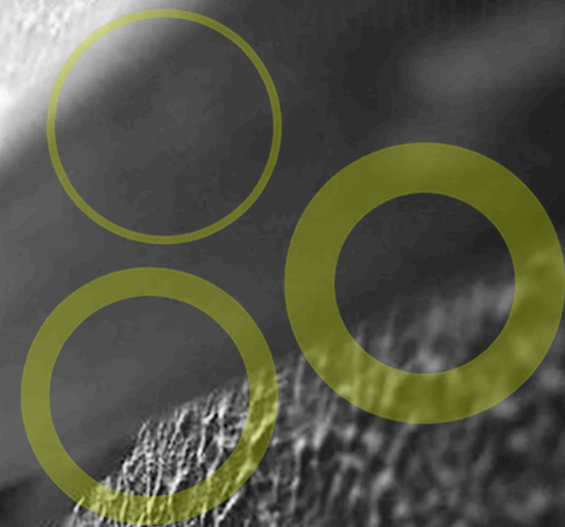




rkkp

regionernes kliniske kvalitetsudviklingsprogram



Sekundær anvendelse af sundhedsdata til kvalitetssikring

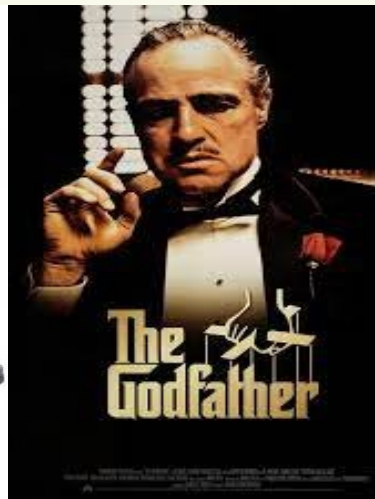
Direktør Jens Winther Jensen, MPH

Odense 12. oktober 2021

Regionernes Kliniske **KVALITET**sudviklingsprogram

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge

<https://www.who.int/news-room/fact-sheets/detail/quality-health-services>



KVALITET		Patientoplevel	Sundhedsfaglig	Organisatorisk
			Effektivt Yde evidensbaseret behandling til dem der har brug for det	
			Patientsikkert Forhindre at patienterne påføres skade som følge af sundhedsvæsenets indsats	
			Patientcentreret Beslutninger i forløbet afspejler patientens værdier og præferencer og forløbet er organiseret med afsæt i patientens behov	
			Rettidig Uden fagligt begrundet ventetid og skadelige forsinkelser	
			Lige og retfærdigt Samme behandlingskvalitet uanset alder, køn, etnicitet, geografi, religion, socioøkonomi, sprog og politisk overbevisning	
			Omkostningseffektivt Højst mulig værdi for patienten for givne ressourcer – undgå spild	
			Integreret Sammenhængende forløb koordineret på tværs af sektorer, behandlere og i hele patientens livscyklus	

<https://www.who.int/news-room/fact-sheets/detail/quality-health-services>

RKKP: strategi 2020-2023

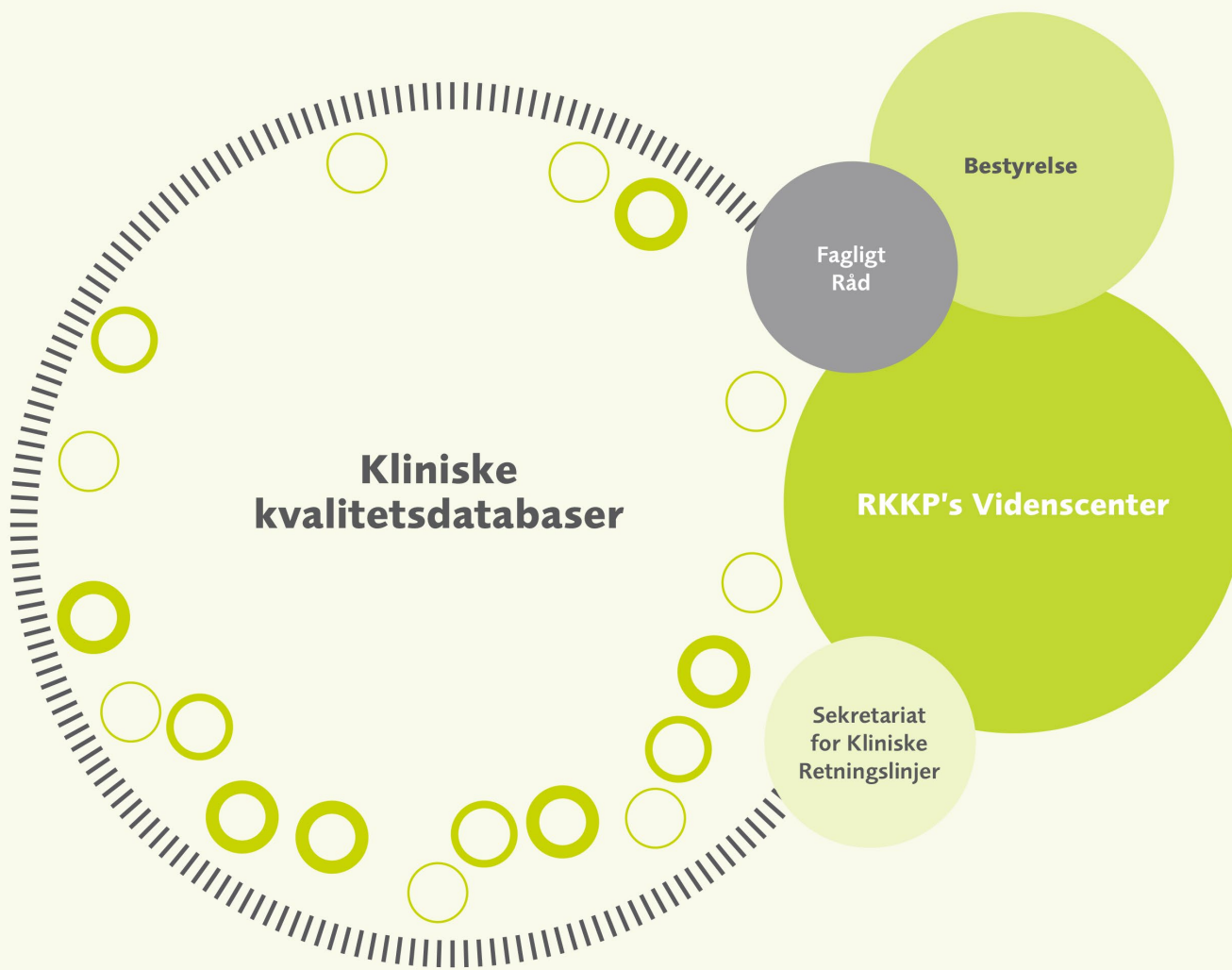


Fokusområder:

