rkkp

regionernes kliniske kvalitetsudviklingsprogram

Klinisk kvalitetsudvikling og *Det Gode Indikatorsæt*

Henrik Møller, dr.med.

Epidemiolog (faglig leder), RKKP og

Professor, Aalborg Universitet

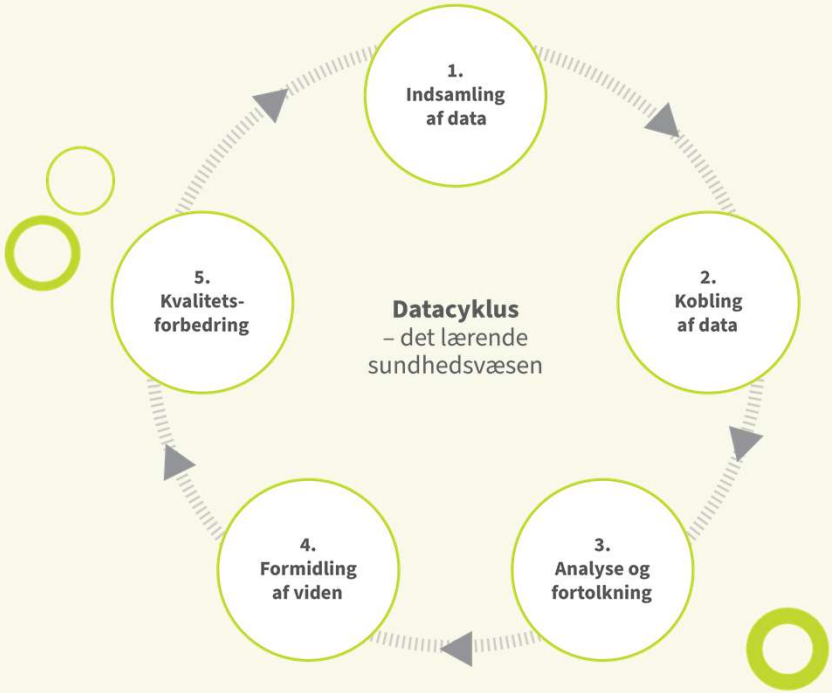
Plan for denne session

- Udsendt materiale til inspiration:
  RKKPs principper om kvalitetsudvikling og indikatorer.
  Eksempler på korte artikler om RKKPs metodevalg.

- I dag: Oplæg om indikatorer og indikatorsæt
- Diskussion

- Videre arbejde med praktisk vejledning om indikatorer

Klinisk kvalitetsdatabase



Det lærende sundhedsvæsen

- En database, som opgør målbare **indikatorer**, der kan belyse kvaliteten af sundhedsvæsenets indsats og resultater.

Indikatorer

PROSTATAKRÆFT: OVERSIGT OVER INDIKATORER

Indikatorområde	Indikator	Indikatortype	Standard
Indlæggelseshyppighed	Indikator 1: Andel af udførte transrektal ultralydsscanning (TRUS) med prostatabiopsi, der har medført indlæggelse indenfor 7 dage efter proceduren	Proces	≤5%
Positiv kirurgisk margin (pT2)	Indikator 2: Andel af radikalt prostatektomerede (pT2) patienter med positiv kirurgisk margen	Resultat	≤15%
Positiv kirurgisk margin (pT3)	Indikator 3: Andel af radikalt prostatektomerede (pT3) patienter med positiv kirurgisk margen	Resultat	≤30%
Morbiditet 30 dage	Indikator 4: Andel af patienter genindlagt indenfor 30 dage efter radikal prostatektomi	Resultat	≤10%
Postoperativ morbiditet	Indikator 5: Andel af radikalt prostatektomerede patienter, der har været indlagt mere end 3 dage postoperativt	Resultat	≤5%
Datakomplethed	Indikator 6: Andel diagnosticerede patienter med PSA, kardinalsymptomer og cTNM-oplysninger angivet i DaProCadata diagnoseskemaet	Resultat	≥90%
Lav risiko/kurativ behandling	Indikator 7: Andel af patienter i D'Amico-lav risiko, der behandles kirurgisk eller med stråleterapi indenfor 3 mdr.	Proces	
Høj risiko/ kurativ behandling	Indikator 8: Andel af patienter i D'Amico-høj risiko, der behandles kirurgisk, med stråleterapi eller endokrin behandling indenfor 6 mdr.	Proces	

