



# How may healthcare leaders use data to monitor and improve quality?



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HOLBÆK SYGGEHUS



*- vi er til for dig*

# Health Care Leadership Past – Present - Future

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- **The past – when CMO's and CEO's where administrators**
  - And QoC was second in line
- **The immediate past – when CMO's and CEO's where Managers and book-keepers on QoC**
- **The future – where CMO's and CEO's are strategic leaders on the road to constant quality improvement**

## **DATA REQUIREMENT AND DATA MANAGEMENT**

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## **DATA REQUIREMENT AND DATA MANAGEMENT**

# Health Care Management 80's and 90's

- **Contract based management**
  - Budget
  - Activity



# Contract based management

- **Budget**
  - Detailed
- **Activity**
  - Detailed
- **Quality**





# Health Care Leadership Past – Present - Future

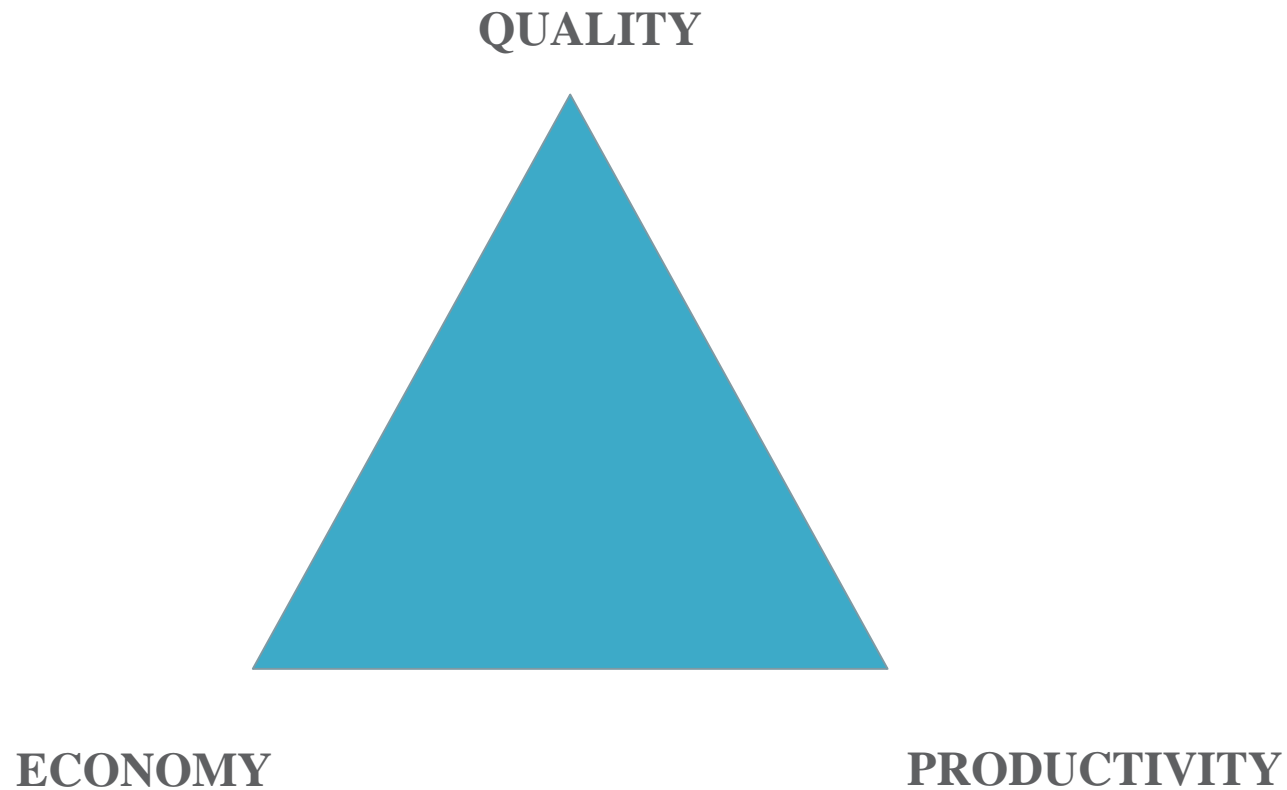
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# Health Care Management late 90's to 2015

