

Features of the project

The Performance Assessment Tool for Quality Improvement in Hospitals (PATH) was developed by the WHO Regional Office for Europe to support hospitals in collecting data on their performance, identifying how they are doing in comparison to their peer group and initiating quality improvement activities. PATH is designed for internal use and on voluntary basis only - it is not meant to be used for external reporting, accreditation or restructuring purposes. The framework for performance assessment encompasses six dimensions: four domains (clinical effectiveness, efficiency, staff orientation and responsive governance) and two transversal perspectives (safety, patient centeredness).

The PATH framework includes 4 steps:

- 1 Motivate**
Hospital participation is voluntary. PATH is designed around and for hospitals as the main users. It presumes their active involvement at all steps.
- 2 Measure**
The PATH framework relies on 17 indicators in a core set but countries can select additional indicators proposed in a tailored set.
- 3 Make sense**
Data are the prerequisite for improvement; however, they are not an end in themselves but a starting point for action. Evaluation of indicators always needs to be done locally, comparing the institutions' performance to reference points and relating performance to local contexts.
- 4 Move**
The aim of PATH is to provide support to quality improvement strategies. It should ultimately impact on actions for quality improvement.

Indicator set

Core indicators

Clinical effectiveness & safety	Efficiency	Staff orientation & safety	Responsive governance	Patient centeredness
C1. Caesarean Section. C2. Prophylactic Antibiotic use (planned surgery for colorectal cancer, coronary artery bypass graft, hip replacement, hysterectomy). C3. Mortality (acute myocardial infarction, stroke, community acquired pneumonia, hip fracture, coronary artery bypass graft). C4. Readmission (acute myocardial infarction, stroke, community acquired pneumonia, hip fracture, coronary artery bypass graft, asthma, diabetes mellitus). C5. Day surgery for eight tracers (cataract surgery, knee arthroscopy, inguinal hernia, curettage of the uterus, tonsillectomy and/or adenoidectomy, cholecystectomy, tube ligation, varicose veins stripping and ligation). C6. Admission after day surgery (some tracers as day surgery). C7. Return to ICU.	C8. Length of stay (acute myocardial infarction, stroke, community acquired pneumonia, hip fracture, coronary artery bypass graft). C9. Surgical Theatre use.	C10. Training expenditure. C11. Absenteeism. C12. Excessive working hours. C13. Needle injuries. C14. Staff smoking prevalence.	C15. Breastfeeding at discharge. C16. Health care transitions.	C17. Patient survey.

Tailored indicators

Clinical effectiveness & safety	Efficiency	Staff orientation & safety	Responsive governance	Patient centeredness
T1. Door to needle time. T2. Computer tomography scan after stroke. T3. Acute myocardial infarction patients discharged on aspirin. T4. Mortality indicators (C3) with more advanced risk-adjustment. T5. Readmission indicators (C4) with more advanced risk-adjustment. T6. Pressure ulcers for stroke and fracture patients. T7. Rate of hospital-acquired infections.	T8. Score on Appropriateness Evaluation Protocol. T9. Costs antibiotics/patients. T10. Length of stay indicators (C8) case-mix adjusted. T11. Cash-Flow/Debt. T12. Cost of corporate services/patient day.	T13. % wages paid on time. T14. Survey on staff burnout. T15. % job descriptions with risk assessment. T16. Staff turnover. T17. Work-related injuries by type.	T18. Audit of discharge preparation. T19. % discharge letters sent. T20. Score on Appropriateness Evaluation Protocol for geriatric patients. T21. Waiting time for day surgery tracers. T22. Acute myocardial infarction and coronary heart failure with lifestyle counselling.	T23. Patient survey score on access to care. T24. Patient survey score on amenities of care.

Acknowledging the differences in the availability of data from hospital information and documentation systems throughout Europe, we developed two sets of indicators:

A core set including indicators that are relevant to all contexts and represent a low burden of data collection. This set includes 17 core indicators.

A tailored set including indicators that either are relevant to a limited number of contexts, or, because of their higher burden of data collection, are suggested if congruent with the organization or country's priorities. This set includes 24 indicators.

