PERFORMANCE ASSESSMENT & QUALITY IMPROVEMENT

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EDITORIAL

BACKGROUND AND FURTHER DEVELOPMENT OF AN INTERNATIONAL PERFORMANCE INDICATOR PROJECT

I am pleased to present this first issue of *"Performance assessment and quality improvement"* –a three-montly newsletter of the Performance Assessment Tool for Quality Improvement (PATH) project. PATH is an internal tool for quality improvement in hospitals, developed by the WHO Regional Office for Europe to support hospitals in collecting data on their performance, identifying how hospitals are doing in comparison to their peer group and initiating quality improvement activities.

The aim of the PATH newsletter is to provide information on activities of the PATH project as well as future plans, and to provide a platform for hospitals to share information on results. The *Performance assessment and quality improvement* newsletter is thus a complementary tool to the newly established Internet platform and to WHO and other scientific publications.

Since the initiation of PATH several important steps have been accomplished: a) identification of the key dimensions of hospital performance assessment and definition of the general architecture of the model, b) review of the literature on performance indicators and building a framework to support the selection of indicators, c) a survey with hospital managers in different European countries on the importance, usefulness and availability of potential indicators, and d) selection of a set of indicators for pilot implementation of the PATH model. The PATH conceptual model piloted between February 2004 and August 2005, in 51 hospitals covering 6 countries (Belgium, Ontario Region in Canada, Denmark, France, Slovak republic and Natal Region in South Africa), provided data for the comparative analysis of performance.

The results of a systematic evaluation with country and hospital coordinators participating in the PATH pilot showed the usefulness of the tool especially the learning experience and the use of indicators for quality improvement (see more in-depth contribution in this newsletter), and the multidimensional framework of PATH was considered useful in integrating various quality activities in the hospitals.

The data collection efforts for PATH depend on level of sophistication of the hospital information system and range from low to high. The evaluation also revealed that the validity of some of the indicators needs to be improved and that feedback to users needs to be timelier.

In future, a more standardized format will be used for data reporting (internet platform) and the next wave of data collection will be supported by two newly established WHO Collaborating Centres in Ancona, Italy and Cracovia (Krakow), Poland. In addition, work is in process on revising and harmonizing the indicators with those of other agencies. Pending tasks also include the overall validation of the PATH model before an operational business plan can be developed.

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So far PATH has been a strictly internal tool: not for public disclosure, not for pay-for-performance and not for regulation – the collaboration has been via country coordinators with individual hospitals. PATH will retain this fundamental orientation as an internal tool; however, hospitals will in the future be able to use the data collected to structure their quality

reports and to identify how they compare to an (anonymous) peer group.

Country coordinators, too, should be able to use the data to describe the extent of variation in their systems, without identifying individual providers in order to use the information generated to raise awareness on quality and variations in provider performance at the regulatory level.

I would like to take this opportunity to thank all those who contributed and shared their experience in this edition of *Performance assessment and quality improvement*. I hope – with the support of all involved in PATH - that this newsletter will become a widely used tool for everyone involved in the project to report on success stories, quality improvement activities based on the performance assessment, as well as suggestions on how to improve the networking in this exciting endeavor.

Oliver Groene, Technical Officer Quality of Health Systems and Services, WHO Regional Office for Europe.

IN THIS ISSUE:

INTERNATIONAL PATH CONFERENCE

The WHO Regional Office for Europe, Barcelona Office, in collaboration with the Federal Public Service, Health, Food Chain Safety and Environment of Belgium, organized the First International Conference on the Performance Assessment Tool for Quality Improvement in Hospitals (PATH), which took place on 26 June 2006 in Brussels (Belgium).

The purpose of the meeting was to present and discuss the architecture of the PATH model, the lessons from the pilot test, contextual factors for implementing PATH at national and hospital levels, issues on data collection and interpretation of indicators in the conceptual framework and to identify steps for the further development of the project.