Prioriteringer og valg

Indikatoranalyse i årsrapporten:

- Tabel
- Forest, funnel og tidsserie plots
- Struktureret kommentar

Andre analyser og andre anvendelser af databasens information:

- Supplerende analyser
- Udviklingsarbejde
- Særkapitler
- Tema rapporter
- Tidsskriftartikler

Indikatorer

- Hvad er en god indikator?
- Hvad er et godt indikatorsæt?

12 forslag til diskussion

- Hvad er en god indikator?
- Hvad er et godt indikatorsæt?
- Standarder og mål
- Målopfyldelse

Hvad er en god indikator?

- Måling af en kvalitetskritisk egenskab i patientforløbet
- Målet har relevans, validitet og præcision
- Viser et forbedringspotentiale
- Muliggør en handling. *Actionability.*
- Undgå indikatoranalyse af sjældne udfald

Hvad er en god indikator?

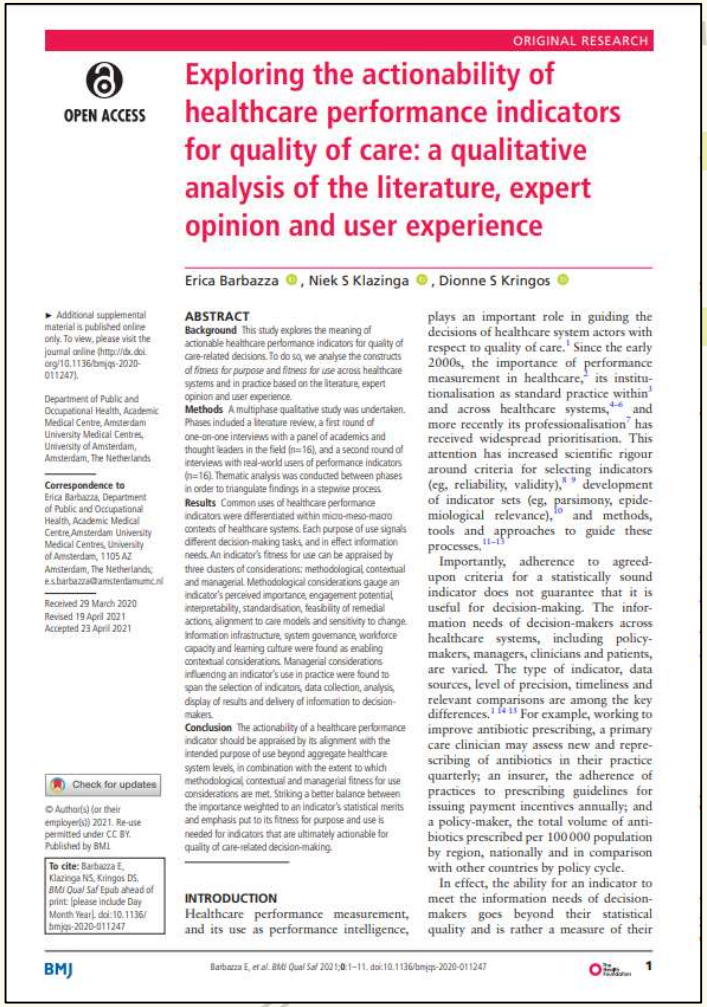
- Måling af en kvalitetskritisk egenskab i patientforløbet
- Databasen bør muliggøre indikatorer i hele patientforløbet, på tværs af sektorer og fagområder

Hvad er en god indikator?

- Viser et forbedringspotentiale
- Muliggør en handling. *Actionability*.
- Undgå indikatorer som udtrykker uniform god kvalitet
- Indikatoranalysen måler fremskridt henimod bedre kvalitet på udvalgte, kritiske områder
- Indikatoranalysen skal ikke følge alt som kan gå galt

Actionability

Emphasis on the indicator's fitness for purpose and for quality of care-related decision-making.



