

Klinik Kalite İyileřtirme

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www.saglikpolitikolari.org

Sağlık Hizmeti Sunumunun Ana Hedefleri

- Herkese gerekli ve uygun sağlık hizmetini sunmak (ulaşılabilirlik),
- İsrafı önlemek ve ihtiyaç duyulan hizmeti verimli bir şekilde sunmak (maliyet),
- Verilen hizmetin her düzeyde kalitesini iyileştirmek ve farklılıkları azaltmak (kalite).

“Crossing the Quality Chasm”

- Hasta bakımında altı spesifik alanda iyileştirme;
 - Daha güvenli,
 - Daha etkili,
 - Hasta-odaklı,
 - Zamanında,
 - Verimli, ve
 - Eşit.

Prof. Dr. H. Erdal Akalın

Başarı Faktörleri

- Hastaya odaklanmak
- Kalite iyileştirme programlarını uygulamak
- İnsan kaynakları
- İnfomasyon teknolojisinin kullanımı
- Sonuçların ölçülmesi ve performans değerlendirmesi (outcomes)
- Stratejik planlama

Sağlık reformu: Temel ilkeler

- Tüm toplumu içine alan bir sağlık hizmeti (universal)
- Maliyet yönetimi
- Sağlık hizmeti kalitesi ve güvenilirliğinin iyileştirilmesi
- Finansman eşitliği (hakkaniyet)
- Sağlık yönetiminin basitleştirilmesi

*Building a better health care system, Specifications for reform.
National Coalition on Health Care, 2004.*

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

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Sağlık Hizmetinde Kalite Tanımı

“Institute of Medicine, USA”

- “Günün mesleki bilgileri içinde, kişilere ve topluma verilen sağlık hizmetinde istenilen ve beklenen sonuçlara ulaşma.”
- “The degree to which health services for individuals or populations increase the likelihood of desired health outcomes and consistent with current knowledge.”

Sağlık Hizmetlerinde Kalite Tanımı

“National Health Service, UK”

- “... doğru işlemleri, doğru kişilere, doğru zamanda uygulamak ve ilk defasında doğru yapmak.”
- “...doing the right things to the right people at the right time, and doing things right-first time.”

Kalite Kavramı

- Ölçülebilir,
- Tüm sağlık hizmetlerini kapsayan,
- Kişilere ve topluma uygulanabilen,
- Belli bir amaca yönelik,
- Verilen hizmetin yararının sonuçların ölçülmesi ile sağlanabilen,
- İşlemlerle sonuçları birbirine bağlayabilen,
- Hastaların ve toplumun değerlerine önem veren,
- Teknik, mekanik ve bilimsel bilgi ile sınırlı,
- Sürekli değişimliğe uğrayabilen **bir yapı....**

“Institute of Medicine”

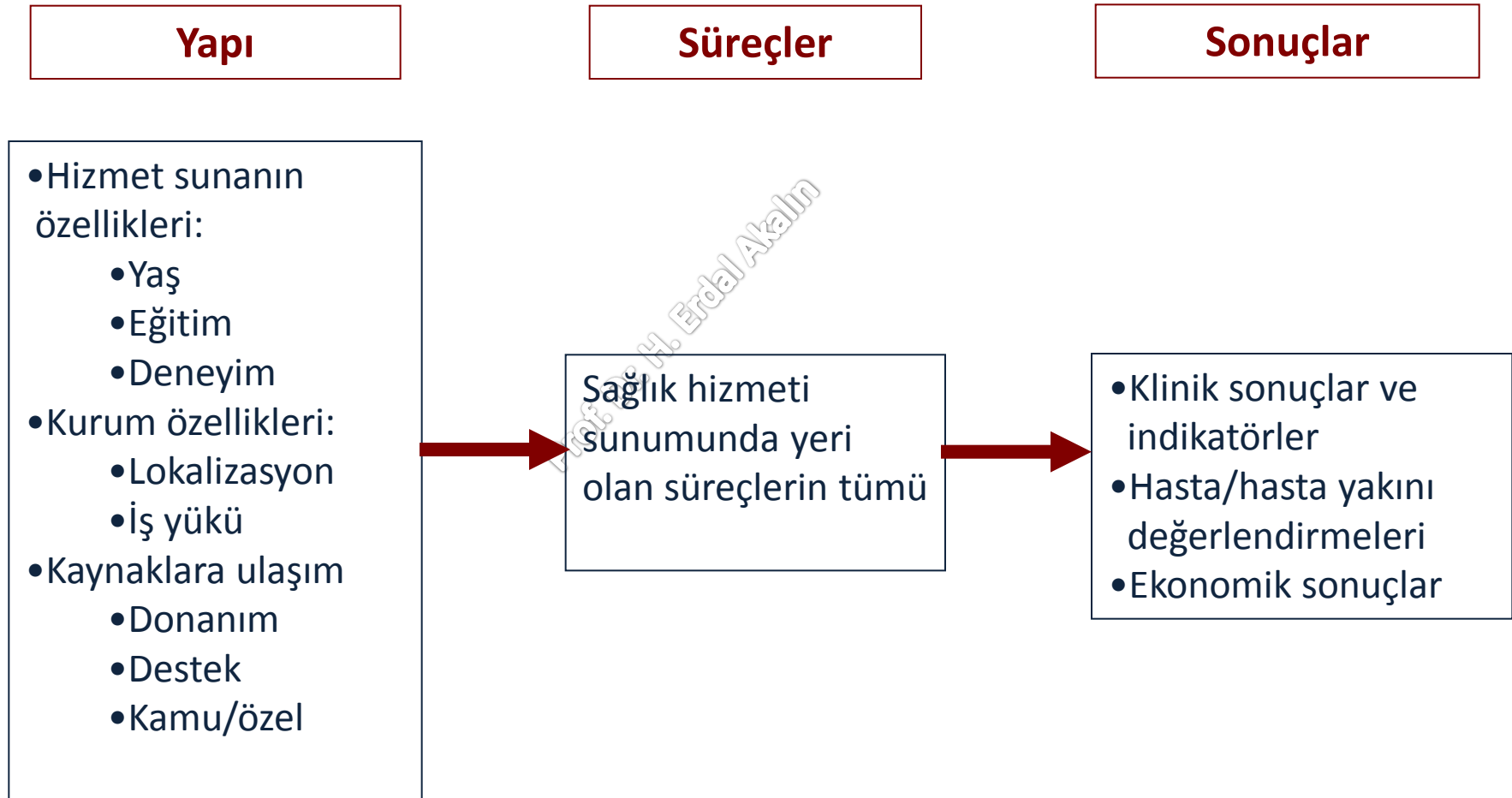
- Definition of Medical Quality
 - Medical quality is the degree to which health care systems, services and supplies for individuals and populations increase the likelihood for **positive health outcomes** and are consistent with **current professional knowledge**.
- Definition of Clinical Quality Improvement
 - Clinical quality improvement is an **interdisciplinary process** designed to **raise the standards** of the delivery of **preventive, diagnostic, therapeutic, and rehabilitative measures** in order to maintain, restore or improve health outcomes of individuals and populations.