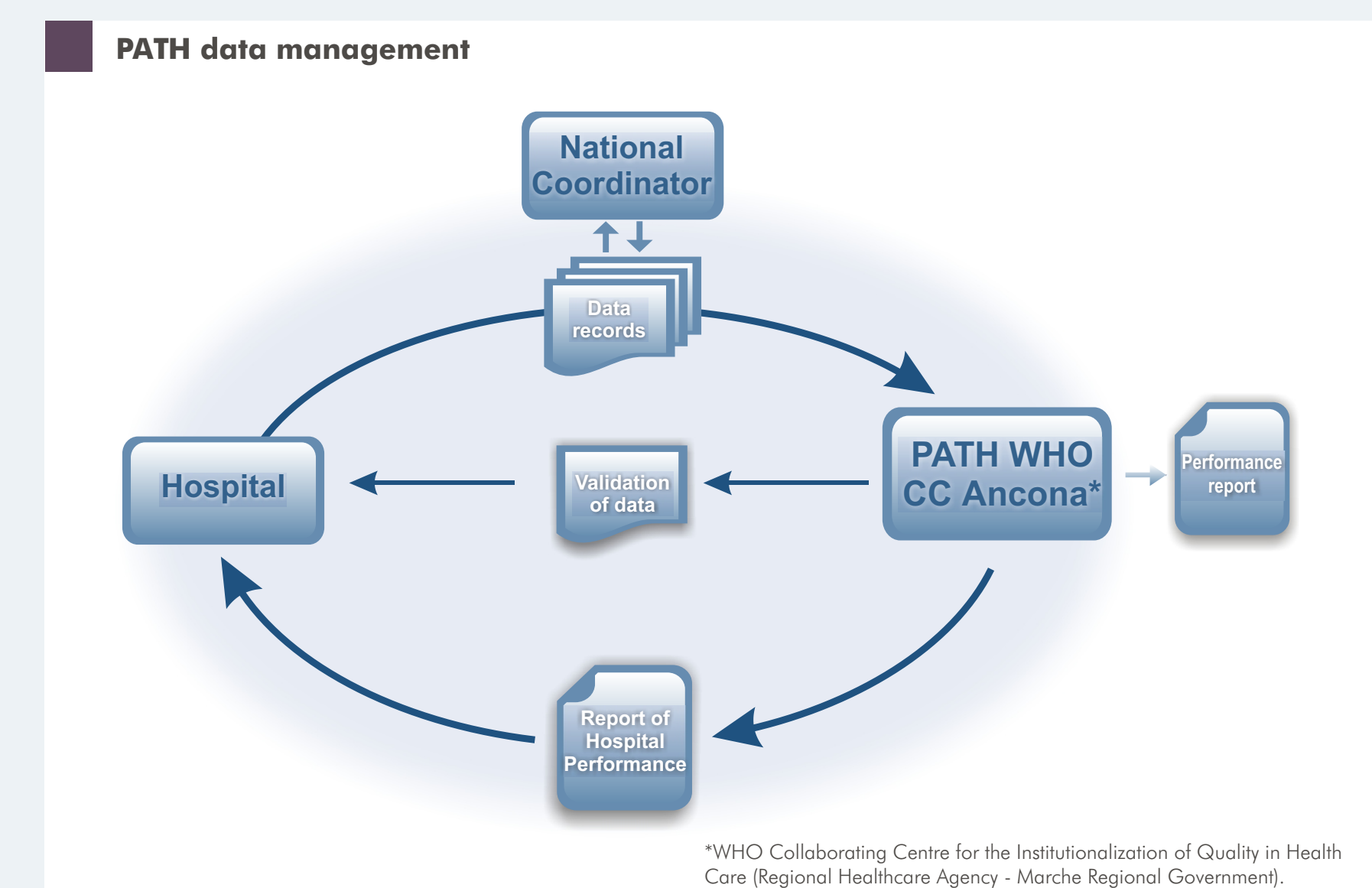
Hospitals participating in PATH are expected to gather the indicators of the core set. It is up to the hospital to decide which of the tailored indicators are collected additionally.

Data collection procedures

The WHO Collaborating Centre for the Institutionalization of Quality in Health Care (Regional Healthcare Agency - Marche Regional Government), in Ancona, in collaboration with the Italian National Research Council is designing an electronic platform to collect, process and report on data collected by the hospitals participating in the PATH project. This platform will be integrated into the existing PATH web pages.

Hospitals will collect data for the PATH indicators as described in the descriptive sheets and using the data collection sheets provided by the project. Once data collection has been finalized, hospitals will be able to log

on the PATH webpage and transfer the information to the WHO Collaborating Centre for the Institutionalization of Quality in Health Care. In some countries, the national coordinator will be granted access to validate the data subject to individual written agreements. After preliminary validation, the data will be reported back to each hospital for verification. Only after passing this process, it will be included in the PATH database for further analysis. It is important to point out that, given the focus of the project on internal quality improvement and not on external reporting, the responsibility for data quality is with each participating hospital.



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