- Tidstrohed og aktualitet
- Fjerne dobbeltregistrering
- PRO og nye dataklider

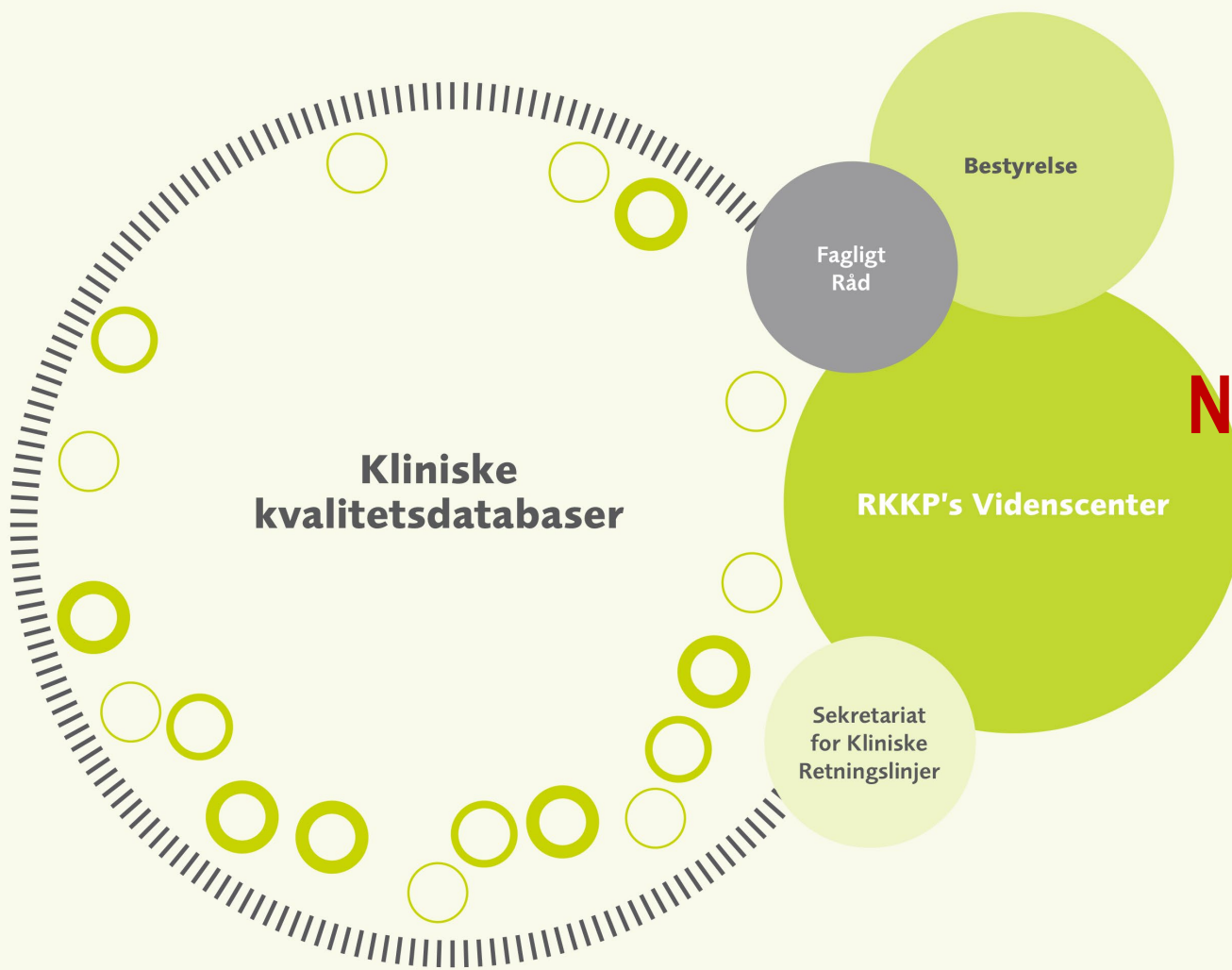


RKKP - karakteristika



Klinisk forankring/førende eksperter
Ambition om excellent behandling
Gentagne målinger over tid

RKKP - karakteristika



Klinisk forankring/førende eksperter
Ambition om excellent behandling
Gentagne målinger over tid
National konsensus og monitorering



Klinisk
forankring



Analyse
kompetence

Kliniske Kvalitetsdatabaser

som opgør målbare indikatorer, der med udgangspunkt i det enkelte patientforløb belyser kvalitet af sundhedsvæsens indsats og resultater for en afgrænset gruppe af patienter