The conference was attended by some 80 people with a high proportion of Belgium participants. Plenary presentations were given by Niek Klazinga, Francois Champagne, Oliver Groene, Margareta Haelterman, Ann-Lise Guisset and C Beguin. These presentations addressed the development of the conceptual model, an overview on the methodology and analysis of data from the PATH pilot test, the results of the evaluation study of the pilot and the use of administrative databases for performance assessment and quality improvement, respectively.

Working groups were organized to review experience with adapting the indicators to local and national contexts and the use of the data to initiate quality improvement activities. Though time for discussion was limited, many issues were identified to help improve indicator definition and data collection in the future. The conference was closed with an interactive session addressing the next steps for the development of the PATH project.

It was agreed that WHO would organize a technical workshop for country coordinators and the scientific committee in October 2006, to review the indicators and plan details for the operational planning of the next wave of data collection.

All presentations from the conference are available on the web pages of the Federal Public Service.

Please enter the following link and click on <more> under PATH Conference:

http://www.euro.who.int/healthcaredelivery/newsevents/newsevents

INSTITUTIONAL SUPPORT FOR THE PATH PROJECT

Two WHO Collaborating Centres have been established to support the future development of the PATH project. WHO Collaborating Centres are institutions that form part of an inter-institutional collaborative network set up by WHO in support of its programme at the country, intercountry, regional, interregional and global levels, as appropriate. In line with the WHO policy and strategy of technical cooperation, WHO collaborating centres also

participate in the strengthening of country resources, in terms of information, services, research and training, in support of national health development

The **WHO Collaborating Centre in Cracovia (Krakow), Poland**, will contribute as follows: issue of three-monthly PATH newsletter, training material for PATH on data collection and interpretation, administration of the project and act as a call centre to provide support to hospital coordinators on all phases of the PATH project.

The National Centre for Quality Assessment in Health Care (NCQA) was designated as a WHO collaborating centre in 2005. It is the Agency of the Ministry of Health, and a government central unit established by Minister of Health in 1994 to inspire and support actions aimed at improving quality of health services provided within the Polish health care system. Main tasks of the NCQA include: standardization of procedures via development of national guidelines, hitherto for treatment of chronic pain, COPD, diabetes II, depression, stable angina, GORD, stroke; adaptation and implementation of quality improvement projects that have either already proved useful or are being implemented in different countries; consultation, inspiration and coordination of quality assurance programmes in medical care institutions; development and implementation of external evaluation of healthcare institutions; monitoring of quality indicators: patient opinion surveys.

Focal person is Barbara Kutryba; co-founder of the Centre and Chief Specialist. Also Secretary of the Board of the Polish Society of Quality Promotion in Health Care and ESQH board member.

The **WHO Collaborating Centre in Ancona, Italy** will take up responsibilities of setting up an Internet platform that will provide public and user information on the one hand and support data collection and reporting on the other.

The Regional Agency for Health Care, Marche Regional Government, Italy (www.ars.marche.it), is a third party health care organization founded in 1997 by the Marche Regional Health System as a R&D institution, whose role is planning and implementing innovative tools for the System.

In the Marche Region, the health system - as well as the Italian system - is a public led comprehensive health system with functions of prevention, care and rehabilitation for all persons living in the region, funded with a share of the National Healthcare Public Fund.

The Regional Agency's commitment comes directly from the Regional Government and its customers are the Regional Health Authority, the Regional Health Trust and the Regional Autonomous and University hospitals.

Its terms of reference and related services are: Epidemiological research, innovation for the integration of the health system with the system of social services, health care planning for immigrants and reducing inequalities in health care, quality system management and implementation (patients rights/empowerment, safety and risk management, accreditation, clinical pathways and clinical networking), professional continuing education activities, planning and monitoring, information systems). The Agency developed the "Avedis Donabedian Quality Documentation Centre" (www.ars.marche.it/cdq)

The Agency was in 2005 designated as the "WHO Collaborating Centre for institutionalization and development of quality in health systems". Is has a well established collaboration with the School of Public Health, Politechnic University, School of Medicine, Ancona.

Among its international activities the Agency collaborates in planning and implementing a national agency for health care in Tirana (Albania) and participates in the programme of development of a continuing education system for the professionals working in children rehabilitation services of Bosnia.

