. The PATH International Secretariat

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Ewa Wójtowicz

WHO Collaborating Centre for Developing

Quality and Safety in Health Systems

PATH International Secretariat

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Poland

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E-mail: who.krakow@cmj.org.pl

3. The WHO Regional Office for Europe

If you wish to discuss how to position PATH in your country and the next steps or to receive additional information, please do not hesitate to contact Ann-Lise Guisset at WHO.

Ann-Lise Guisset

World Health Organization

Regional Office for Europe

Country Policies and Systems (CPS)

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Denmark

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ANNOUNCEMENT OF WORKSHOP IN LJUBLJANA

Invitation to the PATH' 09 Kick off meeting in Ljubljana, Slovenia



To kick off PATH'09, Country Coordinators joined by one hospital representative are invited to attend the international coordination workshop which will take place in Ljubljana on the 12th and 13th of March 2009. The Ministry of Health of the Republic of Slovenia as well as the Institute of Public Health are kindly co-hosting the event by providing meeting rooms for the workshop and lunches during the breaks. The workshop in Ljubljana will take place at the Institute of Public Health in the beautiful historic center of Ljubljana – the Slovene capital.

This event is crucial for the successful implementation of PATH' 09 as country coordinators and hospital representatives will get together to learn from each other, discuss the channels to facilitate national and international networking and initiate collaborations to share tasks and build synergies.

Numerous technical issues will be tackled during the workshop. We will review PATH'09 indicators in order to assess their relevance in the respective settings,

develop common understanding on the terminology, highlight any shadow zone in indicator definition and data collection and further refine if relevant, and also to estimate the burden of data collection, and assess potential for international comparisons.

Hospital representatives are invited to act as “reality check”. The workshop with the attendance of hospital representatives will provide opportunities to initiate sub-networking, such as among university hospitals – as interest in such sub-networks has been repeatedly expressed.

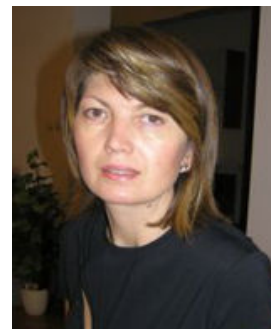
For the official invitation and practical issues related to this workshop, country coordinators will be directly contacted by the PATH International Secretariat at WHO CC Krakow.

The workshop is to be a major step for shaping PATH'09, so do not miss a full report on this event in the next PATH Newsletter.

WELCOME TO THE PATH COMMUNITY

As PATH'09 unfolds, new countries are joining in. We welcome the enthusiasts from Bosnia and Herzegovina, Croatia, Czech Republic, Lithuania, Slovenia and Turkey, and thank them for bringing their experience and expertise to the network. We very much look forward to working and learning together in 2009.

Croatia: PATH Country Coordinator: Jasna Mesarić, M.D. PhD, president of the Croatian Society for Quality Improvement in Health Care.



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Czech Republic: PATH Country Coordinators:

Pavel Bruna – economist, advisor, CFO, COO Na Homolce Hospital (1997 – 2008), Manager of the year in the field Healthcare (2002), The European Healthcare Leadership Program-INSEAD, University Utrecht – Health Care in Transition, Thunderbird – Arizona,-EI MBA in global management.



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Petr Cech, M.D. – neurosurgeon, advisor and co-creator of the Czech modification of case mix payment system currently used in the Czech Republic based on 3M IR-DRG 1.2., member of National Reference Center (relative weights authority) within for the last 8 years.

E-mail: Petr.Cech@consulth.cz

Petr and Pavel are owners and partners of Consult Hospital consulting company - focus on quality, efficiency, critical pathways, evidence-based medicine, DRG coding, etc.

Bosnia and Herzegovina:

Nominations of Coordinators are currently pending.

Greece: PATH Country Coordinator: Moumtzoglou Anastasius, Executive Board Member of the European Society for Quality in Health Care, President of the Hellenic Society for Quality & Safety in Health Care, holds B.A in Economics, MA in Health Services Management, MA in Macroeconomics, Ph.D. in Economics. He has taught the module of quality at graduate and postgraduate level and also written three books, which are the only ones in the Greek references. The first deals with “Marketing in Health Care”, the second with “Quality in Health Care” and the third with “Quality and Patient Safety in Health Care”. He is editing the book “E-Health Systems Quality and Reliability: Models and Standards”. He has served as the scientific coordinator in research programmes in Greece and participated as a researcher in European research programmes. He

has been declared “Person of Quality”, with respect to Greece, for 2004.