Sağlık Hizmetlerinde Kalite

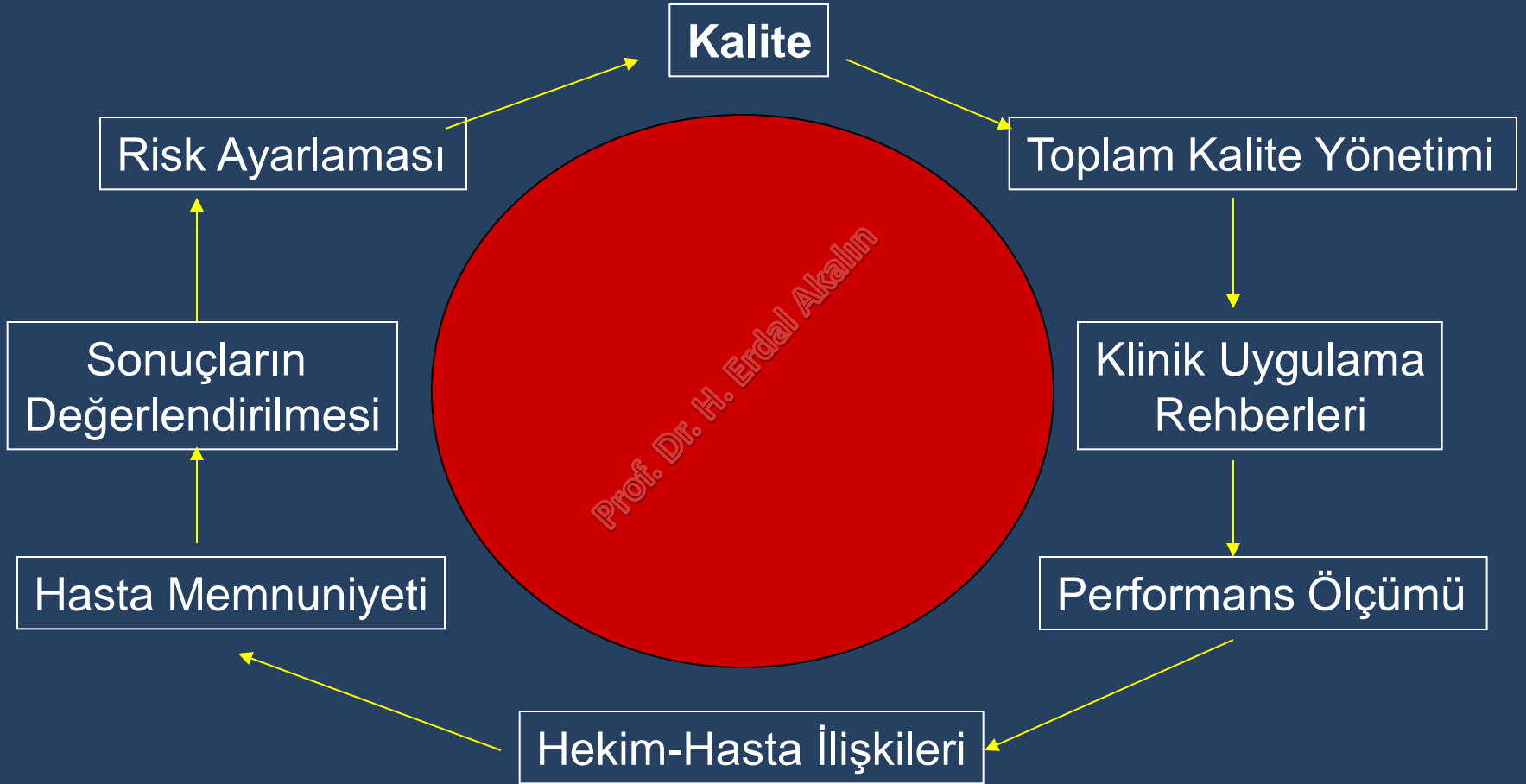
Üç Temel Direkt

- Yapı
- İşlemler (süreçler)
- Sonuçlar

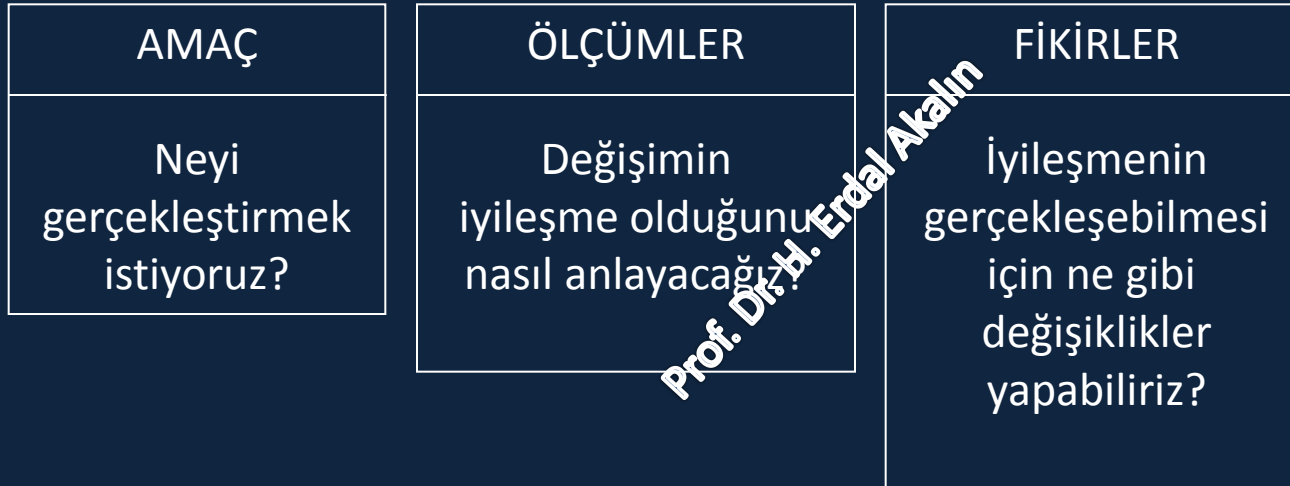
Yapı, süreçler ve sonuçlar arası ilişki



Sağlık Hizmetlerinde Sürekli Kalite İyileştirme



Kalite İyileştirme Sistemi



Kalite İyileştirme Programlarına Yaklaşım Yöntemleri

- Kanıta-dayalı tıp
- Klinik uygulama rehberleri/demetler
- Karar verme kolaylaştırıcı yöntemleri
- Mesleki eğitim ve gelişim
- Değerlendirme ve hesap verme yöntemleri
- Kamuya duyuru
- Hasta-merkezli hizmet
- Hastaların karar verme mekanizması içine alınması
- Ortak karar verme
- Toplam kalite yönetimi felsefesi
- Kalite sistemleri

Kalite İndikatörleri

- Sağlık hizmeti sunumu ile ilgili özel bir süreç veya sonucun değerlendirilmesinde kullanılan ölçüt.
- Hasta sonuçlarını etkileyen yönetim, klinik, veya destek fonksiyonların izlenmesi ve değerlendirilmesinde kullanılan kantitatif ölçüt.
