

Quality based Governance

LEVERAGING VALUABLE INFORMATION
TO IMPROVE HEALTH CARE



Introduction

For an Executive Board, it is important to have reliable and valid quality information.

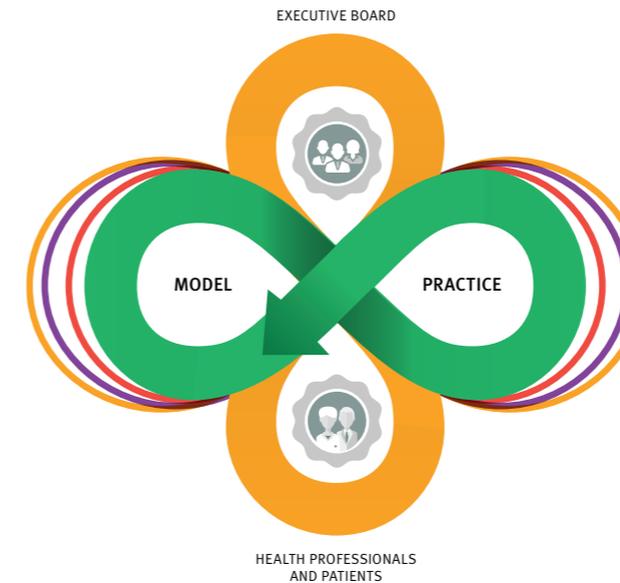
The multitude of quality information that is collected by the hospital at the request of several parties (external and internal), provides little guidance to the Executive Board to make decisions regarding continuous quality improvement. Moreover, the meaning of this quality information is not always clear. As a result, a significant opportunity is missed: it obstructs the provision of guidance for continuous improvement of the quality of patient care. What information is needed, where this can be distilled from, and how this can be used by an Executive Board are questions that receive primary focus within the Quality based Governance program.

What quality information is most relevant for the Board, according to board members, patients, and professionals?



In the 2016-2017 period, twenty projects focused on answering that question. Each of the projects highlighted its own part of the care provided within a hospital, a patient group, and/or regional care network. The twenty

projects provided many valuable core sets and insights about the selection, interpretation, and use of management information. Often, this entailed a selection of quantitative indicators, while providing room for qualitative information. This enriches the conversation between board members and department heads, and offers guidance in navigating towards continuous quality improvement.



The Quality based Governance program is executed by the NFU consortium, Quality of Care. The results are important for university medical centers as well as other hospitals and organizations, such as patient associations, health insurers, and regulatory bodies. The program runs until the end of 2018.

Vision and Framework

With each other and together with healthcare professionals, board members developed a shared vision on navigating towards quality of care.



The essence of the vision is the following:
Many developments are currently taking place, predominantly using data for internal quality improvement. Therefore, this is the right time to work on establishing proactive quality management. The intrinsic motivation of the healthcare professional to improve quality plays an important role in this.

The purpose of quality information is to conduct a dialogue between department heads and other clinical staff members and the Executive Board regarding a joint idea regarding the quality of healthcare and its improvement. Based on interviews with board members and healthcare professionals as well as research into current approaches, it was investigated how the role of the Executive Board can be optimally facilitated.

In particular, this involved the question regarding what information provision is needed to support this and what best reflects the ultimate responsibility of the Executive Board. To this end, the program developed a framework for quality information, on the basis of Dutch and international



examples. In this framework, we make a distinction between a small number of generic indicators and disease-specific indicators. The indicators that have been included in a quality dashboard must be useful and action-oriented. In addition, the selection of indicators must be suited to local priorities. We invite our regional partners to work together on this.

The proposed framework contains a mix of indicators (“signals”) and their determinants, in turn connecting process indicators to outcome indicators. And with that, the program ties in with the enormous interest in value-driven care that there is at the moment.