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Lithuania: PATH Country Coordinator Tomas Kuzmarskas



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Slovenia: New PATH country coordinator: dr Rade Pribakovic,



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Turkey: PATH Country Coordinator Dr. Mehmet DEMİR



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Dr. Mehmet Demir is a medical doctor. He has worked as a practitioner for a while. After that, he was assigned as Province Health Vice Manager and Hospital Chief Doctor and performed duties during various periods. He has also served on administrative boards of Professional Medical Doctors organizations, private health centers' prior establish-

ment periods and their management. He is Advisor to the Minister of Health particularly on performance management, quality improvement, patient safety and GHI (General Health Insurance) areas beside his duty as a hospital manager at a public hospital. He takes an active role in implementation of the Health Transformation Program in Turkey. His specialties are performance management in health, quality improvement in health services and patient safety. He has written many books related to these subjects and he has papers among various scientific journals on health policies in general. He is married. He has a son.

NEW COMERS TO PATH – INFORMATION NOTICE

MINISTRY OF HEALTH OF TURKEY

Performance Management and Quality Improvement Directorate

Performance Assessment Tools for Quality Improvement in Hospitals (PATH) Strategic Information Notice

The performance-based management and quality improvement system which has been under implementation in Turkey under the administration of the Ministry of Health involves more than one component and is a genuine model of our country.

The system, which has been defined by Ministry of Health, is now being implemented among more than 800 hospitals and 6000 primary health institutions through setting performance and quality targets which are affiliated to the Ministry of Health. These are being supported via incentive mechanisms by ensuring their appropriate functioning nationwide. Since 2004, the system has been implemented in all our health institutions to facilitate access of citizens to health services, to improve services, to promote quality, to provide efficient health delivery and to motivate health workers. The system has gained an integrated supervision of the quality model by engagement of institutional performance and quality improvement criteria in 2005.

Quality improvement implementation carried out in Turkey has a multi-dimensional approach, and institutional performance assessment is realized under the

topics of service access, efficiency, service quality standards and also satisfaction questionnaires for patients and staff. Significant progress has been achieved since the beginning of the implementation.

According to forthcoming plans, quality improvement studies would continue parallel to the development of global examples while also considering the requirements of the country.

Initially Turkey would participate in the studies with a group of 10 hospitals including public and research-training hospitals which are all affiliated to Ministry of Health. These hospitals are still working with full automation (software) and fully aware of the performance and quality studies though it would be possible to make comparisons with international examples. These hospitals continuously make information transactions to the Ministry about related data. Thus they have been ready for data flow for a long time. In addition, they are truly volunteers to participate in such an experience. We as the Ministry of Health also totally support them in participating in the project as well.

There is a team within Performance Management and Quality Improvement Directorate under Ministry of Health and this team would execute related duties under the coordination of Dr. Mehmet DEMİR who is the country coordinator.

PATH in Croatia

Unfortunately, Croatia did not participate in the previous two waves of the WHO PATH project. The starting point for PATH'09 in Croatia was an ini-

tiative of the Croatian Society for Quality Improvement in Health Care (Society). This was supported by the Ministry of Health and the WHO country office. The Society nominated Jasna Mesarić, M.D. PhD, president of the Society as the PATH country coordinator.

The society was founded at the Croatian Medical Association on May 27, 2003. Society activities include efforts for continuing professional and scientific education in the field of assurance and improvement of health care quality and patient safety; proposing to respective authorities appropriate measures for quality improvement; and developing collaboration with other partners involved in health care. During the 10-year period of developing the quality system in Croatia, the concepts of health care quality and quality improvement and patient safety have been acquired and continuously upgraded and adopted as a basis of modern medical practice. In October 2007, the Act on Health Care Quality was enacted by the Croatian Parliament, among others defining activities of the Quality and Accreditation Agency. In the time to come, the Society will take active part in the promotion and implementation of the national strategy for health care quality improvement.