Its task in the PATH quality project is implementing an informatics platform and a web site so as to link the participating hospitals in a European IT network. The person in charge of this project is Dr Andrea Gardini, who is quality manager, physician, President of the Italian Society for Quality in Health Care (www.siquas.it) and board member of ISQua (www.isqua.org). The webmaster for the PATH project is Mr Paolo Paliaga (p.paliaga@regione.marche.it).

Andrea Gardini and Basia Kutryba,, PATH focal persons at the Collaborating Centre for Institutionalization and Development of Quality in Health Systems , Ancona, and the WHO Collaborating Centre for Developing Quality and Safety in Health Systems, Krakow.

RESULTS FROM THE PATH PILOT TEST

During a WHO workshop in Barcelona in November 2005 a review of experiences with the PATH pilot test identified various issues, such as general delays in submitting data, lack of response (only 51 out of initially 68 completed the pilot), none of the hospitals provided the full dataset, major variations in the local adaptations of the indicators, lack of date in indicators to adjust for case-mix and lack of standardized measures on patient experience. It was decided to carry out a more systematic evaluation of country and hospital coordinators' experience in order to identify which factors might facilitate or obstruct the implementation of performance indicator projects.

The evaluation addressed two levels: the experience of country coordinators captured by a structured interview guideline and the experience of hospital coordinators, captured by a standardized questionnaire.

Interviews with all country coordinators were carried out between April and May 2006 addressing the context (project organization and links to existing quality initiatives), process (reporting of results, difficulties and adaptations of indicators) and benefits and future plans (resources required selling points and limiting factors).

Hospital coordinators filled in the online questionnaire in June 2006; the questionnaire consisted of three parts: 10 items addressing the overall experience with the pilot test, an assessment of each indicator in terms of burden of data collection and clarity of definition and textboxes allowing commenting on difficulties, use of results and recommendations. The questionnaire did not include an assessment of the gap between expectation and experience, the impact of data collection on documentation and quality improvement procedures and an assessment of the resources required for the pilot in terms of financial resources, staff time, data collection and coordination efforts.

By 23 June 2006, 33 of the 51 hospitals participating in the PATH pilot had filled in the electronic questionnaire, reaching an overall response rate of 64%. The response rate varied between countries and efforts will be made to retrieve more data from countries with a low rate. Due to the large number of Belgian hospitals participating in the PATH pilot, about two thirds of the responses are from Belgian hospitals.

Sensitivity analysis will be carried out to test if the results are biased by the Belgian experience. Further quantitative analysis will also be carried out to test association with implementation experience and hospital management structures.

Qualitative interviews with country coordinators were analysed with regard to context, process and benefits. In most countries, PATH was linked to existing initiatives, in some this yielded benefits, in others the project suffered from competition. Resources required to implement PATH were considered difficult to quantify, but clear responsibilities, seed funding and technical support during data collection were considered essential elements. The selection of hospitals did not seem to be fully on a voluntary basis in all countries and this effect should be taken into consideration.

With regard to implementation, the amount of preparatory work for data collection is linked to the level of sophistication of quality systems in a given country. Preparatory work also included considerable efforts on local adaptations for some indicators. PATH hospital coordinators complained about the delay in providing feedback on the data; however, appreciated feedback workshops once the dashboards became available.

Concerning the benefits, the independent role of WHO and the possibility to compare internationally were assessed as a major benefit. In addition, the PATH conceptual framework helped integrate different quality assessment activities and led to improved knowledge on different data systems in the hospital. Finally, the multidisciplinary approach required to assess the global hospital performance framework and the empowerment of staff through feedback on performance were considered major benefits.

The main achievement of PATH up to date is the collection and analysis of a set of indicators for comprehensive hospital performance assessment in 51 hospitals in 6 countries. The main limitations are the limited group of hospitals involved, some validity concerns (with regard to major local adaptations), and the untimely feedback of data. Further standardization and improved validity of indicators, fewer resources for data collection, increased use of routine data and more timely feedback with a stronger focus on international benchmarking and further support on interpretation of results will be the main directions which PATH needs to take in the future.