- Hasta sonuçlarını etkileyen sağlık kalite süreçleri, klinik destek servisleri, organizasyonel fonksiyonların izlenmesi, değerlendirilmesi ve iyileştirmesinde kullanılan tarama ve uyarı yöntemlerinin tümü.

Kalite İndikatörleri-Sınıflandırma

- Hıza-bağlı (görülme sıklığı)
- Yapı/süreç/sonuçlara bağlı
- Genel veya hastalık bazlı
- Verilen hizmete bağlı
 - Koruyucu, akut, kronik
- Fonksiyona bağlı
 - Tarama testleri, tanı yöntemleri, tedavi, izleme
- Bölümsel hizmete bağlı
 - Hikaye alma, fizik muayene, laboratuvar ve radyolojik incelemeler, ilaç yönetimi, diğer işlemler

*J Mainz, Defining and classifying clinical indicators for quality improvement.
Intern J Q Health Care, 2003; 15:523-530.*

Hıza-Bağlı İndikatörler-Örnekler

- Hastane infeksiyon hızları
- Cerrahi girişim sırasında ölen hasta sayısı
- Perinatal dönemde ölen hasta sayısı
- Yalancı pozitif laboratuvar sonuçları
- Kritik laboratuvar değerlerinin bildirilme oranı
(critical values/trigger points)