ORIGINAL RESEARCH

OPEN ACCESS

Exploring the actionability of healthcare performance indicators for quality of care: a qualitative analysis of the literature, expert opinion and user experience

Erica Barbazza, Niek S Klazinga, Dionne S Kringos

► Additional supplemental material is published online only. To view, please visit the journal online (http://dx.doi.org/10.1136/bmjqs-2020-011247).

Department of Public and Occupational Health, Academic Medical Centre, Amsterdam University Medical Centres, University of Amsterdam, Amsterdam, The Netherlands

Correspondence to
Erica Barbazza, Department of Public and Occupational Health, Academic Medical Centre, Amsterdam University Medical Centres, University of Amsterdam, 1105 AZ Amsterdam, The Netherlands; e.s.barbazza@amsterdamumc.nl

Received 29 March 2020
Revised 19 April 2021
Accepted 23 April 2021

To cite: Barbazza E, Klazinga NS, Kringos DS. *BMJ Qual Saf* Epub ahead of print: [please include Day Month Year]. doi:10.1136/bmjqs-2020-011247

ABSTRACT

Background This study explores the meaning of actionable healthcare performance indicators for quality of care-related decisions. To do so, we analyse the constructs of *fitness for purpose* and *fitness for use* across healthcare systems and in practice based on the literature, expert opinion and user experience.

Methods A multiphase qualitative study was undertaken. Phases included a literature review, a first round of one-on-one interviews with a panel of academics and thought leaders in the field (n=16), and a second round of interviews with real-world users of performance indicators (n=16). Thematic analysis was conducted between phases in order to triangulate findings in a stepwise process.

Results Common uses of healthcare performance indicators were differentiated within micro-meso-macro contexts of healthcare systems. Each purpose of use signals different decision-making tasks, and in effect information needs. An indicator's fitness for use can be appraised by three clusters of considerations: methodological, contextual and managerial. Methodological considerations gauge an indicator's perceived importance, engagement potential, interpretability, standardisation, feasibility of remedial actions, alignment to care models and sensitivity to change. Information infrastructure, system governance, workforce capacity and learning culture were found as enabling contextual considerations. Managerial considerations influencing an indicator's use in practice were found to span the selection of indicators, data collection, analysis, display of results and delivery of information to decision-makers.

Conclusion The actionability of a healthcare performance indicator should be appraised by its alignment with the intended purpose of use beyond aggregate healthcare system levels, in combination with the extent to which methodological, contextual and managerial fitness for use considerations are met. Striking a better balance between the importance weighted to an indicator's statistical merits and emphasis put to its fitness for purpose and use is needed for indicators that are ultimately actionable for quality of care-related decision-making.

INTRODUCTION

Healthcare performance measurement, and its use as performance intelligence, plays an important role in guiding the decisions of healthcare system actors with respect to quality of care.[1] Since the early 2000s, the importance of performance measurement in healthcare,[2] its institutionalisation as standard practice within[3] and across healthcare systems,[4–6] and more recently its professionalisation[7] has received widespread prioritisation. This attention has increased scientific rigour around criteria for selecting indicators (eg, reliability, validity),[8 9] development of indicator sets (eg, parsimony, epidemiological relevance),[10] and methods, tools and approaches to guide these processes.[11–13]

Importantly, adherence to agreed-upon criteria for a statistically sound indicator does not guarantee that it is useful for decision-making. The information needs of decision-makers across healthcare systems, including policymakers, managers, clinicians and patients, are varied. The type of indicator, data sources, level of precision, timeliness and relevant comparisons are among the key differences.[1 14 15] For example, working to improve antibiotic prescribing, a primary care clinician may assess new and repeat scribing of antibiotics in their practice quarterly; an insurer, the adherence of practices to prescribing guidelines for issuing payment incentives annually; and a policy-maker, the total volume of antibiotics prescribed per 100 000 population by region, nationally and in comparison with other countries by policy cycle.