The next round of data collection using improved indicators and reporting should also address the testing of the assumptions contained in the conceptual model (interrelations between indicators and impact of performance assessment on quality improvement).

Oliver Groene, Technical Officer, Quality of Health Systems and Services, WHO Regional Office for Europe.

WORK IN PROGRESS

Several activities are in process to take forward the work of the PATH project and planning is in process with regard to establishing a formal network to compare hospital performance, setting up an Internet platform for data collection and analysis and a training centre to support countries in their implementation and development of supporting guidelines and manuals.

The WHO Collaborating Centre (WHO CC) in Krakow has started to develop training material by adapting the "Statistics in a Nutshell" series published once in "Qualityka", the NCQA Bulletin. The statistics for dummies content will be an integral part of the training material, designed to support medical professionals in hospitals in data management.

Together with the Steering Committee ,we plan to organize a week-long interactive session at the Amsterdam University at the end of

September 2006 for WHO CC Krakow staff involved in the PATH project. The initiative is, among others, aimed at obtaining the final sample of an exemplary dashboard.

The team at the **WHO CC in Ancona** started its work to support the PATH project in 2006. In May 2006, a mission of WHO with an expert from the German Federal Office for Quality Assurance (BQS), Burkhard Fischer, took place to assess the technical needs to develop a platform for the PATH project. Suggested **data flow** for next wave of data collection: Hospitals will report directly to the WHO CC in Ancona (Italy) using the online data transfer options. Reports will be printed as PDF and available to hospitals in the protected section on the PATH web page. The team in Ancona has also already developed the PATH web pages that will inform the public, users and the steering group about ongoing activities, host PATH articles and background materials and provide a platform for data collection (see LINKS section at the end of the newsletter).

Andrea Gardini and Basia Kutryba,, PATH focal persons at the Collaborating Centre for Institutionalization and Development of Quality in Health Systems, Ancona, and the WHO Collaborating Centre for Developing Quality and Safety in Health Systems, Krakow.

EXPERIENCE WITH IMPLEMENTING PATH: COUNTRY REPORTS

Implementing PATH in Belgium

The Belgian Ministry of Health, Public Federal Service for Public Health, Food Chain Safety and Environment (MoH) launched PATH within the country and served as a facilitator throughout its implementation. Twenty-two out of 119 acute care hospitals participated, answering to an open call to all acute care hospitals and participated in the whole process. Hospitals did not receive any financial support for their participation. Cost estimated for the MoH is below 100,000 euros/year.

Process

Each hospital nominated a coordinator. Four plenary sessions were organized with hospital coordinators to review WHO's definitions and refine or adapt them to the Belgian context to make data collection feasible and as uniform as possible. For each indicator one of the hospital coordinator was responsible to inform the Ministry of Health and develop registration forms. The MoH computed all indicators from the Clinical Minimum Data Set on request of the participating hospitals. Two indicators were not available (return to higher level of care, readmissions for tracer conditions).

While waiting for international dashboards, a national feedback was organized. Then, thematic working groups were set up to 1) compare results and understand differences, 2) share practices and 3) develop action plans and set goals for next measurement. Participation in the thematic working groups was voluntary (between 4 and 13 hospitals in each group). Themes covered breastfeeding, operating theatre, human resources management, patient satisfaction survey, and the use of administrative database to compute performance indicators. Practically, we noted that results were rapidly discussed during the first meeting of working groups and then set aside to compare practices –with a more global view than just the indicator– or to examine methodological issues around information systems.

Lessons learned

PATH was usually a strong lever within hospitals rather than a trigger in itself. According to some hospitals, it was used to reinforce awareness and support current initiatives, reorganizations, or priority setting. Networking and collaboration among hospitals was also an important contribution of PATH. Upstream, PATH stimulated improvements in internal information systems:

a) Some indicators required ad hoc collection of data (e.g. compliance with antibioprophylaxis guidelines, last-minute cancellation for surgery) and allowed hospitals to identify gaps in information systems. Our experience indicates that burden of data collection is not just a challenge but also sometimes an opportunity. Indicators should not be dropped from future adaptations of PATH merely because data are not readily available but instead simple and short-period registration should be considered.

b) When trying to explain results, working groups were systematically limited by lack of data. Hence, the working group on operating theatre decided that its first task would be to design a dashboard for management of the theatre, and the working group on human resources decided to implement an information system to monitor absenteeism.

