**First PATH'09 coordination workshop**
**12-13 March 2009**

**Participants**: See appendix 1

**Opening:**

The Ljubljana consensus workshop is the first event organized in the frame of PATH'09. It is the opportunity for the PATH coordinators in the countries as well as some hospital representatives to meet, get to know each other, learn from each other, and identify ways to build close collaborations but also to learn about PATH, its underlying values and how can PATH contributes to build an enabling environment for quality improvement and performance management in hospitals. Both objectives build on the renewed focus on PATH'09 for the local ownership and international networking as well as on using PATH also as a policy tool, to develop a forum for national stakeholders to learn about and discuss quality improvement strategies.

For PATH'09, a number of hospitals/coordinators have already committed to participate in Turkey, Croatia, Bosnia and Herzegovina, Slovenia, Hungary, Czech Republic, Slovakia, Poland, Lithuania, Estonia. France and Germany will very likely participate to PATH'09 too. Participation of Israeli hospitals is also very likely.

It was observed that many hospitals are originating from South Eastern Europe. This might be explained by the relative degree of maturity of performance measurement systems and quality improvement initiatives in those countries. Awareness to assess performance is good but there is no or very few initiatives to do so. Hence, PATH is providing a "ready tool" to embark in the process. While, in Nordic countries, there is a strong culture of measurement and assessment and PATH does not bring much in addition, especially if data analysis and reporting is at the national level. International networking of university hospitals might raise interest to participate in PATH in the countries which already have assessment systems in place.

**Presentation and discussion: PATH – Towards capacity building for performance assessment in the frame of the Tallinn Charter.**

PATH is presented in the background of accountability and transparency, a culture of measurement and of continuous quality improvement. PATH is a tool for hospitals to measure and improve their performance. It is also a forum to bring national (regional) stakeholders together to discuss how to build an enabling environment for performance assessment and continuous quality improvement, through PATH and/or other national or international initiatives. Local ownership was highlighted as a crucial success factor. The balance between using the standardized tool and tailoring the tools to embed it in local context is challenging.

This led to a discussion in small groups on the use of indicator / indicator systems in participating hospitals / countries (what is the current situation, how you view the

situation in 5 years, what are the challenges and opportunities to get there, how can PATH contribute, at what conditions, what are the stakeholders that might benefit from PATH, how to bring them together, etc.). This discussions highlighted great variations among countries; with PATH either as a "self standing" initiative, either as closely related to a national quality strategy and with direct involvement of a number of stakeholders within a "steering committee". Participation fees might be asked by the country coordinator to the hospitals to cover administrative cost or cover data analysis cost. This is to be decided locally.

**Data analysis and reporting:**

PATH is a "franchised concept" with most actions better done at a local level (region or country). Data analysis is the responsibility of the "country coordinator". This entity might outsource it to another country coordinator (e.g. Germany coordinator BQS would be available and have the capacity for this) or to another entity (e.g. university) within the country. Even if data collection and analysis and reporting is a national responsibility, the participants requested to have some international comparisons performed. Hence, a repository for international data will be created in which all countries can upload their anonymous data and download international anonymous data to perform comparisons. Those comparisons might not be meaningful for all indicators as some are too "contextual" or need to have local adaptation.

It is critical to develop user-friendly reports. This is also challenging. It is however not advisable to propose a common structure of reports centrally, from the international level for several reasons. The number of participating hospitals and numbers of indicators vary widely. Some national indicators might be incorporated into the PATH indicator set. Some countries will have more focus on international comparisons than others. Some countries have other reports and the hospitals are used to some form of graphical representations. Also, PATH is to be used as a tool for capacity building. Hence, it is preferable to support country coordinators to develop the structure of the report, to learn about how to present results in a user-friendly way.

Next workshop will take place in September in Krakow. Country coordinators are invited to attend the workshop with their database on clinical indicators. They will first learn the concepts and tools for developing dashboards and then will have the opportunities for hands-on session during which they will develop the reports for their country for one or two indicators.