In collaboration with the WHO country office a strategic note of PATH, roles and responsibilities was drafted. The invitation to potential hospital participants (to all hospitals) asking them to appoint a hospital coordinator was distributed. As a result 18 hospitals decided to participate. The hospital coordinators are mainly quality managers or persons in charge of quality.

Under the auspices of the MoH and in collaboration with Andrija Štampar School of Public Health, Croatian Medical Chamber, the WHO Country Office in Croatia, the WHO Collaborating Centre for Development of Quality and Safety in Health Systems in Krakow – Poland and ESQH, the Croatian Society will organize a one-day National conference on the PATH project to be held in Zagreb, February 13, 2009. Before the Conference on February 12, we plan to hold a stakeholders meeting including representatives of the MoH, medical association, chambers, school of public health, health insurance fund and academic institutions.

We perceive PATH as the first national campaign in Croatia to collect data on hospital performance for voluntary improvement per se. We believe and hope the PATH project is a useful tool to improve the quality in our health services and to share experience with other European countries.

Jasna Mesarić, Country Coordinator, Croatia

NEWS FROM INDICATORS FIELD



The ESQH Aarhus Office for Quality Indicators opened in the summer of 2005; it is supported by the Central Denmark Region and the Danish National Indicator Project, and staffed by:

- Head of Office; Medical Director MD Paul Bartels
- Project Management; MHSc Solvejg Kristensen
- Professor MD. PhD. Jan Mainz

The Office participates in indicator-related projects in the European setting (SimPatIE, EUNet-PaS) and disseminates knowledge by arranging European seminars in the field of quality monitoring. The ESQH Office for Quality Indicators is located in the Danish National Indicator Project organisation, www.nip.dk

For more information please check on www.esqh.net

THE PATH INTERNET PLATFORM

www.pathqualityproject.eu

The website is currently under reconstruction, to be launched in March 2009 within the same domain.

Links:

- Agency for Health Care Research and Quality (AHRQ), Quality Indicators: <http://www.qualityindicators.ahrq.gov/>
- Agency for Health Care Research and Quality (AHRQ), National Quality Measures Clearing House: <http://www.qualitymeasures.ahrq.gov/>
- European Society for Quality in Healthcare: www.esqh.net
- ESQH Office for Quality Indicators in Aarhus, Denmark: www.esqh-office-aarhus.dk
- Methods of Assessing Response to Quality Improvement (MARQuIS): www.marquis.be
- Organization for Economic Development and Cooperation (OECD), Health Care Quality Indicator Project: <http://www.oecd.org/health/hcqi>
- Public Health Portal of the European Union (EU), Health Care (including safety and patient mobility): http://ec.europa.eu/health-eu/care_for_me/index_en.htm
- Safety Improvement for Patients in Europe (SIMPATIE), <http://www.simpatie.org/Main>
- The Joint Commission, Performance Measurement: <http://www.jointcommission.org/PerformanceMeasurement/>
- WHO Regional Office for Europe, European Hospital Morbidity Database (based on discharge abstracts): http://www.euro.who.int/InformationSources/Data/20061120_1
- European Union Network for Patient Safety (EUNeTPaS): <http://www.eunetpas.eu>
- WHO World Alliance for Patient Safety: <http://www.who.int/patientsafety/en/>
- WHO Baby-friendly hospital initiative: <http://www.who.int/nutrition/topics/bfhi/en/index.html>
- The European Network of Smoke Free Hospitals <http://ensh.free.fr>
- The Safe Injection Global Network (SIGN) Alliance http://www.who.int/injection_safety/sign/en/
- The Tallinn Charter: Health Systems for Health and Wealth: http://www.euro.who.int/document/HSM/6_hsc08_edoc06.pdf

Dates:

- 12-13 March 2009, Ljubljana, PATH coordination meeting
- 17-19 March 2009, Berlin - International Forum on Quality and Safety in Health Care: <http://internationalforum.bmj.com>
- 13-14 May, Brussels, World Health Care Congress: <http://www.esqh.net/members/noel/nieuws/news>