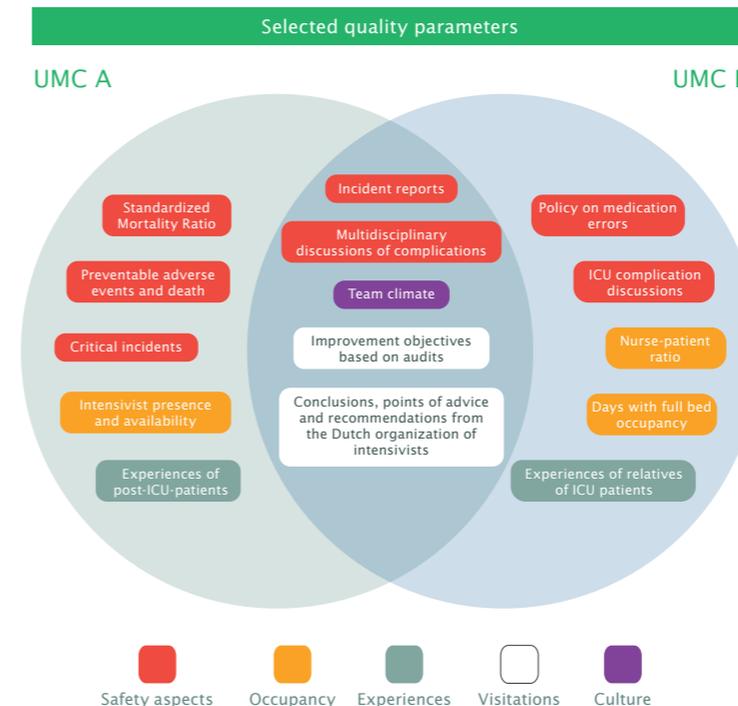
Intensive Care

Hospital boards are legally responsible for the quality of care delivered by healthcare professionals in their hospitals, but experience difficulties in overseeing quality and safety risks. This study aimed to select a core set of parameters for boards to govern quality of care in the intensive care unit (ICU). Two university medical centers took part in this study.

The participants were 12 former ICU patients or their family members, 12 ICU nurses, 12 ICU physicians and 12 members of boards of directors and quality managers. Participants indicated the relevance of existing parameters for assessing the quality of ICU care for governance purposes (Delphi round 1) and selected 10 quality parameters that together provide boards of directors with a good representation of quality of care in their ICU (Delphi round 2).

Related to care in the ICU, 122 quality parameters were identified, which was limited to a short list to present to participants in round 1. The final set consisted of the 10 most frequently selected quality parameters per hospital. Five parameters were included in both sets; all related to patient safety and continuous quality improvement.

Parameters in the core set were mostly qualitative and generic, rather than quantitative and ICU-specific in nature. To engage in a true dialog about quality of care, boards are more interested in the story behind the numbers than in just the numbers themselves.



“What I think is great about this core set is that it leads to dialogue and that was the purpose of it. That you get to the essence of what it’s about. It’s not about a to-do-list and a score list, rather it’s about the dialogue regarding where the challenges lie, where the concerns lie, and where the bottlenecks are.”

Executive Board member on the use of the core set for the ICU

Dashboard Development

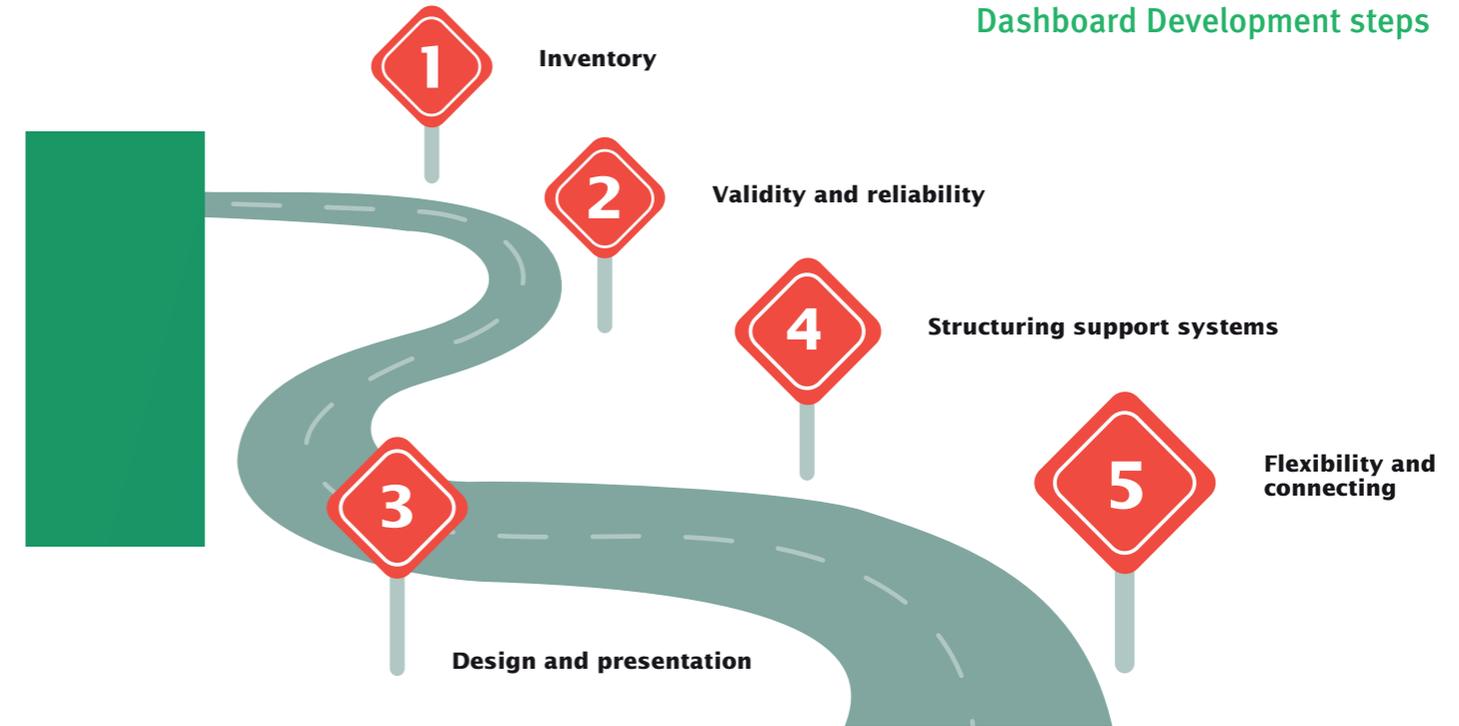
At hospitals, a large amount of quality information is being collected, displayed, and distributed via dashboards.