International comparisons and networking were among the main reasons for hospitals to embark upon PATH. Unfortunately, it was very limited due to number of participating hospitals in other countries, variations in definitions and delays in international feedback. Those aspects need to be further developed to maintain the motivation of Belgian hospitals. It is crucial as a number of performance assessment initiatives are started within the country and PATH needs to offer a strong added-value to position itself competitively compared to alternative (or complementary) initiatives.

From the point of view of the MoH, PATH experience was paramount for motivation and successful implementation of a national project of performance indicators built on administrative databases (databases

available to the national administration). It borrows from the PATH guiding principles (same objective, similar methods). An individual feedback was sent to all acute care hospitals in Belgium. The indicators list was adapted to reflect Belgian priorities taking into account the availability of data at the MoH, as all indicators were computed centrally.

Our experience demonstrates that resources need to be dedicated both by the national coordinator and by individual hospitals for successful implementation of PATH, especially in the first phases of implementation. Success factors within hospitals are: strong role of coordinator, support from top management and positive culture for self-evaluation. Hospitals were really keen on regular support from MoH and demanded clear directions from the MoH, even though it positioned itself only as a facilitator. On average, MoH committed 1/3 FTE during the whole process.

To conclude, more than measurement (with all limits inherent to variation in interpretation of definitions and lack of control on data quality), PATH was a great tool to convey a message on the multidimensional nature of performance and to foster a culture of self-evaluation for improvement with all each levels feeling accountable for performance in the hospital. But we observed that in most hospitals results were reported by the coordinator to the board of management and then sent back to each operational unit responsible for the specific indicator and analysed independently, while the loop back to top management was then ignored.

The major pending question remains: how to translate multidimensional approach of performance – as advocated by PATH– into practice?

Ann-Lise Guisset, Pascal Meeus, Margareta Haelterman, Public Federal Service for Public Health, Food Chain Safety and Environment, Ministry of Health, Belgium

The PATH Experience in Canada

In Canada, the province of Ontario currently has an advanced performance reporting system that is in place to collect and report on hospital performance data. The PATH project which aims to facilitate international collegial support, benchmarking and networking is appealing to hospitals because of the opportunity to expand beyond the provincial and national scope.

The pilot test of PATH in Ontario was conducted in four hospitals: three teaching hospitals and one community hospital. With collaboration from the hospitals, fifteen of the 18 PATH indicators were modified to fit the Ontario context and collected, and 14 additional indicators from the tailored set were collected.

There were challenges experienced in the pilot test such as the lack of technical specification for these groups of indicators, unavailable data at the hospital level, limited resources in terms of finance, human resources and time, competing priorities within the hospitals and the extended time interval between the collection of indicator data and the publication of the dashboards. It was recognized that regular communication with the WHO to provide guidance, updates and tools to hospitals would be important for maintaining the momentum of and interest in the PATH project. For sustainable uptake by hospitals in Ontario, PATH will have to demonstrate substantial value in quality improvement and comparable international benchmarking in hospital performance.

Emily Siu, Canadian PATH Coordinator

The Danish experience

The PATH Project for Performance Assessment in Hospitals was introduced in Denmark in 2003 under very promising circumstances:

Firstly, one of the members of the original expert group, Dr Johan Kjærgaard was able to participate very actively in the introductory meetings with representatives from the Danish Public Hospital Services (Chief Executives, quality managers, Medical Directors and various specialists in data collection and presentation) so that the aims and methodologies of the project were clear from the beginning. Secondly, the current discussion about Danish health care quality at that time was very focused on the issue of broad, multifaceted benchmarking, especially with hospitals in the European Community. So initially 4 of the thirteen Danish hospital regions, including three of the biggest university hospitals, expressed interest in participating in the project.