In addition, it is critical that descriptive sheet do not only include definition of indicators but also procedures for data analysis: level of aggregation of results, reporting on age categories, departments, by sub-category of indicator, etc.

**Review of the indicators**

| Name | Comments, recommendations |
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| C-section | Use the **Core indicator for PATH-II** but have exclusion criteria specified with ICD-codes – Compute indicators retrospectively on 3 years (2006, 2007, 2008) to follow the trends – provide instructions on data analysis (e.g. stratify by age? which categories?). If exclusion criteria cannot be identified, it should be made very specific when reported to the national coordinator and uploading the data in international database. This issue need to be discussed specifically within country between participating hospitals and country coordinators to identify the quality of coding of exclusion criteria and to have a common approach in the country. |
| Antibioprophylaxis | **Good indicator of team work**: anaesthesiologist gives the antibiotic and surgeon cuts.<br>Define a **common algorithm** for all countries and tracers (except maybe for hip replacement for which there can be a discussion on stop antibioprophylaxis within 24 or 48h):<br>1) appropriate antibiotic type (to be defined nationally)<br>2) appropriate dose (to be defined nationally)<br>3) within one hour of incision<br>4) discontinued within 24 hours<br>5) if no exclusion criteria (e.g. sign of infection…)<br>Criteria 3-5 are built on international evidence (see CDC and EDC). Criteria 1 and 2 are built on national guidelines (if available)<br>Data analysis: Specify how to assess data quality (inter-rater reliability on a sample?). Define algorithm to compute indicator (when to exclude a patient, etc.) Specify sub-indicators to understand the sources of non compliance and hence be better prepared to propose corrective actions, e.g. sources of non compliance (% not compliant with criteria 1, 2, 3, 4, 5) criteria not fulfilled) or appropriate / over-use /under-used / other inappropriate use.<br>Data collection: Provide a **grid to be included in the patient record** (common for all hospitals in all countries – just specify the type and dosage nationally). **Prospective data collection** (for 2 months? Stopped when minimum number of records achieved?): might bias positively the results (do better because know that being observed) but not an issue if the objective is to improve practices. |

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| Length of stay | AMI: many issues with this tracer (e.g. transfer for stent). Might need to select other tracers.<br>In general, though rationale for exclusion of transferred patients (in and out) is well understood, it might create major bias when part of the process to limit LOS is to have transfers or if the technology is not available.<br>→ Focus on comparison of hospital over time: replace indicator of "absolute" LOS with indicator of trend in LOS or a combined indicator of both or combine with number of days between admission and elective surgery. In such case, all patients would be included and we have a global average LOS (% or number of days of decrease between last 2 years and between last 5 years)<br>How to take into account when rehabilitation beds?: only consider stay in acute beds<br>If compute LOS for tracer procedures and condition. A possible option for selecting tracers would be to look at 1) the tracers that contribute more to the LOS and 2) look at the procedures that have recently improved (e.g. hernia, gallstone,…). The tracer selection would be done at the international level. |
| Post-operative embolism | Question on denominator. All surgical procedures (really necessary to have prophylaxis for all patients or pressure from pharmaceutical industry? What is the evidence?)<br>Issue with coding and identification (post-mortem while data alreasy sent to central administrative database?).<br>**Proposed alternative PSI: wound infections** |
| Number of blood components per type of surgery | Suggested by one participant and interest by all other participants → to be further developed and proposed to advisory committee<br><u>Rationale</u>: Indicator of the quality of surgery (more blood → more risk) and efficiency (cost and availability). Evidence and gold standards available. Surgery without blood proved to be better.<br>Easy data collection (though might need to go back to the patient records)<br><u>Alternative indicators</u> (for specific tracers):<br>- % of surgeries without blood<br>- % of patients with more than 10 units |
| % of AMI patients with aspirin at discharge | Proposed as an additional indicator to have internal medicine indicator (and complement the outcome indicator on lethality rate for AMI) |
| Smoke free hospital | Self-audit of the European Network for Smoke Free Hospitals (see webpage) preferred over staff survey (difficulties to collect during PATH-II, considered to have little impact: hospital influence on smoking is |