Dashboards play a role in monitoring, identifying deviations, providing accountability, making comparisons (benchmarking), and providing guidance for quality improvement.

In this project, data was collected in eight university medical centers, two general hospitals, and two teaching hospitals regarding the way in which information on the quality of care is collected, displayed on dashboards, and what support structures are helpful (such as standing sessions, periodic interviews, and learning meetings).

On the basis of the experiences in hospitals in the Netherlands, a roadmap with 5 steps was developed within this project in order to arrive at a dashboard.

Dashboard Development steps



Head and Neck Oncology Care Pathway

Head and Neck Oncological Care in the Netherlands is concentrated in 8 HHO-centers (HHOCs) and 6 preference partner hospitals. In order to measure and improve the quality of HHO integrated care that is delivered in these centers, the Dutch Head & Neck Audit (DHNA) was established in 2014.

Data are registered in here in order to measure the quality of integrated care with 39 indicators, selected from a medical-specialist, paramedical, and patient perspective. Medical and paramedical staff are able to maintain the overview of the large amount of information and annual decisions to be made for improvements. However, the large amount of information is not suitable as management information for the Executive Board and heads of departments that participate in the care pathway, while at this level, there is a need for insight into this highly complex care.

In this project, a compact set of integrated care indicators was extracted (by patients, medical specialists, and paramedics) from the available quality information from the DHNA. This set provides the Executive Board, department heads and care pathway owners of a HHOC, and preference partners with useful and meaningful management information. The selected set can be applied in all 8 Dutch HHOCs and 6 preference partners, and also serves as a template for other oncological care pathways.

• “Quality indicators need to be brought back to achieving the following aim: to improve quality of care by the professional and the patient. This requires a limited selection of action-oriented indicators that is in line with the actual practice situation, in other words: the context of the professionals.”

• Prof. Martine C. de Bruijne, MD PhD, Professor of Public Health, especially Quality of Care, Department of Public and Occupational Health, VU University Medical Center



• “Navigating towards Porter’s standard outcome indicators does not work for a patient group that suffers from a progressive disease. A different approach to value-driven care is needed for that.”

• Prof. Bernard Uitdehaag MD PhD, Head Neurology Department, VU Medical Centre Amsterdam, about value-driven care for MS patients



Lessons learned

1. Dilemma because of the large amount of information, for which the Executive Board is responsible.

More and more, directors of hospitals are also providing quality-focused guidance. However, many hospitals are still searching for a good way to do this and are searching for the quality information that can be selected, interpreted, and used for this. By now, most hospitals use their own dashboard and/or methods for that, but there are still many different practices, the effectiveness of which is unknown.

2. From top-down dashboard to material for a good dialogue.

The purpose of quality information is to encourage a dialogue between department heads and other clinical staff and the Executive Board

regarding a joint idea of the quality of healthcare and its improvement.

3. Existing data can be used to provide information, unless the importance of new developments must be weighed more heavily and the benefits of that are convincing. Disclosing the data is often still a problem.

The method of providing information for improving quality is a responsibility of the hospital, not just the doctors and nurses. Registration at the source is the starting point and the EHR (electronic patient records) is the primary source. As a consequence of this, the quantity of data for structure and processes will decline. In contrast, the patient will increase the reported outcomes and experiences. The entire

program must contribute to a reduction in registration difficulties. Ultimately, business informatics experts will work with healthcare professionals in determining which information is necessary for the continuous improvement process.

4. In the framework for quality information for the Executive Board, there should be room for both generic and disease-specific indicators, which together provide a comprehensive picture of quality.