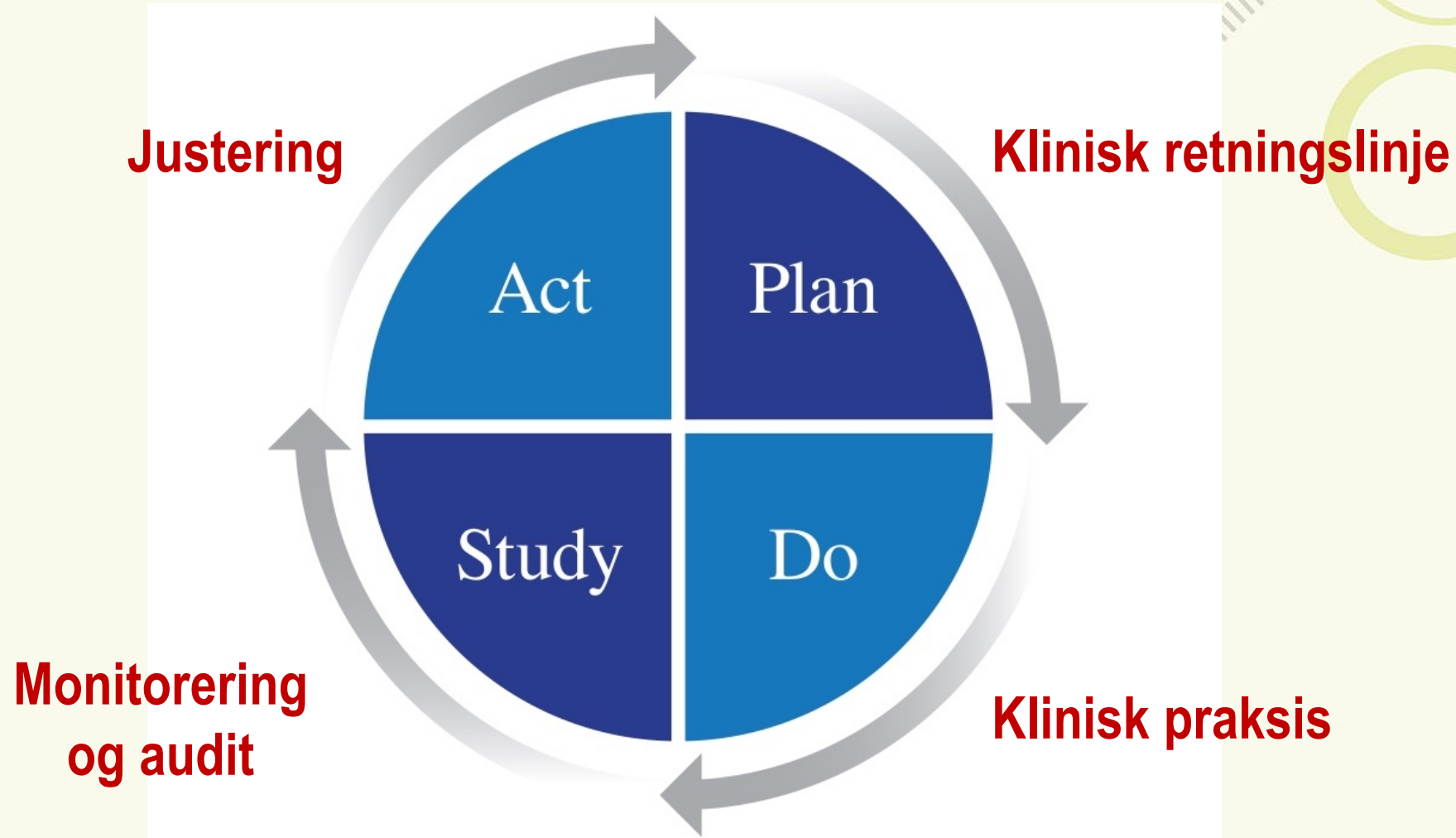
og kliniske retningslinjer

systematisk udarbejdede udsagn (anbefalinger), der kan bruges som beslutningsstøtte af fagpersoner, når de skal træffe beslutning om passende og korrekt sundhedsfaglig ydelse i specifikke kliniske situationer



Evidensbaseret medicin

Kvalitetsudvikling



Databasernes ramme

Sundhedslovens §196

Sundhedsdatastyrelsen godkender databaserne

Rapporteringspligt

Dataindsamling uden patientsamtykke

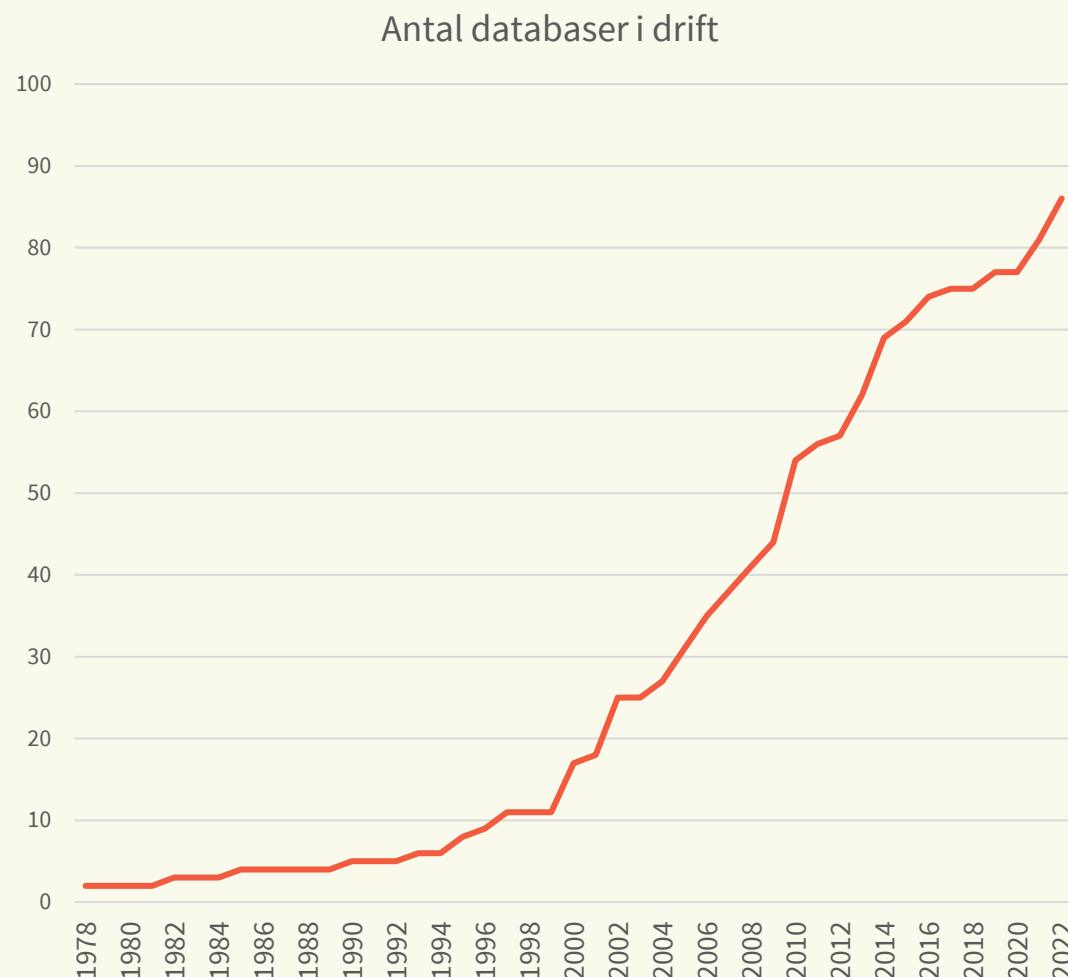
Anvendelse: indikatorbaseret kvalitetsudvikling

Vejledning vedr. Kliniske Kvalitetsdatabaser

BEK om godkendelse af landsdækkende
og regionale databaser

BEK om indberetning til godkendte kliniske
kvalitetsdatabaser og videregivelse til SDS

Status – 85 Kliniske Kvalitets Databaser



- Bedst dækket: cancer; hjerte-kar & gynækologi/obstetrik
- Men også kroniske og psykiatriske
- meget smalle: et indgreb/en tilstand (ablation) – meget brede: akutte hospitalskontakter
- Nogle monofaglige andre tværdisciplinærer/-faglige
- Få der dækker tværsektorielt

<https://sundhedsdatastyrelsen.dk/da/registre-og-services/om-de-kliniske-kvalitetsdatabaser>

Databasens styregruppe

- National
- Sammensætning : repræsentanter fra faglige selskaber (spredning på sektor, geografi, hospitalsstørrelse) + patienter + evt. ledelse + RKKP team
- Opfyldelse af formål, herunder:
 - Definere god kvalitet på området
 - Beslutte hvordan kvaliteten måles og opgøres: databasens indicatorsæt
 - Analysere indkomne data løbende
 - Evaluere kvaliteten og indsatsen på området
 - Anbefale forbedringsindsatser (DK, region, afdeling, kommune/klynge)
 - Understøtte vidensformidling, inkl. faglig dialog

Formål og målgruppe

Hvorfor måler vi?

Hvem måler vi til/for?

- Evaluering og kvalitetsudvikling (klinikere og kliniske ledelser)
- Overvågning og synliggørelse (ledelser, patienter og borgere)
- Ny viden: forskning og sekundær anvendelse (klinikere, forskere)

Sæt mål

Standard (kvalitetsmål, grænseværdi, tærskelværdi, referenceværdi)

- Et mål der beskriver et ønsket niveau og muliggør vurdering
- Minimumsstandard eller (realistisk) udviklingsstandard?