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| | moderated by many factors outside the scope of hospital management) |
| Exclusive breastfeeding | Definition: Need to clarify the definition on "exclusive" (in line with Baby-friendly initiative definition)<br>**Prospective data collection** (2 months? Minimum number of observations?). Provide grid to be included in the patient records<br>Data analysis: Clarify criteria for exclusion. Provide analysis (e.g. stratify between LOS= 24 hours or less and LOS>24 hours, breastfeeding initiated or not, etc).<br>Next steps for quality improvement: Link with the 10 steps to baby friendly hospitals (UNICEF/WHO)<br>Rationale: In the descriptive sheet, insist on impact by hospital on decision to breastfeed (though might be moderated by cultural factor and contacts between future mothers and hospitals before delivery might be more limited in some countries)→ international comparisons might not make much sense. |
| Occupancy rate of the operating theatre | This indicator was used in PATH-pilot. Because of many issues to agree on a common definition (what is a operating theatre, when is it occupied, etc.) and to balance usefulness of the indicator with burden of data collection (need ad-hoc system for most hospitals as it is not currently monitored, this indicator has been replace in PATH-II by a generic question "Do you measure occupancy rate of the theatre and how". Though, it was considered as extremely useful with PATH hospitals that measured it (see Estonia and Belgian experience) and a consensus emerged during the meeting to work further on this indicator to propose a common definition. Very important issue with potential impact of measurement. Several potential approaches were proposed..<br>- measure occupancy of OT as a whole<br>- focus where some possible "bottlenecks" in the process and focus on those, for instance<br>  - time between entry into OT and incision<br>  - time difference between expected time for first surgery and real time for first surgery of the day |
| Financial indicator | It is suggested to include (at least nationally defined) one or two indicators on the financial health of the institution. It is an indicator of the performance of the management but it also brings an additional light on clinical effectiveness and staff orientation indicators (as in a context of extremely limited financial resources and debts, it is more difficult to invest and be proactive and innovative, motivation of staff might suffer, etc…). It is an important part of the performance of the hospital and one that hospitals are accountable for and regularly report on. International comparisons have very limited value. |

Staff survey and patient survey:

1. Country coordinators are asked to send to the International Secretariat information on the surveys used in their country (tools, references, estimated cost). Those will be shared across the countries.

2. Countries interested in having common survey will appoint a member to a "PATH survey taskforce". This taskforce will review the different tools and agree on a common standard. For staff survey, might include a visit to the university in Germany to discuss the details or the tool sued in the CC Krakow.

   CC Krakow also presented a web-based tool for analysis of staff and patient (PASAT) surveys. The use of the tool has a fee but the questionnaire could be made available free of charge to all PATH participants.

Some countries already have a common national tool and will continue to use it (Estonia, France, Slovenia, Croatia, Israel, Poland).

For all administrative database indicators:

- compute on 3 years, to build a baseline even if did not participate in PATH pilot and PATH-II and highlight that the first step is to compare to oneself before comparing to others in the country and comparing to others internationally

For all indicators:

- Provide a standard format on how to evaluate and analyse the data. Specify how to compute the indicator (e.g. case-mix adjustment? Aggregation? Stratification?), at what level alternative or sub-indicators can also be computed (e.g. by department, over or under use, etc.) and data quality check
- Specify minimum number of cases
- Suggest generic report (minimum)