In effect, the ability for an indicator to meet the information needs of decision-makers goes beyond their statistical quality and is rather a measure of their

Hvad er en god indikator?

- Undgå indikatoranalyse af sjældne udfald
- Sjældne udfald bør være genstand for *utilsigtet hændelse audit*

Struktur – Proces – Resultat

Evaluating the Quality of Medical Care

AVEDIS DONABEDIAN

THIS PAPER IS AN ATTEMPT TO DESCRIBE AND evaluate current methods for assessing the quality of medical care and to suggest some directions for further study. It is concerned with methods rather than findings, and with an evaluation of methodology in general, rather than a detailed critique of methods in specific studies.

This is not an exhaustive review of the pertinent literature. Certain key studies, of course, have been included. Other papers have been selected only as illustrative examples. Those omitted are not, for that reason, less worthy of note.

This paper deals almost exclusively with the evaluation of the medical care process at the level of physician-patient interaction. It excludes, therefore, processes primarily related to the effective delivery of medical care at the community level. Moreover, this paper is not concerned with the administrative aspects of quality control. Many of the studies reviewed here have arisen out of the urgent need to evaluate and control the quality of care in organized programs of medical care. Nevertheless, these studies will be discussed only in terms of their contribution to methods of assessment and not in terms of their broader social goals. The author has remained, by and large, in the familiar territory of care provided by physicians and has avoided incursions into other types of

The Milbank Quarterly, Vol. 83, No. 4, 2005 (pp. 691–729)

Reprinted from The Milbank Memorial Fund Quarterly, Vol. 44, No. 3, Pt. 2, 1966 (pp. 166–203). Style and usage are unchanged.

691

Resultatindikatorer

Det som sker eller ikke sker

Procesindikatorer

Det som gøres eller ikke gøres

Resultatindikatorer

Det som sker eller ikke sker

Høj relevans for patienten

Procesindikatorer

Det som gøres eller ikke gøres

Høj *actionability*

Resultatindikatorer

Det som sker eller ikke sker

Høj relevans for patienten

Følsomhed for case-mix

Lang opfølgningstid: lav relevans for aktuel praksis

Procesindikatorer

Det som gøres eller ikke gøres

Høj *actionability*

Resultatindikatorer

Det som sker eller ikke sker

Høj relevans for patienten

Følsomhed for case-mix

Lang opfølgningstid: lav relevans for aktuel praksis

Procesindikatorer

Det som gøres eller ikke gøres

Høj *actionability*

Strukturindikatorer

Måles på enhedsniveau, ikke patientniveau. Bruges sjældent.

Resultatindikatorer

Det som sker eller ikke sker

Høj relevans for patienten

Følsomhed for case-mix

Lang opfølgningstid: lav relevans for aktuel praksis

Procesindikatorer

Det som gøres eller ikke gøres

Høj *actionability*

Strukturindikatorer

Måles på enhedsniveau, ikke patientniveau. Bruges sjældent.