Apart from the possibility of international benchmarking, the main attractions of the project for the Danish hospitals appeared to be the utilization of data already existing in the hospitals' databases (minimal data collection burden), and the broad scope of the indicators.

The subsequent fate of the project in Denmark, however, proved to be rather disappointing. One by one, the hospitals opted out of the project, leaving only two university hospitals. The main reasons for this appeared to be the following.

(i) Competition from national quality projects, where especially the launch of a Danish accreditation plan, implying collection of indicators, both concerning organizational quality, patient experience together with an expanding scheme for clinical indicators. This competition appeared to be especially demotivating for the participating smaller regions, while the attitude of the two university hospitals was still positive.

(ii) Also, one of the two university hospitals opted out because of lacking man power to the central data collection part of the project. This was seen in conjunction with the implementation of the major health care reform.

It is obvious that an internationally driven project like PATH will get into difficulties in competition with active and starting national quality projects, and it is not surprising that a reform of the hospital structure affected voluntary PATH project participation. The one remaining – university – hospital and the corresponding region have however found the PATH pilot very useful as a data collection exercise. Firstly, we now have a mapping of a system of variables derived from routine data with a practical capacity to describe hospital performance in many dimensions. Secondly, the pilot phase induced a demand for validation and indicator definition, which expand the original PATH material and improves the quality of the administrative databases.

The conclusion of the pilot phase, formulated by the one participant, is a wish to go into production, together with a limited number of district hospitals.

Paul Bartels, Danish PATH Coordinator

PATH Pilot testing in France

The French component of the PATH project included thirteen volunteer institutions (five teaching hospitals, three general hospitals and five private institutions). In each institution, a correspondent was responsible for local coordination of the project and a steering committee was set up at the national level led by our team. The work was structured around four phases:

Adaptation to the French context of the WHO indicators, specification of the definitions and the methods of data collection. A consensus was obtained around a panel of indicators issued of the « core» and the « tailored» sets (Figure 1). Preference was given to indicators which could be calculated from routinely collected data (DRGs databases, data provided by the human resources department, prevalence rate of nosocomial infections), as well as those whose collection was already programmed in certain institutions as part of specific accreditation or quality procedures (audits of antibiotic prophylaxis, time to sending discharge letters to the treating physician, patient satisfaction index).

Data collection in the health institutions, coordinated by the local correspondents. This involved numerous professionals in each structure, such as managerial staff in human resources, operating room managers, pharmacists, doctors responsible for DRGs data, quality control officers, and also clinicians who carried out the audits of antibiotic prophylaxis.

Several feedback meetings organized by those in charge of the project in each institution, before delivering results in each participating institution through various channels before the feedback of Montreal's dashboards. Discussions between those involved led to exchange of experiences as well as to comparisons of practices and of internal organization.

Implementation of actions for improvement in each centre. The final step was to evaluate the impact of these measures in each centre and the capacity of the institution to launch a dynamic process of change and improvement.

The first feedback of results to the teams taking part in the PATH project revealed that differences between centres varied according to the indicators collected. Comparative analysis of the results obtained from the DRGs indicators clearly showed that the disparities observed were largely related to lack of uniform coding of disorders between centres, particularly in asthma and diabetes. The results of the patient satisfaction survey were very similar overall, although several significant differences were observed between teaching hospitals and other types of institution. Satisfaction with information given on treatment aims and on the results of complementary investigations was significantly lower in teaching hospitals; similarly, perceived satisfaction with time to answer a patient's urgent call for help was also significantly lower in teaching hospitals. Among the results of clinical audits, evaluation of prophylactic antibiotic practices in colon cancer surgery and total hip replacements revealed several disparities between centres, whereas practices within the same centre were almost always homogeneous. While antibiotic prophylaxis for these tracer conditions was given in nearly 100% of cases studied, excess consumption of antibiotics was more frequently observed than inadequate consumption, in particular in colon cancer surgery.