Yapı/Süreç/Sonuçlara Bağlı İndikatörler-Örnekler

- Yapısal
 - Uzman doktor oranı (tüm doktorlara göre)
 - Yeni teknolojilere ulaşım (lab. testleri, MR gibi)
 - Her iki yılda bir gözden geçirilen rehber sayısı
- Süreçler
 - Ayak bakımı verilen diyabetik hasta oranı
 - Trombolitik tedavi verilen AMI hasta oranı
 - Klinik rehberlere göre tedavi alan hasta oranı (pnömoni)
- Sonuçlar
 - Diyabetik hastalarda HbA1c sonuçları
 - Hiperlipidemik hastalarda lipid profili sonuçları
 - Hipertansif hastalarda kan basıncı değerleri

The structure of improvement knowledge

BMJ Qual Saf 2011;20(Suppl 1):i13ei17.
doi:10.1136/bmjqs.2010.046524

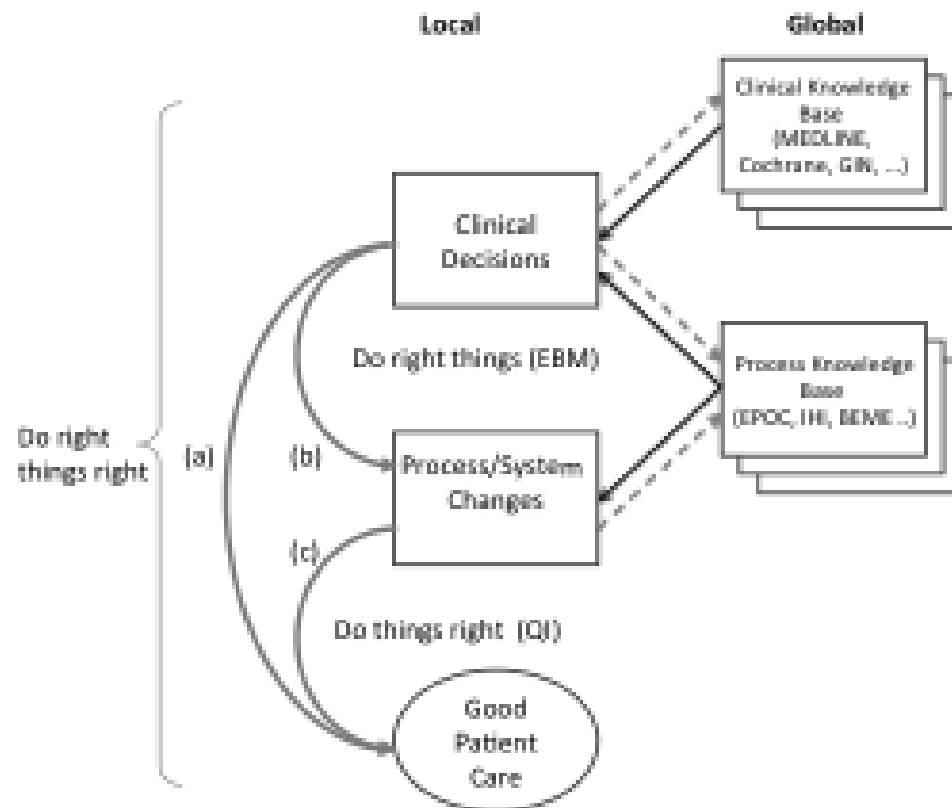


Figure 1 Relationships between Quality Improvement (QI) and Evidence-Based Medicine (EBM). (a) sequence of EBM followed by QI; (b) EBM uses clinical knowledge to inform individual clinical decisions about patient care; (c) QI focuses on improving *recurrent* problems in the processes of care (Acronyms: GIN—Guidelines International Network; EPOC—Effective Practice and Organisation of Care Group; IHI—Institute for Healthcare Improvement; BEME—Best Evidence Medical Education).

The EBM perspective

One cause of the evidence–practice gap, for example, is the sheer volume of evidence—around 350 new articles added to MEDLINE each week. But much of this is research that is insufficiently robust to change practice. So keeping up to date with developments and information is problematic. EBM has been to synthesise and summarise research, and be able to access it whenever it is needed. To achieve this, ready access (to resources such as the Cochrane Library) and skills (in finding and applying evidence) that few health professionals have. The EBM movement has focused on both the skills and tools to better clinical practice, with some¹² but not all success.

A particular focus of EBM has been a sceptical approach to innovative evidence before changing practice. Innovations represent a real attraction, but

Klinik Kalite Değerlendirme

- Sonuçlar- Mortalite hızları, enfeksiyon hızları gibi, (genel)
- Kanıta-dayalı süreçlere uyumun ölçülmesi, (rehber/demet)
- Karmaşık sorunları olan ve riskli işlemlerin uygulandığı hasta sayısı, (Leapfrog örneği)
- Kurumun hasta güvenliği ile ilgili sonuçları, (Leapfrog ve AHQR)

Sonuçlar-Outcomes

- Readmission rates – Yeniden yatış hızı
- Risk-adjusted mortality rates- Risk ayarlanmış mortalite hızı
- Surgical Care Improvement Project- SCIP
- Transplant quality indicators- Transplant kalite indikatörleri