Eksempel

Andel af alle primær Total Hofte Alloplastik operationer, som ikke er revideret uanset årsag indenfor 5 år efter operationsdato $\geq 95\%$

God behandling (værdinorm)

- På hvilket grundlag defineres standarden?
 - evidens/viden, f.eks. retningslinjer eller 'dokumentalistrapporter'
 - ekspertkonsensus
 - politik/værdier

Sundhedsdatastyrelsens minimumskrav #10:
Databasens indikatorer skal belyse relevante kliniske retningslinjer inden for databasens kliniske anvendelsesområde

(§ 5, stk. 1)

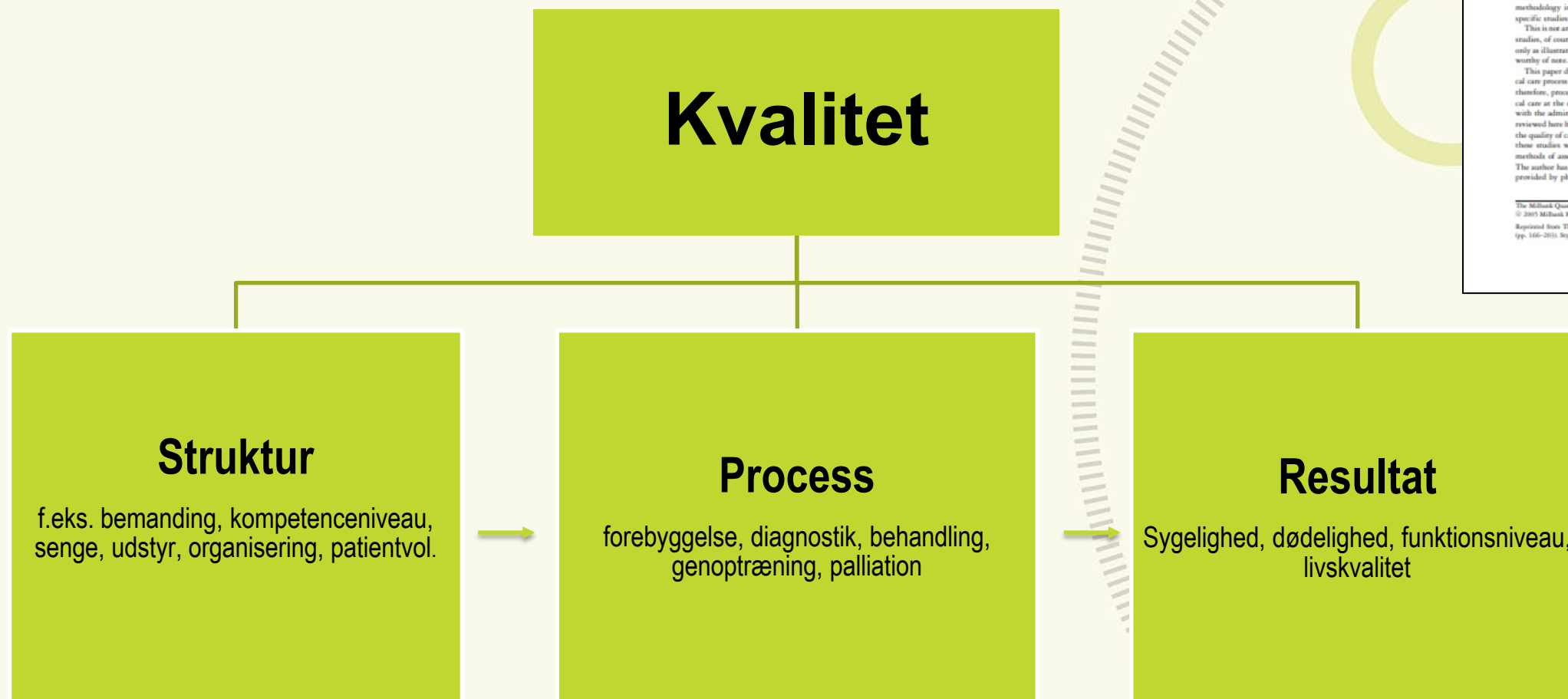
Etabler måling

- Indikator: målbar variabel som anvendes til at overvåge og vurdere kvalitet ('Er standarden opfyldt?')
- Kvantificerer og simplificerer information om komplekse fænomener
- Typer
 - Struktur
 - Proces
 - Resultat (outcome, effektmål)
 - Evt. balancerende/ulempe
- Format
 - Antal
 - Andel
 - Måling

Tabel 6.1 Indikatoroversigt

Indikator nummer	ID-nr der henfører til dokumentationsskabelon	Indikatorer	Standard	Format
1	DHR_43_001	Komplethedsgraden af indberetninger 1A: Andel af primær total hoftealloplastik (THA) operationer som indberettes til DHR.	≥95 %	Andel
	DHR_44_001	1B: Andel af total hoftealloplastik revisioner som indberettes til DHR.		
3	DHR_34_002	Genindlæggelse 3A. Andel af patienter, der genindlægges uanset årsag indenfor 30 dage efter primær THA operation.	≤10 %	Andel
	DHR_35_002	3B. Andel af patienter, der genindlægges uanset årsag indenfor 30 dage efter primær THA operation med grundlidelse primær artrose.	≤9 %	
	DHR_36_002	3C. Andel af patienter, der genindlægges uanset årsag indenfor 30 dage efter primær THA operation med grundlidelse frisk eller følger efter proksimal femurfraktur.	≤18 %	

Donabedian's model



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, those studies will be discussed only in terms of their contribution to methods of assessment and not in terms of their broader social goals. The author has remained, by and large, in the familiar territory of care provided by physicians and has avoided incursions into other types of

The Milbank Quarterly, Vol. 43, No. 4, 2005 (pp. 691-729)
© 2005 Milbank Memorial Fund. Published by Blackwell Publishing.
Reprinted from The Milbank Memorial Fund Quarterly, Vol. 44, No. 3, Pt. 2, 1966
(pp. 166-203). Style and usage are unchanged.

691

Modified from *JAMA*. 1988;260:1743-8)

Analyse og fortolkning

The patient

- Demographic factors (age, sex, height)
- Lifestyle factors (smoking, alcohol use, weight, diet, physical exercise)
- Psychosocial factors (social status, education)
- Compliance

+

The illness

- Severity, prognosis
- Comorbidity

+

The treatment (prevention, diagnostics, care, rehabilitation, therapy and control)

- Competence
- Technical equipment
- Evidence based clinical practice
- Efficacy, accuracy