The selection of indicators must be suited to local priorities. On the one hand, the framework developed by the program works on the premise of a hospital-wide quality dashboard with generic indicators. On the other hand, the framework assumes that the Executive Board

facilitates teams in working and reporting to the Executive Board on the basis of a disease-specific dashboard. An alignment with the system of ICHOM, in which multiple levels of patient outcomes and costs are measured, seems an obvious choice.

5. Information for improvement is fundamentally different from information for transparency.

The Quality based Governance program is dedicated to the responsibility and intrinsic motivation of university medical centers and hospitals to improve quality. An important starting point is that information for improvement has a fundamentally different function than information for transparency and accountability purposes. In this way, quality information becomes an improvement

tool, of which the use (but not so much the content) can eventually serve for the accountability requirements that external parties impose.

6. The model will not be static. It is a dynamic model, which is in a state of “permanent beta”.

This concept (of Asman and Witteveen, 2015) of beta versions that permanently continue to develop and adapt, fits into the reality of many, continual changes (internal and external). There is no more time for the old approach, in which one would work on a perfect end model only after a great deal of preparation. The program does not work towards a lasting and complete end result for Quality based Governance, but on a model for Quality based Governance. This model contains methods, examples of core sets, and

guidelines for use. The model can be directly applied to components and will simultaneously be adapted and improved.

7. Information is quantitative and qualitative.

Not all important quality themes can be captured in numbers. As a director, in what way can you, for example, determine whether the collaboration in the multidisciplinary teams is not good and therefore risky? How can you determine whether the patient’s participation at different levels is accommodated not just on paper but also in practice? Have improvement measures after calamities been properly addressed and are they sufficiently effective? These are often exactly the themes that directors are held responsible for when things go wrong (IGZ, 2017).

The program tries to find an answer to these questions as well.

8. All change happens at the front line.

In addition to the modules for different types of management information, the program also works on developing a vision of the role of the Executive Board in the pursuit of a proactive approach to quality and safety. The dialogue on quality of care between healthcare professionals and hospital management has an important place in this vision.

9. Quality & safety of the care network is still a black box.

The program has launched a pilot regarding the possibilities for monitoring quality and safety in care network, with specific attention to the role and responsibilities of the Executive Board. The quality

Lessons learned

of integrated care is often still a “black box”. From multiple studies (ZonMw, 2014), it is well known that in places where the care is fragmented, where multiple disciplines are involved or transmission to various sectors takes place, safety is at stake within the entire care pathway. In the pilot, three hospitals developed guidelines together for the Executive Board to map the risks of regional and care network cooperation as well as to improve the safety through reactive and proactive management possibilities.

Learning Collaboratives and Experiments

In 2018, the main focus is on the implementation and dissemination of the results and new insights gained from the twenty projects of the program. These Learning Collaboratives and Regional Experiments offer a platform to apply or adjust the valuable knowledge gained from the program to an individual, local situation. Through a small intervention, the core sets from this program can be copied by other hospitals or (regional) care networks. The core set ensures that appropriate management information is distilled from existing information, and that a meaningful conversation about quality and safety can take place with the Executive Board. That way, specific guidance towards quality can be provided.

Toolkit

The toolkit for quality based governance is aimed at board members, clinical leaders, and quality officers of hospitals and contains methods, examples of core sets, and guidelines for using these. The toolkit enables hospitals to start implementing the knowledge and examples that were collected in the program in their own practice. The toolkit can be found via www.sturenopkwaliteit.nl.



- **References**
- Bohmer, R. (2016). The Hard Work of Health Care Transformation. *N Engl J Med*, 375, 709-711.t
- Meyer, G.S., Nelson, E.C., Pryor, D.B., James, B., Swensen, S.J., Kaplan, G.S., Weissberg, J.I., Bisognano, M., Yates, G.R., Hunt, G.C. (2012). More quality measures versus measuring what matters: a call for balance and parsimony, *BMJ Quality and Safety*, 21, 964-968.
- Oerlemans, A.J.M., De Jonge, E., Van der Hoeven, J.G., & Zegers, M. (2018). A systematic approach to develop a core set of parameters for boards of directors to govern quality of care in the ICU. *International Journal for Quality in Health Care*, 2018, 1-6.
- Porter, M.F. (2010) What is value in health care? *N Engl J Med*, 363, 2477-81
- Vincent, C., Burnett, S., & Carthey, J. (2013). The measurement and monitoring of safety. The Health Foundation.
- Weggelaar-Jansen, A.M.J.W.M., Broekharst, D.S.E., & De Bruijne, M. (2018). Developing a hospital-wide quality and safety dashboard: a qualitative research study. *BMJ Quality and Safety Published Online First*: 27 June 2018.
- **Coordinator**
- Daphne Delsing BA, Program Advisor
- **Design**
- Terralemon

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For more information:

Rose Trooster MSc, Program Manager

roos.trooster@nfukwaliteit.nl

www.sturenopkwaliteit.nl