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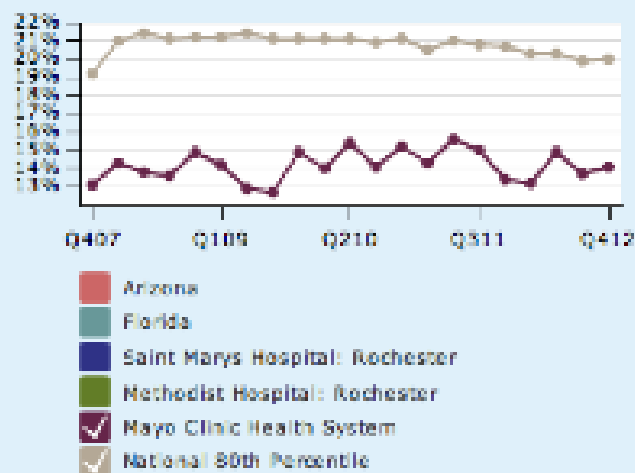
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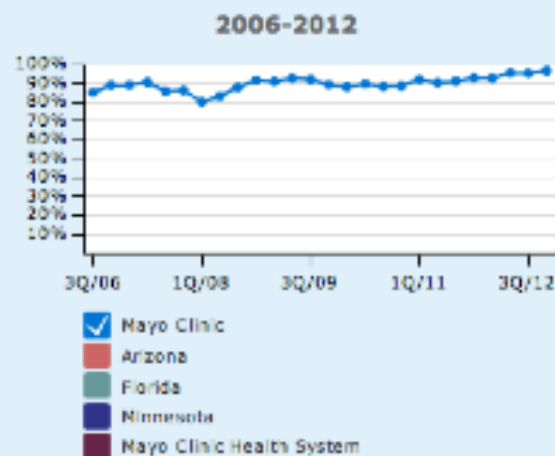
Readmission Rates



Check or uncheck the legend icons to view or hide data.

Surgical Care Improvement Project

Surgical Care Improvement Project



Kanıt- Dayalı Süreçler- Processes

- Heart attack (acute myocardial infarction)-AMI
- Heart failure-Kalp yetmezliği
- Inpatient pneumonia-Hastaneye yatırılan pnömonili hastalar
- Patient safety indicators (AHRQ)-Hasta güvenliği indikatörleri
- Ventilator-associated pneumonia-VİP
- Warfarin-Warfarin tedavisi

Hasta Memnuniyeti ve Kalite Sıralamaları- Satisfaction and rankings

- Hospital Consumer Assessment- Hastane tüketici değerlendirmesi
- Patient satisfaction-Hasta memnuniyeti
- Quality rankings- Kalite sıralamaları

2011 LEAPFROG TOP HOSPITALS

Kaiser Permanente Antioch Medical Center (CA)	Baystate Medical Center (MA)
Kaiser Permanente Fontana Medical Center (CA)	Beth Israel Deaconess Medical Center (MA)
Kaiser Permanente Los Angeles Medical Center (CA)	Brigham and Women's Hospital (MA)
Kaiser Permanente Oakland Medical Center (CA)	Anne Arundel Medical Center (MD)
Kaiser Permanente Panorama City Medical Center (CA)	University of Maryland Medical Center (MD)
Kaiser Permanente Richmond Medical Center (CA)	Detroit Receiving Hospital/University Health Center (MI)
Kaiser Permanente Riverside Medical Center (CA)	Spectrum Health Blodgett Hospital (MI)
Kaiser Permanente Roseville Medical Center (CA)	Spectrum Health Butterworth Hospital (MI)
Kaiser Permanente San Diego Medical Center (CA)	St. Joseph Mercy Oakland (MI)
Kaiser Permanente San Francisco Medical Center (CA)	University of Michigan Health System (MI)
Kaiser Permanente San Jose Medical Center (CA)	Regions Hospital (MN)
Kaiser Permanente South Bay Medical Center (CA)	St. Mary's Hospital of Rochester (MN)
Kaiser Permanente South Sacramento Medical Center (CA)	University of North Carolina Hospitals (NC)
Kaiser Permanente South San Francisco Medical Center (CA)	Hackensack University Medical Center (NJ)
Kaiser Permanente Vacaville Medical Center (CA)	The Valley Hospital of Ridgewood (NJ)
Kaiser Permanente Walnut Creek Medical Center (CA)	Presbyterian Hospital (NM)
Kaiser Permanente West Los Angeles Medical Center (CA)	Montefiore Medical Center, Weiler Division (NY)
Kaiser Permanente Woodland Hills Medical Center (CA)	Roswell Park Cancer Institute (NY)
Mills-Peninsula Health Services (CA)	The Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (OH)
Stanford Hospital and Clinics (CA)	The Christ Hospital of Cincinnati (OH)
UC San Diego Health System, Hillcrest (CA)	University Hospitals Case Medical Center (OH)
Baptist Health South Florida Homestead Hospital (FL)	Lehigh Valley Hospital (PA)
NorthShore University HealthSystem-Evanston Hospital (IL)	Bon Secours St. Francis Health System - Downtown (SC)
NorthShore University HealthSystem-Glenbrook Hospital (IL)	Vanderbilt University Hospital (TN)
Northwestern Memorial Hospital (IL)	Swedish Medical Center First Hill Campus (WA)
Rush University Medical Center (IL)	Virginia Mason Medical Center (WA)

2011 LEAPFROG TOP RURAL HOSPITALS

Mariners Hospital (FL)
Miles Memorial Hospital (ME)
Seabrook Valley Hospital (ME)

2011 LEAPFROG TOP CHILDREN'S HOSPITAL

Children's Hospital Los Angeles (CA)
CHOC Children's (CA)
Children's National Medical Center (DC)
Children's Memorial Hospital (IL)
Children's Hospital Boston (MA)
Cincinnati Children's Hospital Medical Center (OH)
Children's Hospitals and Clinics of Minnesota-St. Paul (MN)