+

The organization

- Use of clinical guidelines
- Cooperation
- Delay

= **OUTCOME**



Klinisk
forankring

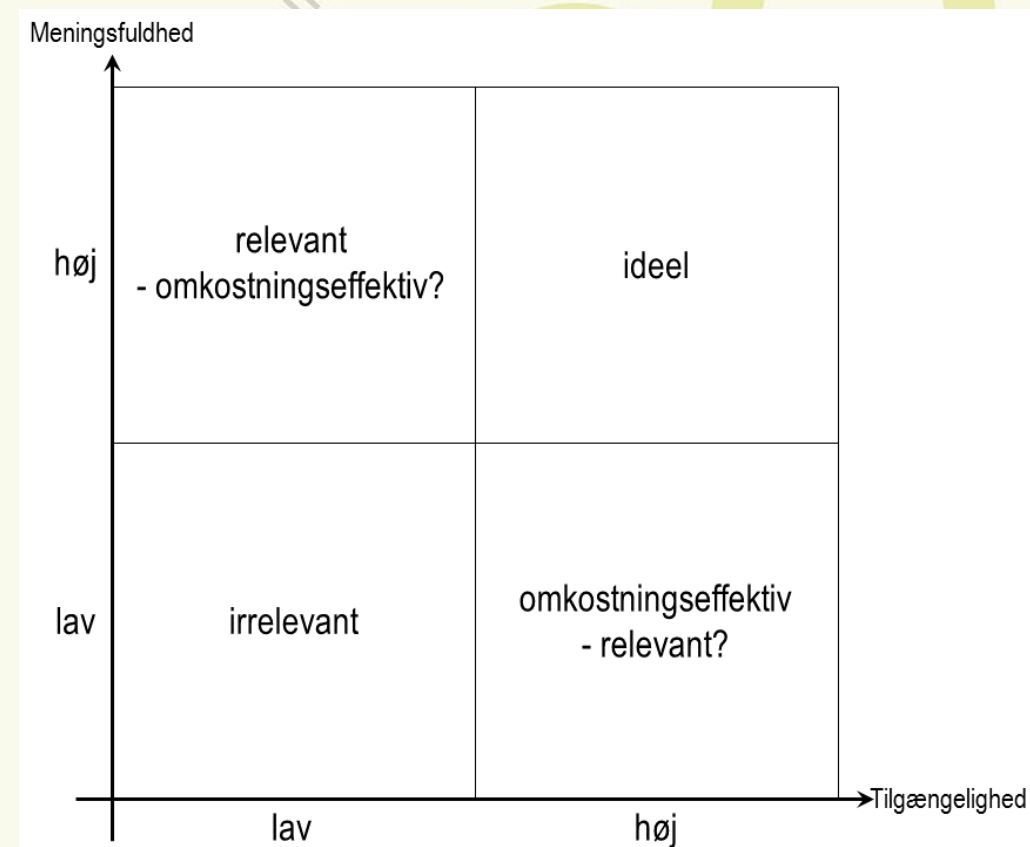


Analyse
kompetence

Mainz J. *International Journal for Quality in Health Care* 2003; Volume 15, Number 6: pp. 523–530

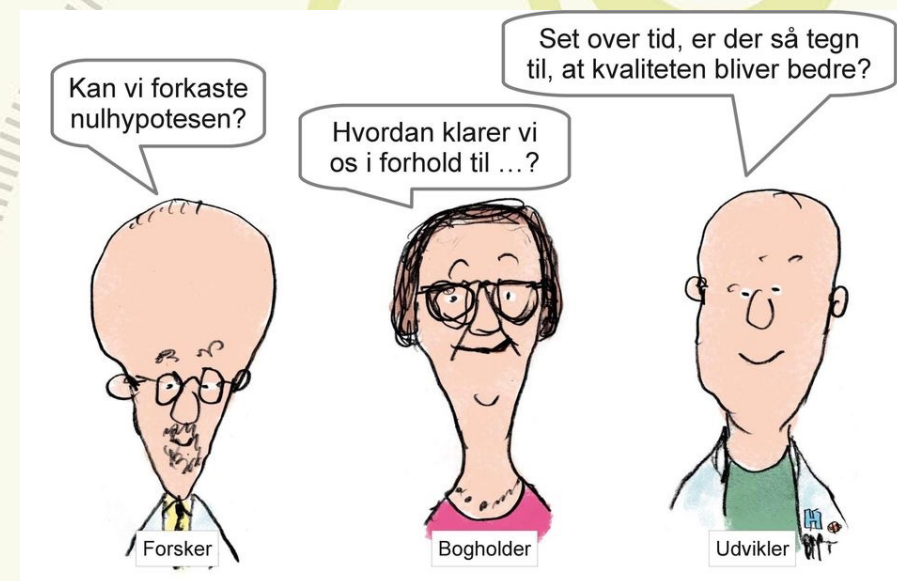
Indikator idealet

- Klinisk meningsfulde
- Relevante for patienterne
- Veldefinerede og velbeskrevne
- Målelige/operationelle
- Høj specificitet og sensitivitet
- Valide og pålidelige
- God skelneevne
- Omkostningseffektive



Bartels P et al. *Monitorering. Kræftens Bekæmpelse* 2012.

Analyse og vurdering: RKKP output

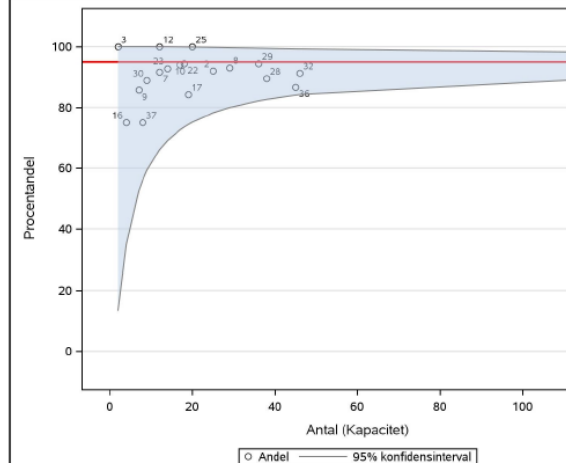


Brugere af RKKP viden



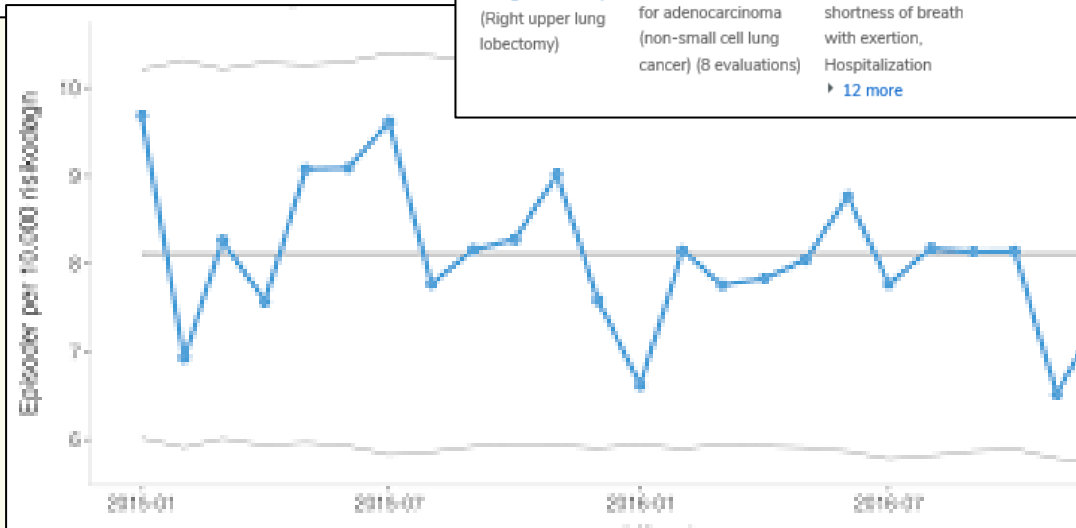
Data – information – viden

Indikator 5: Endoskopisk hæmostatisk kombinationsbehandling. Funnelploj på afdelingsniveau