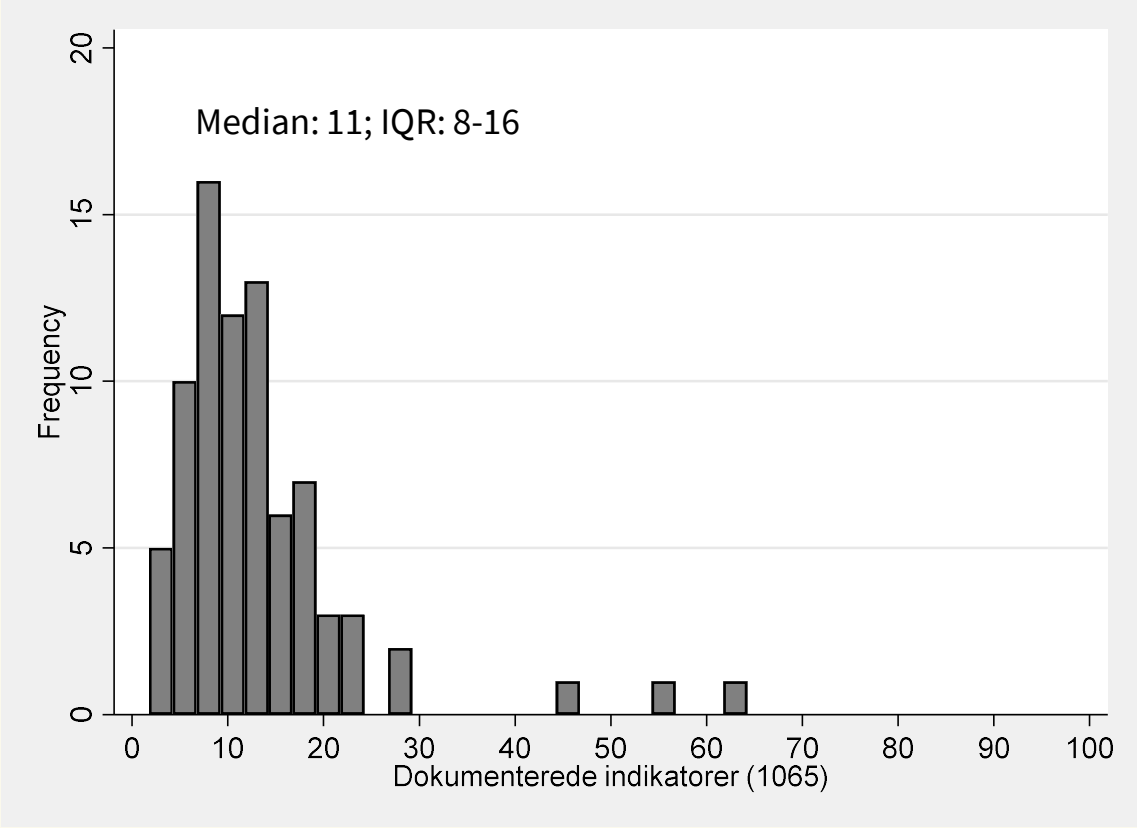
Datakvalitetsindikatorer

Bør undgås.

Indikatorsæt

- Hvad er et godt indikatorsæt?
- Består af gode indikatorer
- Antal indikatorer som kan analyseres og kommenteres grundigt på styregruppens årlige møde om årsrapporten
- Typisk 5-15 indikatorer
- Bør kunne dække begivenheder i hele patientforløbet
- Opdateres løbende

Hvor mange indikatorer?



Indikatorsæt

- Undgå stratifikationer og multiple tidsvinduer
- Undgå multiple patientstrata og alternative tidsvinduer i indikatoranalysen. Supplerende opgørelser kan vises og medtages i kommenteringen af indikatoranalysen.

Standard

- En kvalitetsstandard
- En målsætning; en ønsket udviklingsretning; en ambition
- Et mindstemål: manglende målopfyldelse er alvorlig og handlingskrævende
- De fleste standarder er målsætninger, og det er ønskværdigt
- Fokus på positive eksempler og udviklinger
- Mindre fokus på negative, sanktionskrævende situationer

Målopfyldelse

- Opfyldelse af en standard er en indikation af kvalitet.
- Opfyldelse af en standard er ikke i sig selv en kvalitet.
- Hold fokus på kvaliteten af de kliniske processer. Når kvaliteten forbedres stiger kvalitetsmålet af sig selv.
- Fokus på kvalitetsmålet medfører risiko for perverse incitamenter.

12 forslag til diskussion

- Kvalitetskritiske egenskaber; patientforløb; forbedringspotentiale; *actionability*; fremskridt; sjældne begivenheder; proces og resultat; 5-15 indikatorer; opdatering; stratifikationer og tidsvinduer; målsætning; positiv ikke punitiv.
- Hvis disse forslag vinder gehør får vi:

- Bedre indikatorer og færre indikatorer
- Plads til nye indikatorer hvor dette efterspørges
- Bedre mulighed for tematisk arbejde

henrik.moller@rkkp.dk