Evidence-based Hospital Referral

Recommended Annual Hospital Volumes/ (Recommended Annual Surgeon Volume)	
1. Coronary artery bypass graft	≥ 450
2. Percutaneous coronary intervention	≥ 400
3. Abdominal aortic aneurysm repair	≥ 50
4. Aortic valve replacement	≥ 120
5. Pancreatic resection	≥ 11
6. Esophagectomy	≥ 13
7. Bariatric surgery	>125 / 50
High-risk delivery: <ul style="list-style-type: none">▪ Expected birth weight < 1500 grams,▪ Gestational age < 32 weeks, or▪ Pre-natal diagnosis of major congenital anomaly	Neonatal ICU with Annual Count of Very-Low Birthweight Babies ≥50

In its latest version, Leapfrog places a large emphasis on direct outcome measures (i.e., risk-adjusted mortality) for coronary artery bypass graft and percutaneous coronary interventions, using robust and approved measurement systems for the EBHR Safety Standards. While the standards also include specific process measures for coronary artery bypass graft, percutaneous coronary interventions, abdominal aortic aneurysm repair and certain high-risk deliveries, there is somewhat less emphasis on these measures. The Leapfrog website provides specific details about these performance measures.

The Leapfrog Group, working in partnership with Thomson Healthcare, invites hospitals to record their volume and process or performance measures for these procedures and conditions on the Leapfrog Web site. Leapfrog purchasers will work to

conducting surgery and/or referring patients.

Why Purchasers Need to Get Involved

Given these obstacles, greater use of EBHR is unlikely to happen without the involvement of purchasers.

Using their leverage as purchasers, Leapfrog members can recognize and reward hospitals that meet EBHR standards for selected procedures and conditions. Purchasers, including health plans also can promote EBHR by educating consumers and calling attention to the importance of choosing the right hospital.

Although it will not be easy to implement, referring patients for high-risk conditions and procedures to hospitals meeting

Leapfrog EBHR standards could have substantial

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1996;276:1054-9.

Leapfrog Grubunun

Diğer Kriterleri:

•CPOE

•ICU uzmanı

•Hasta güvenliği

Indicators to improve clinical quality across an integrated health care system

DAVID J. BALLARD

Institute for Health Care Research and Improvement, Baylor Health Care System, Dallas, Texas

Abstract

Purpose. To describe key historical and operational elements of change that may assist an organization to develop quality indicators for implementing a strategic plan to improve care, align health care improvement efforts with national directions, and examine the types of medication indicators used to assess these changes.

Setting. The Baylor Health Care System (BHCS) is an integrated health care delivery organization in Dallas-Fort Worth, Texas. It includes 11 hospitals with 83 000 admissions per year and 47 primary care and senior centers with more than 500 000 visits annually.

Intervention. Following a charter by the BHCS Board of Trustees to develop a health care quality improvement strategic plan, BHCS undertook a system-wide effort to improve care supported by the use of clinical quality indicators.

Results. Consistent with the direction of the US Institute of Medicine, BHCS has implemented a clinical indicator system focused on measures of health care underuse, overuse, and misuse. These indicators demonstrated the accomplishments of specific process of care improvements throughout BHCS. Despite implementing Web-enabled error reporting systems and pilot work with an adverse drug event hospital medical record abstraction tool, BHCS indicators of medication misuse continue to be in a formative stage, much like the national consensus.

Conclusion. Organizational, compensatory, and cultural commitments may be important for successful implementation of clinical indicator initiatives by health care systems. Using clinical indicators to establish baseline performance and to assess the effectiveness of proposed quality improvements provides quantitative and qualitative means to identify and disseminate best care practices. Although indicators to measure underuse of clinically necessary care are well established, there remains a need to achieve consensus regarding practicable medication quality indicators for overuse, misuse, and adverse drug events.

Keywords: adverse drug event, medication error, misuse, overuse, underuse

Health care delivery organizations around the world are focusing considerable attention on the definition and use of clinical quality indicators to identify health care improvement opportunities, to measure the efficacy of specific interventions, and to provide a quantitative link between quality of care and cost effectiveness. In many countries, including the United States [1,2], efforts are underway to develop a national health care report card, although this remains elusive for the near future given the evolutionary state of scientific evidence about the effectiveness of health care interventions and the practicability of specific clinical indicators. Despite this absence of imminent authoritative standards, there is nonetheless an opportunity for public and private health care delivery organizations to align their own clinical quality indicator development efforts with anticipated national directions.

The Baylor Health Care System (BHCS) is a large, US, integrated health care delivery system with a recent but strong commitment to using clinical indicators as powerful tools in the implementation of its organizational strategy. As more and more health care delivery systems embrace the value of clinical indicators in improving their quality of patient care, the BHCS experience in building its own program serves as an instructive case study. Health care organizations around the world—rural or urban—of all sizes and affiliations, in any political economy, and using any business model, face organizational, clinical, and professional barriers to implementing clinical quality indicator tools, as did BHCS. As such, it is useful to explore the BHCS process in addressing its constraints as much as how it used clinical indicators—in this case those associated with medication quality—to achieve its strategic goals.