Compare treatments taken by people with lung cancer

Treatment name(s)	Perceived effectiveness	Side effects	Total evaluations	Tried for
Chemotherapy				
for adenocarcinoma (non-small cell lung cancer) (28 evaluations)		nausea, fatigue ▶ 54 more	59	adenocarcinoma (non-small cell lung cancer) (47), non-small cell lung cancer (26), 12 more
Radiation Therapy (Total Skin Electron Beam Therapy (TSEBT))				
for adenocarcinoma (non-small cell lung cancer) (11 evaluations)		fatigue, swallowing difficulty (dysphagia) ▶ 26 more	28	adenocarcinoma (non-small cell lung cancer) (27), non-small cell lung cancer (13), 7 more
Lung lobectomy (Right upper lung lobectomy)				
for adenocarcinoma (non-small cell lung cancer) (8 evaluations)		shortness of breath with exertion, Hospitalization ▶ 12 more	15	adenocarcinoma (non-small cell lung cancer) (19), non-small cell lung cancer (6), 6 more



Inpatient Volume and Quality of Mental Health Care Among Patients With Unipolar Depression

Line Ryberg Rasmussen, R.N., M.H.Sc., Jan Mainz, M.D., Ph.D., Mette Jørgensen, Ph.D., Poul Videbech, M.D., Ph.D., Søren Paaske Johnsen, M.D., Ph.D.

Objective: The relationship between inpatient volume and the quality of mental health care remains unclear. This study examined the association between inpatient volume in psychiatric hospital wards and quality of mental health care among patients with depression admitted to wards in Denmark.

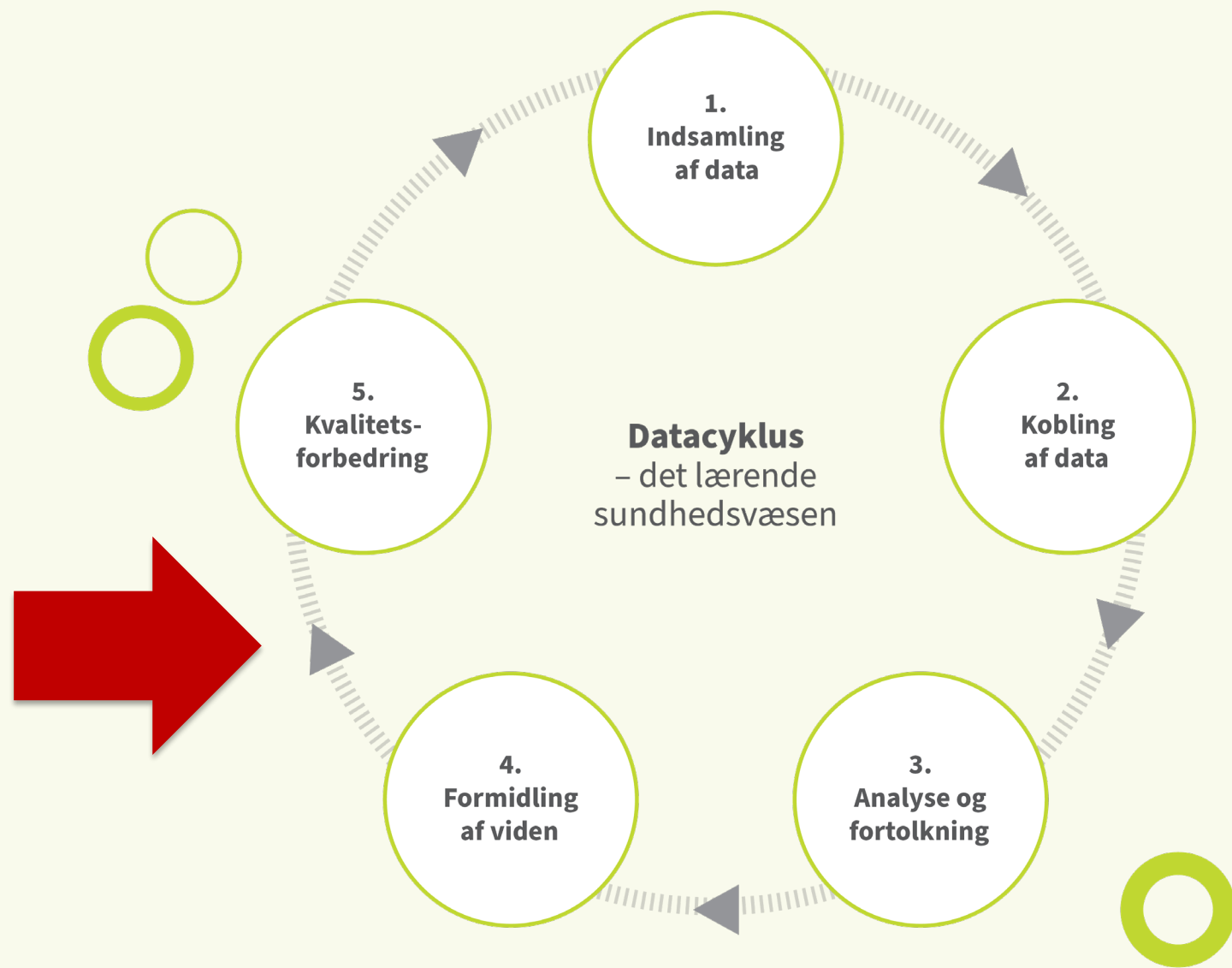
Methods: In a nationwide, population-based cohort study, 17,971 patients (N=21,120 admissions) admitted to psychiatric hospital wards between 2011 and 2016 were identified from the Danish Depression Database. Inpatient volume was categorized into quartiles according to the individual ward's

measures reflecting national clinical guidelines for care of depression.

Results: Compared with patients admitted to low-volume psychiatric hospital wards, patients admitted to very-high-volume wards were more likely to receive a high overall quality of mental health care ($\geq 80\%$ of the recommended process performance measures) (adjusted relative risk [ARR]=1.78, 95% confidence interval [CI]=1.02–3.09) as well as individual processes of care, including a somatic examination (ARR=1.35, CI=1.03–1.78).