**Participation of psychiatric and rehabilitation hospitals**

A major interest for rehabilitation and psychiatric indicators has been raised previous and during the meeting. There is a clear request from participating hospitals, several of which are specialized, to develop specific indicators for those fields. Hence, the participants agreed to have a taskforce set up for each of those. Country coordinators will assess the interest from their hospitals and identify one or two members for the taskforce (opinion leader or more experience with using indicator in their facility or more motivation for being actively involved) and forward the name, affiliation and contact details to the international secretariat. Further contacts will be facilitated over the next months. The objective is to have a few (2-3?) indicators proposed in September-November(?).The taskforce will share the indicators currently used by participating hospitals or reviewed in the literature and will map how to adapt some of the acute-care indicators into the rehabilitation or psychiatry setting. A specific meeting (workshop) of the taskforce could be considered. WHO and the International Secretariat's role is to facilitate the process

and not to lead it. In the meanwhile, a number of indicators (e.g. staff orientation) are applicable also to non-acute hospitals and those can already join PATH on this limited basis.

**Next workshop:** It will take place in September in Krakow and be organized in two parts.

- Part 1: invite one or a few international experts to share on e.g. indicator system in their country or hospital governance and the use of dashboards
- Part 2: development of a report format. Use a generic report format as a basis. Have countries attend with preliminary data available. Work together to have a final report format available for at least one or two clinical indicators (wave 1). Might require to have a computer room available.

It is suggested to hold workshop on a Biannual basis. Those workshops are open to all country coordinators and PATH participating hospitals.

**Communication and networking:**

Participants brainstormed on how to facilitate international communication between country coordinators and directly between hospitals. Bilateral contacts and multilateral contacts are a key to move from comparisons on indicator results to real benchmarking to understand the reasons for variations and learn from best practices.

- PATH dictionary (Wikipedia style) – interactive with link to descriptive sheets
- Section "literature review" on the website with available literature for the specific indicators or for quality and performance management
- Section "tools" on the website (e.g. staff and patient surveys, quality tools in the participating countries))
- Organize bi-annual PATH workshops

It is decided to adopt a "conservative approach" for the next few months with most the website and the international secretariat as key tools for communication. Other "smart" tools using new technologies (e.g. skype seminars, listserver, forum on facebook) are to be considered in the future. The international secretariat is available to act as an "information broker" (e.g. answer questions such as "I'd like to contact the best hospital in this country on this indicator…").

**PATH terminology:**

The terminology of "country coordinators" might bring confusion. Country coordinators are not officially representing a country. They are representing a number of hospitals that participate to PATH. They can be positioned at a regional level. Their can be several coordinators in a country for different regions or different hospital groups. No alternative name was considered proper by all participants (local coordinator –might represent the hospital level, regional coordinator – might represent the European Region).

**Hospital registration form:**

The registration form is reviewed to incorporate basic information for to support sub-networking among "similar" hospitals. The following information will be requested from hospitals when entering to PATH and will be made available on the website (restricted section to PATH participants, except if explicit agreement from hospital to have it in public section).

Ownership:
- Public:
- Private not for profit
- Private for profit

Description:
- University hospital
- General hospital offering residency training
- General non teaching hospital
- Specialist hospital
    - Rehabilitation
    - Psychiatry
    - Others

Number of beds:
Departments:
Link to website (on a voluntary basis)

**Next steps:**

From PATH international: To be provided in 2 weeks (so that countries/hospitals can estimate the burden of data collection and make a choice on participation and what indicators to select):
- definitions
- sources of data
- timing for data collection

To be provided in a month: descriptive sheets for "purple" indicators
Under development: yellow (to be considered in the future, have a taskforce)

For countries:
- Send to the international secretariat, their tools for patient and staff surveys, experience with pressure ulcer prevalence study or with occupancy rate theatre use
- Discuss during next national workshop on concrete examples how indicators work, to whom are indicators reported within hospitals, how it contributes to quality improvement and internal accountability. The objective is 1) to position PATH as a tool for building a culture of measurement, internal accountability, and

continuous quality improvement and 2) to gather concrete examples for the next PATH newsletter.

- Discuss during next national workshop or on an informal basis if there is an interest to participate to a taskforce for rehabilitation and psychiatric hospitals. Inform the international secretariat.
- Discuss and agree during national workshop (End April, early May) on what indicators to measure