The changes decided on the basis of these comparisons were more rapid and numerous in small centres than in teaching hospitals. It has to be appreciated if they were successful and long-lasting (see next newsletter !). Nevertheless, this pilot-test is in keeping with a movement which is now beginning in France. It seems that volunteer hospitals (or at least volunteer teams within these hospitals) are capable of carrying out benchmarking experiments in multidisciplinary teams and can also apparently use them to advantage to bring about improvements in the quality of the services they provide. Participating hospitals in the pilot-test are waiting for the second wave of data collection and we plan to expand the group for a better validity of the comparisons, leading to the production of more convincing results. Meanwhile, the group has continued to work on indicators trying to balance the need of further local adaptation and the need of international comparability (many thanks to the Belgian team and to Emily Siu from Ontario).

Pierre Lombrail, Yassen Yordanov, Cécile Paillé-Ricolleau, Leïla Moret, Centre Hospitalier Universitaire de Nantes

Experience with the PATH Project in Slovakia

Health care reform brought concepts of quality of care into the focus of health care decision-makers in Slovakia. New legislative acts postulated requirements for internal quality systems obligatory for all providers of care. Those acts set up an environment for developing indicators for evaluation of providers, along with diagnostic and therapeutic guidelines, all covered within the quality system. During initial implementation a certain degree of resistance to those innovations was discernible. The need for international support to implement the quality concepts into practice was recognized and several projects were initiated. Among others, a project sponsored by the government of the Netherlands, oriented to performance indicators for out and in-patient care was initiated. During initial months of the project an offer came from the WHO Liaison Office in Bratislava to join resources under the WHO Project PATH. The WHO PATH conceptual framework offered indicators of clinical effectiveness and efficiency, but also indicators on patients and staff orientation, safety and indicators of effective governance in hospital management.

Consequently, a joint project team was established bringing together consultants of Interaction in Health, the Netherlands, PATH consultants, experts from the Association of Slovak Hospitals. The project was managed by the PATH country coordinator – a person with previous background in health administration and informatics education. Ten hospitals joined voluntarily the pilot study initially. Among them there were university, public and private hospitals.

Several meetings were organized during initial phases, where participants were introduced into the PATH concepts. Once initial data collection was finished preliminary results were discussed among representatives of participating hospitals as well. In general, this first step brought positive feedback. It was decided to stick with the core group of PATH indicators. However, some of them were found problematic for specialized facilities in pediatric hospital, respiratory and long term care facilities. Finally, data from eight hospitals were submitted for final evaluation and international comparisons.

A number of problems was followed and discussed within the pilot period. Despite precise description of indicators with the undisputable instruction and education potential of offered PATH documentation, unavailability of definitive grid for data collection from the beginning limited more effective progress. Data collection in hospitals was time- and effort-consuming due to unprepared hospital information systems in the majority of participating hospitals. Dubious quality of data collected manually or combined from several sources with limited standardization was observed. The precise interpretation of results and broader utilization of sophisticated final presentation offered for participating hospitals was found problematic.

Final form of presetting indicators in dashboards was generally accepted, although time delay from submitting data and receipt of final evaluation was repeatedly mentioned by hospitals as a factor limiting broader use of results. Modest valuation of inter hospital benchmarking and international comparisons in some cases was partly forced by a fear from data being misused and misinterpreted by third parties.

Difficulties with particular indicators as day surgery, prophylactic ATB therapy, or set of indicators "staff orientation" reflected specific local conditions but represent a challenge for managers to adequately handle the situation in future. PATH was the only indicator initiative in Slovakia dealing with staff orientation and definitely this issue will gain higher significance when human resource management becomes more developed in health care facilities.

In conclusion, based on the feedback from participating hospitals, the project represented the first experience with collecting, interpreting and benchmarking of performance indicators in Slovak hospitals. Creation of quality units in hospitals was stimulated by the project participation in a number of cases. The continuation of the interest in PATH activities, especially in a group of smaller autonomous hospitals, was expressed. In future, the attention of PATH coordinator and project members could be oriented to broader utilization of collected and presented indicators for managerial purposes inclusive communication with major stakeholders such as the Ministry of Health, Health Insurance Companies, and Health Surveillance Authority. It is anticipated that more effort should be focused to improving quality of data collected, training activities and consultancy to foster quality improvement philosophy in Slovak hospitals.