	HELE LANDET	NORDJYLLAND	MIDTJYLLAND	SYDDANMARK	HOVEDSTADEN	SJÆLLAND
pct. 1 ²	11,6	10,8	11,9	11,1	12,0	12,3
pct. 3	22,3	15,4	23,2	22,1	23,7	19,9
pct. 4	12	13	13	13	13	10
pct. 2 ⁵	3,6	1,7	2,1	2,3	6,4	3,2
pct. 3	4,1	3,8	4,8	1,6	4,9	5,2
2016, pct. 7	16,4	20,5	18,7	14,7	13,1	18,2
2016, pct. 8	80,9	77,7	79,4	79,6	83,2	81,0
2016, pct. 9	47,4	45,3	45,0	48,9	47,8	48,2
Tilknytning til uddannelse for unge med psykiske lidelser (under udvikling – mulig sammenkobling med arbejdsmarkedsindikatoren undersøges)	–	–	–	–	–	–
Akutte indlæggelser pr. 1.000 KOL-patient, antal 2 ⁸	547,2	469,0	531,8	450,6	641,6	595,4
Akutte indlæggelser pr. 1.000 diabetes type 2-patient, antal 2 ⁸	356,7	301,4	355,7	291,4	410,5	390,0
Forebyggelige indlæggelser pr. 1.000 ældre (65+), antal 2 ⁸	59,0	50,8	54,5	48,4	71,3	64,7
Overbelægning på medicinske afdelinger på de offentlige sygehuse, pct. 9	0,59	0,83	0,78	0,49	0,41	0,68
Andel borgere med demens, som har købt antipsykotika, pct.	19,2	14,5	19,4	19,0	22,1	16,1
5-års overlevelse efter kræft (2014-2016), pct. 10	63	62	63	64	65	61
Hjertedødelighed (2016), dødsfald pr. 100.000 borgere	126	126	123	122	130	131
Overdødelighed blandt borgere med psykiske lidelse (under udvikling)	–	–	–	–	–	–
Sygehus erhvervede infektioner – bakterier antal pr. 10.000 risikodage 2	8,2	6,7	6,7	9,8	8,8	8,0
Sygehus erhvervede infektioner – clostridium difficile, antal pr. 100.000 borgere	59	49	48	53	70	67
Andel af patienter som overlever mindst 30 dage efter hjertestop, pct. 11	27	28	35	26	25	23
Indløste recepter på antibiotika i almen praksis (under udvikling)	–	–	–	–	–	–

Fra viden til forbedring



‘Actionability’

**OPEN ACCESS**

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

Erica Barbazza , Niek S Klazinga , Dionne S Kringos 

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

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BMJ Barbazza E, et al. *BMJ Qual Saf* 2021;0:1–11. doi:10.1136/bmjqp-2020-011247  1

ORIGINAL RESEARCH

ABSTRACT

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

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

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

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

INTRODUCTION

Healthcare performance measurement, and its use as performance intelligence,

plays an important role in guiding the decisions of healthcare system actors with respect to quality of care.¹ Since the early 2000s, the importance of performance measurement in healthcare,² its institutionalisation as standard practice within³ and across healthcare systems,^{4–6} and more recently its professionalisation⁷ has received widespread prioritisation. This attention has increased scientific rigour around criteria for selecting indicators (eg, reliability, validity),^{8–9} development of indicator sets (eg, parsimony, epidemiological relevance),¹⁰ and methods, tools and approaches to guide these processes.^{11–13}

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

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

Konklusion

“Striking a better balance between the importance weighted to an indicator’s statistical merits and emphasis put to an indicator’s fitness for purpose and use is needed for indicators that are actionable for quality of care-related decision-making”

Viden til et bedre sundhedsvæsen

23

www.rkkp.dk

Vælg ændring

Klare anbefalinger med 'adresse': *hvem bør gøre hvad?*

- myndigheder
- regioner
- hospitaler
- afdelinger
- faglige miljøer
- andre?



Den gode indikator



...og det gode indikatorsæt

Dansk Apopleksiregister



Stræk

Hænger den ene arm?

Ring straks 1-1-2, hvis du selv eller en i din nærhed pludselig oplever nedsat eller manglende kraft i en arm eller et ben.



Snak

Hænger ordene ikke sammen?

Ring straks 1-1-2, hvis du selv eller en i din nærhed pludselig har usammenhængende sprog, begynder at vrøvle eller ikke kan finde ordene.



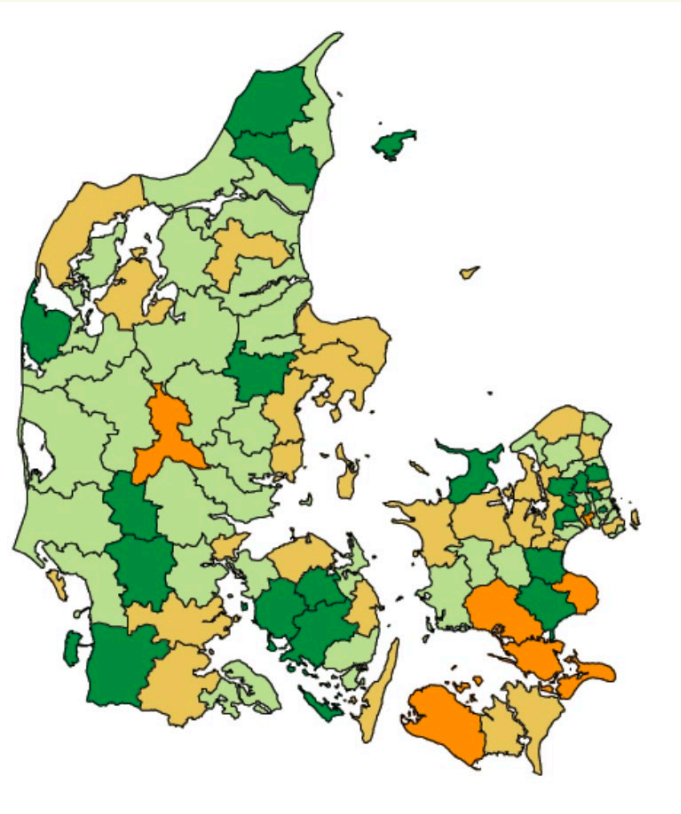
Smil

Hænger den ene mundvig?

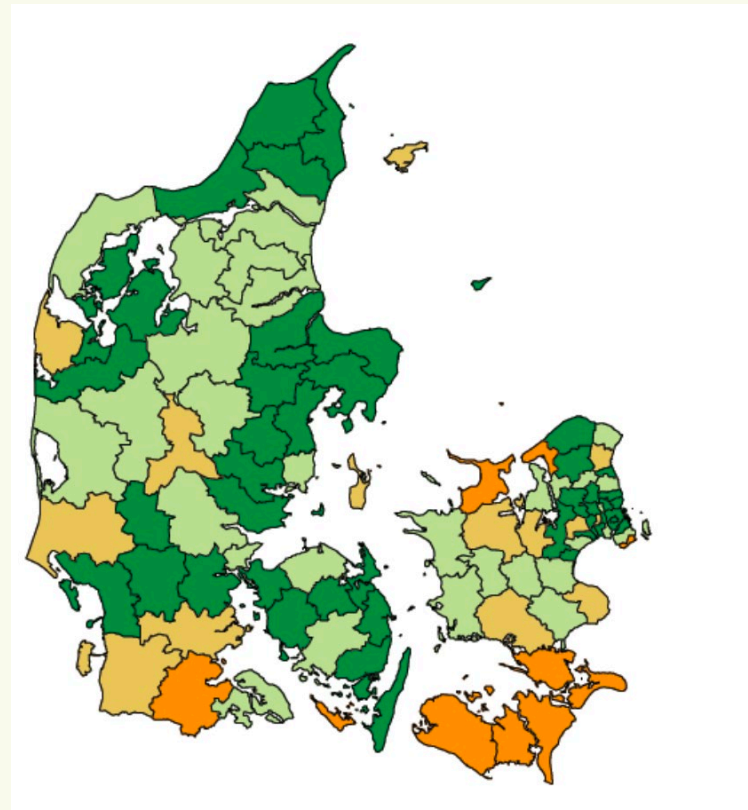
Ring straks 1-1-2, hvis du selv eller en i din nærhed pludselig er svar i den ene side af ansigtet eller virker asymmetrisk i ansigtet.