Address reprint requests to David J. Ballard, Senior Vice President, Health Care Research and Improvement, Baylor Health Care System, 8080 N. Central Expressway, Suite 1050, LB 81, Dallas, TX 75206, USA. E-mail: dj.ballard@baylorhealth.edu

This material was presented, in part, at the ISQua Quality of Care Indicators Workshop, 1–2 October 2001, Buenos Aires, Argentina.

IoM Önerileri

- Daha güvenli,
- Daha etkili,
- Hasta-odaklı,
- Zamanında,
- Verimli, ve
- Eşit.

Prof. Dr. H. Erdal Akalın

Table 1 Clinical preventive services indicators of areas of focus for improvement aligned with the US Clinical Preventive Services Task Force recommendations, June 2003 [Baylor Health Care System (BHCS), Dallas-Fort Worth, TX]

Clinical preventive services Measures (HTPN)	BHCS current performance	Goal ¹	Greenlight status (comment reflects change from previous period)
Overall performance	80%	82.1%	Improved
Colorectal cancer screening	69%	80.8%	Worse
Cervical cancer screening	81%	88.1%	Improved
Breast cancer screening	68%	82.8%	Worse
Hypertension screening	99%	100%	Improved
Cholesterol screening	88%	91.5%	Improved
Diphtheria-tetanus done/recommended	56%	63.3%	Improved
Pneumococcal immunization done/recommended	77%	87.5%	Worse
Influenza immunization done/recommended	69%	74.8%	Worse
Tobacco use screening	93%	97.7%	Improved
Tobacco use counseling	68%	84.6%	Improved

HTPN, Health Texas Provider Network.

¹Defined as the physician-level 75th percentile performance of HTPN for the previous fiscal year, 1 July 2001 to 30 June 2002, for each measure.

This table can be viewed in colour as Supplementary data at *IJQHC* Online.

Table 3 Executive summary of the process of care measures for acute myocardial infarction, March 2003 [Baylor Health Care System (BHCS), Dallas-Fort Worth, TX]

Clinical preventive services measures (HTPN)	BHCS current performance	Goal ¹	Greenlight status (comment reflects change from prior period)
AMI			
Early aspirin use	98%	90%	Improved
Aspirin at discharge	96%	90%	Improved
Early beta-blocker use	85%	90%	Improved
Beta-blocker at discharge	90%	90%	Improved
Thrombolytics within 30 minutes of arrival	35%	80%	Worse
Median time for thrombolytic administration	39.5 min	TBD	Worse
PTCA within 90 minutes of arrival	42%	80%	Improved
Median time for angioplasty administration	101 min	TBD	Improved
ACEI use for LVEF	84%	90%	Improved
Smoking cessation counseling	94%	90%	Improved
In-patient mortality	5.5%	TBD	Improved

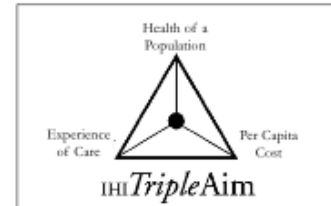
ACEI, angiotensin converting enzyme (ACE) inhibitor; LVEF, left ventricular ejection fraction; PTCA, percutaneous transluminal coronary angioplasty; TBD, to be determined.

¹Goals set by the VHA Inc. Chief Executive Officer Workgroup on Clinical Excellence.

This table can be viewed in color as Supplementary data at [JGIM Online](http://jgim.oxfordjournals.org/).

“Mayo Clinic” Pnömoni Kalite İndikatörleri

- Standards of care for inpatient pneumonia
 - Percent of patients cared for in an ICU who had blood culture testing performed within 24 hours of hospital arrival
 - Percent of patients whose blood culture testing was performed before the first antibiotic was given while in the care of the Emergency Department
 - Percent of patients given appropriate selection of antibiotics for pneumonia
- Explanation of this care
 - Blood culture testing can yield useful clinical information for treatment options and is recommended for pneumonia patients ill enough to be treated in an ICU.
 - Obtaining blood culture tests for bacteria before administering the first antibiotic can yield more useful clinical information for treatment options.
 - Selecting the most appropriate antibiotics has been shown to improve patient outcomes.



Innovation Series 2012

A Guide to Measuring the Triple Aim:

Population Health, Experience of Care,
and Per Capita Cost



Perspective

Launching Accountable Care Organizations — The Proposed Rule for the Medicare Shared Savings Program

Donald M. Berwick, M.D., M.P.P.

A common criticism of U.S. health care is the fragmented nature of its payment and delivery systems. Because in many settings no single group of participants — physicians, hospitals, public or

private payers, or employers — takes full responsibility for guiding the health of a patient or community, care is distributed across many sites, and integration among them may be deficient. Fragmentation leads to waste and duplication — and unnecessarily high costs.

Section 3022 of the Affordable Care Act (ACA) establishes the Medicare Shared Savings Program for accountable care organizations (ACOs) as a potential solution.¹ The creation of ACOs is one of the first delivery-reform initiatives that will be implemented under the ACA. Its purpose is to foster change in patient care

so as to accelerate progress toward a three-part aim: better care for individuals, better health for populations, and slower growth in costs through improvements in care. Under the law, an ACO will assume responsibility for the care of a clearly defined population of Medicare beneficiaries attributed to it on the basis of their patterns of use of primary care. If an ACO succeeds in both delivering high-quality care and reducing the cost of that care to a level below what would otherwise have been expected, it will share in the Medicare savings it achieves.