Website with relevant documents: www.quality.healthnet.sk

Viera Rusnaková, Country Coordinator and the member of PATH Steering Group

The PATH Experience in South Africa

"Quality Improvement Programmes! Clinical Audits !Accreditation!" These are the buzz words mentioned by every Hospital Administrator, and mumbled in corridors by health care staff in South Africa. The introduction of the PATH project into KwazuluNatal, South Africa, has made sense of Hospital performance and brought about a structured

system of Health Measurement. Prior to the PATH, hospitals had formed Quality Improvement Teams and were working on an Accreditation System. Some hospitals had found this accreditation task too massive and very few had reached accreditation status.

Data, at present, are collected in the hospitals but analysed centrally with those supplying the data having little knowledge on how to interpret, use or improve from the data. These were some of the strong selling points for hospitals to join the PATH project.

The PATH Coordination team from South Africa has attended numerous PATH meetings in Barcelona, Spain and had the responsibility of getting the Pilot project into an implementable form by making sense of the indicators and drawing up data sheets/capturing of information and collating data. Three pilot hospitals: Edendale, Greys and Northdale Hospital were invited to join the project.

Professor M.H. Cassimjee as well as Dr S. Sirkar and the provincial team under Dr Zungu coordinated meetings and facilitated information sharing /capacity building and data collection. These hospitals were also strategically chosen as they represent the three tiers of hospitals in the country ranging from the superspecialized to the primary health care district hospital. The Northdale hospital became the hub for data collection, and a full-time data capturer was employed. Funding was provided by the Provincial unit and hospitals were also asked to use their own budgets towards quality improvement.

Numerous workshops were held with the hospitals during the PATH implementation phase. The final report back with benchmarking and WHO analysis was done in June 2006. Lots of enthusiasm and interest was shown and the 3 hospitals are keen to participate in phase 2 of the PATH. The majority of the indicators required the setting up of new data collection systems. Tailored indicators were much easier as these were chosen on the burden of data availability and high numbers cases.

The main difficulties hospitals faced during the pilot included:

- Understanding and contextualizing indicators
- Burden of data collection
- Staff shortages
- Time constraints
- Buy in from clinicians

The biggest benefit in participating in the PATH pilot: The data collector and the hospital understood what data they were collecting, why they were collecting it and realized that they now can use these data to improve their services on their own.

The people on the coalface of service delivery were empowered to understand the need for data and make sense of indicators and for the first time they understood the true meaning of what is required for quality improvement and how to measure it.

Dr. S. Sirkar, Chief Medical Officer, PATH Provincial Hospitals Coordinator, Kwazulu Natal Department of Health.

INITIATING THE NEXT WAVE OF DATA COLLECTION

A technical workshop will be organized by WHO on 13-14 October 2006, in Barcelona. The objectives of the workshop will be to discuss suggestions and revision of the operational definition of PATH indicators, decide on the indicators to be included in the next wave of data collection and agree on the timetable and other operational issues for the data collection period. Participants will be country coordinators and core members of the PATH Steering Group, as well as representatives of the WHO Collaborating Centres in Krakow and Ancona and selected representatives of other national and international agencies working in the field of performance assessment.

Hospitals interested in joining the project in the next wave of data collection should contact WHO at: ogr@es.euro.who.int

DATES TO KEEP IN MIND

Teleconference of the PATH steering group: 6 September 2006, 16.00CET.

PATH Technical Workshop for steering group members and country coordinators, Barcelona: 13-14 October 2006.

ISQUA Conference 2006, 22-25 October 2006, London.

LINKS

The newly established PATH web page:

www.pathqualityproject.org

The PATH project at the WHO Regional Office for Europe:

http://www.euro.who.int/hosmgt/20060714_1

Other links:

Health Care Quality information on the web pages of the European Commission:

http://ec.europa.eu/health/ph_information/dissemination/hsis/hsis_14_en.htm