Indikator 1: Andel af patienter med akut iskæmisk apopleksi der modtager revaskulariserende behandling

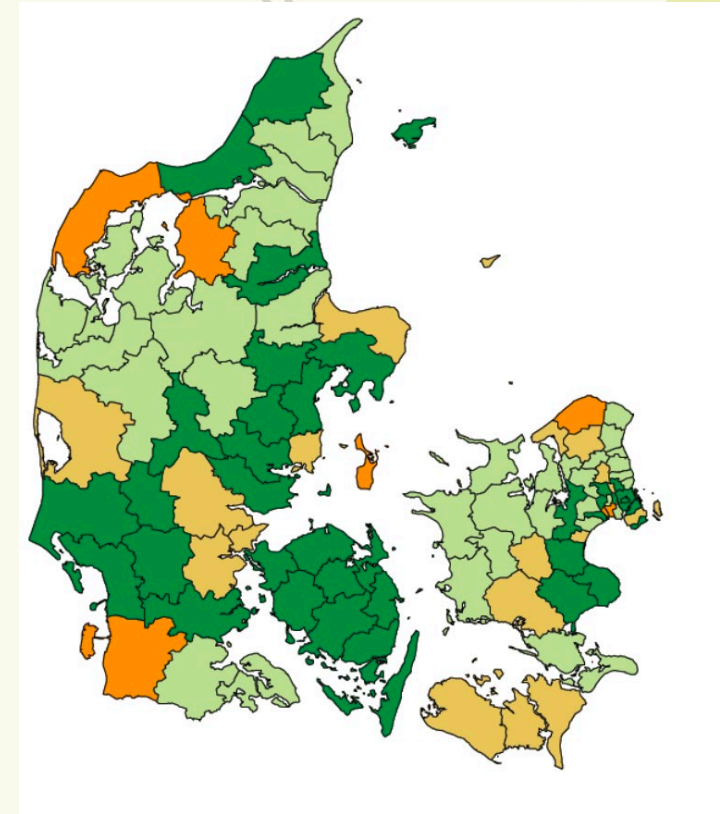
2018



2019



2020



Andel  25%+  [20%;25%)  [15%;20%)  [0%;15%)

Dansk Apopleksiregister
Årsrapport 2020
Juni 2021

Neurologi/Apopleksi casen



- Klar og forståelig målsætning – ”mindre lammelse”
- Faglig retning
- Ny behandling
- Prestige i specialet og udvikling til akutspeciale
- Fælles data
- Borgerkampagne
- Langt sejt træk

Kvalitetsdatabaser



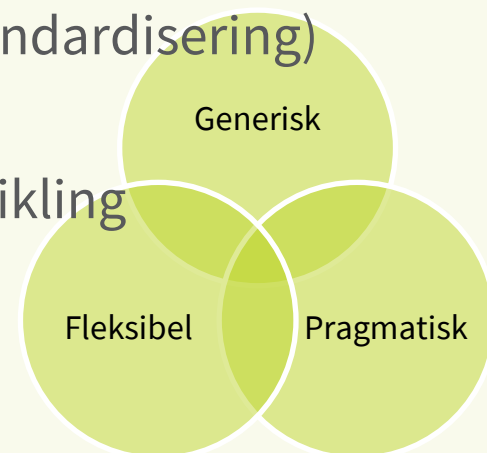
RKKP datamodel

Én fælles datamodel: Hvad er udfordringen?

- 80 siloopdelte kliniske kvalitetsdatabaser med knap 20 tusinde variable
- Udfaldsrum er ofte databasespecifikke for variabler med samme betydning
- Ikke optimal anvendelse af nationale klassifikationer
- *Skal kunne rumme nuværende dataindhold samt være forberedt til fremtidig klinisk standardisering af dataindhold*

Målsætning: at opnå

- Ensartede datastrukturer for samme begreb, fx diagnose (teknisk standardisering)
- Transparens på tværs af kliniske kvalitetsdatabaser
- Samstilling af data til formidling og analyseformål mhp. kvalitetsudvikling
- Dokumentation ved anvendelse af artefakter for datamodeller (Digitaliseringsstyrelsens modelleringsanbefalinger)



class RKKPs begrebsmodel



Visioner for sundhedsdata

- Stort behov for **fælles nationale initiativer**
 - Ingen part i DK har data nok
- **Agilitet** - løbende brug for nye data
 - DK har meget gode eksisterende data, men de er ofte utilstrækkelige
- **Registreringsbyrden** skal mindskes og **validitet** af data sikres
 - Der mangler grundlæggende IT arbejde som f.eks. fælles datamodel



SIKRING AF KRITISK INFRASTRUKTUR

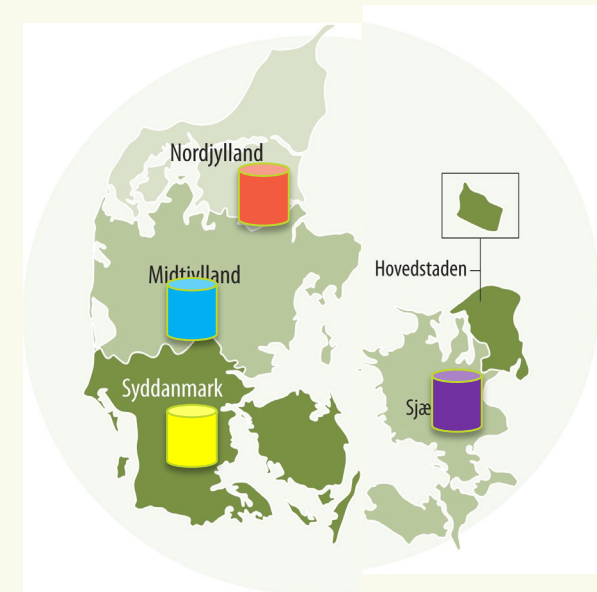
- **Banedanmark som eksempel (styrelse under Transportministeriet)**
- Skaber forudsætningen for, at hundredtusindvis af danskere hver dag kan tage toget, og at mange tusind tons gods kan transporteres på jernbanen.



Efter Martin Bøgsted

SIKRING AF KRITISK INFRASTRUKTUR

- **Sundhedsdatadanmark**
- Skaber forudsætning for, at hundredtusindvis af danskere hver dag kan få den bedste evidens/data-baserede behandling



Efter Martin Bøgsted

Centrale spørgsmål

- Er den nuværende **data infrastruktur** et problem for Danmark?
- Har vi brug for fundamental **nytænkning** på dataområdet?
- Hvad skal **løsningen** bestå af?
- Hvordan kommer vi **videre**?

Efter Martin Bøgsted

STOP