On March 31, 2011, the De-

partment of Health and Human Services took a major step toward establishing ACOs by issuing a notice of proposed rule-making that will define how physicians, hospitals, and other key constituents can adopt this new organizational form. The issuing of the proposed rule follows months of obtaining informal and formal input from throughout the health care delivery system, but at this point the rule is only a proposal. The Centers for Medicare and Medicaid Services (CMS) will carefully review the comments we receive in response to the proposed rule before issuing a final rule later this year.

A critical foundation of the proposed rule is its unwavering focus on patients. We envision that successful ACOs will honor individual preferences and will

Aim: improved care

Patient and caregiver experience

- Getting timely care, appointments, and information
- How well your doctors communicate
- Helpful, courteous, respectful office staff
- Patients' ratings of doctor
- Health promotion and education
- Shared decision making
- Health status or functional status

Care coordination — transitions

- Risk-standardized, all-condition readmission
- 30-Day post-discharge physician visit
- Medication reconciliation
- Care transitions measure
- Management of ambulatory-sensitive conditions: diabetes; chronic obstructive pulmonary disease (COPD); congestive heart failure (CHF); dehydration; bacterial pneumonia; urinary tract infections (UTIs)
- % of all physicians meeting HITECH meaningful use requirements

Care coordination — information systems

- % of PCPs meeting HITECH meaningful use requirements
- % of PCPs using clinical decision support
- % of PCPs meeting eRx incentive program requirements
- Patient registry use

Patient safety

- Health care–acquired conditions composite (includes foreign object retained after surgery, central-line–associated bloodstream infections [CLABSI], falls and trauma, catheter associated UTI, and others)
- CLABSI bundle use

Aim: improved health

Preventive health

- Influenza immunization
- Pneumococcal vaccination
- Mammography screening
- Colorectal cancer screening
- Cholesterol management for patients with cardiovascular conditions
- Adult weight screening and follow-up
- Blood-pressure measurement
- Tobacco-use assessment and intervention
- Depression screening

At-risk population — diabetes

- Composite and individual measures (glycated hemoglobin, LDL cholesterol <100 mg/dl, blood pressure <140/90 mm Hg, tobacco nonuse, aspirin use)
- Poor glycemic control (glycated hemoglobin >9%)
- Blood pressure control in diabetes
- Screening rates for microalbuminuria
- Dilated eye exam; foot exam

At-risk population — heart failure

- Left ventricular function assessment
- Left ventricular function testing
- Weight measurement
- Patient education
- Heart failure prescription rates for left ventricular systolic dysfunction (LVSD)
- Angiotensin-converting–enzyme inhibitor or angiotensin-receptor blocker (ACE/ARB) rates for LVSD
- Warfarin therapy for patients with atrial fibrillation

At-risk population — coronary artery disease

- Coronary artery disease (CAD) composite and individual measures (oral antiplatelet therapy for patients with CAD; drug therapy for lowering LDL cholesterol; beta-blocker for patients with CAD with prior myocardial infarction; LDL cholesterol <100 mg/dl; ACE/ARB therapy for patients with CAD and diabetes, LVSD, or all of the above)

At-risk population — hypertension

- Blood-pressure control rates (<140/90 mm Hg)
- Hypertension plan of care

At-risk population — COPD

- Spirometry evaluation
- Smoking-cessation counseling
- Bronchodilator therapy based on FEV₁

At-risk population — frail elderly

- Screening for fall risk
- Osteoporosis management in women who had a prior fracture
- Monthly INR for beneficiaries on warfarin

Evidence:

How do you get clinicians involved in quality improvement?

An evaluation of the Health Foundation's Engaging with Quality Initiative – a programme of work to support clinicians to drive forward quality

August 2010



How do you get clinicians involved in quality improvement?

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Engaging with Quality Initiative
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drive forward quality

Final report

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Identify Innovate Demonstrate Encourage



EUROPE



Öneriler

- Çok hızlı davranıp, kalite iyileştirme konusunda özel ve öncelikli bir aksiyon başlatılmalı, (takım ve liderlik gerekiyor).
- Değişimin gerekliliğini iyi anlatıp, tüm kaynakları kullanmalı, (klinisyen, eğitici, yönetici birlikte).
- Değişimin sürekliliğini sağlamalı, sağlık sistemini değişime paralel hale getirmeli, (kısa ve çabuk kazanılacak bir zafer olmadığı vurgulanmalı).
- Kalite iyileştirme desteklenmeli: sağlık kurumlarınca, tüm profesyonel kurumlarca, eğitim veren kurumlarca, (eğitim, eğitim, eğitim).
- Öğrenme becerisi güçlendirilmeli, (yetişkinlerin hem değişim isteği, hem yeni bir şey öğrenme isteği, hem de öğrenme kapasiteleri kısıtlıdır!).

The Opportunities and Challenges of a Lifelong Health System-Editorial, NEJM

- The main challenge to creating a lifelong health system lies in moving from a fee-for-service model to paying for value and better outcomes.
- Innovation in care delivery, integration of services, and development or adaptation of new fiscal tools can all contribute to strategies for improving health.

N Halfon and PH Conway, NEJM 2013; 368 (April 25):1569-1571.



TEŞEKKÜR EDERİM....

Erdal Akalın



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