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# Health Care Management late 90's to 2015

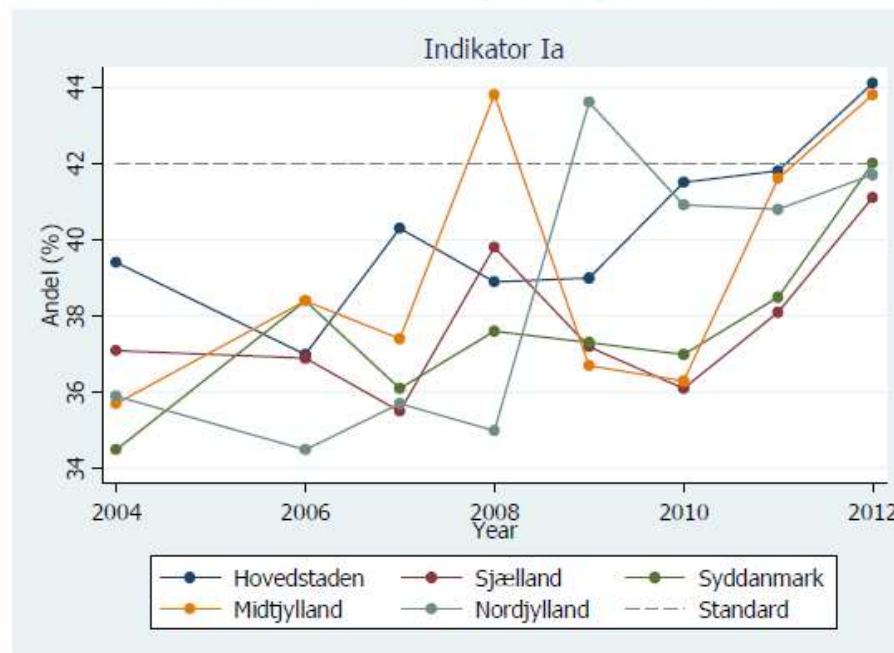
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- **Contract Based Health Care Management**
- **Economy and Productivity**
  - DRG-based
- **Quality of Care**
  - Clinical Data Bases
  - Accreditation
  - Quality Organization
  - PDSA

# Clinical Databases

## Association to QoC (Lung Cancer)

### 1 års overlevelse



42,7%

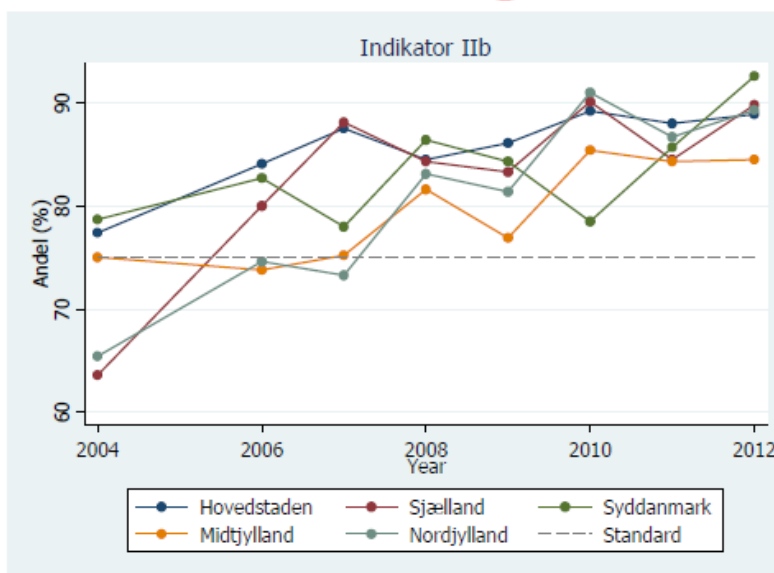


12-01-2014

# Clinical Databases

## Association to QoC (Lung Cancer)

## 1 års overlevelse efter kirurgi



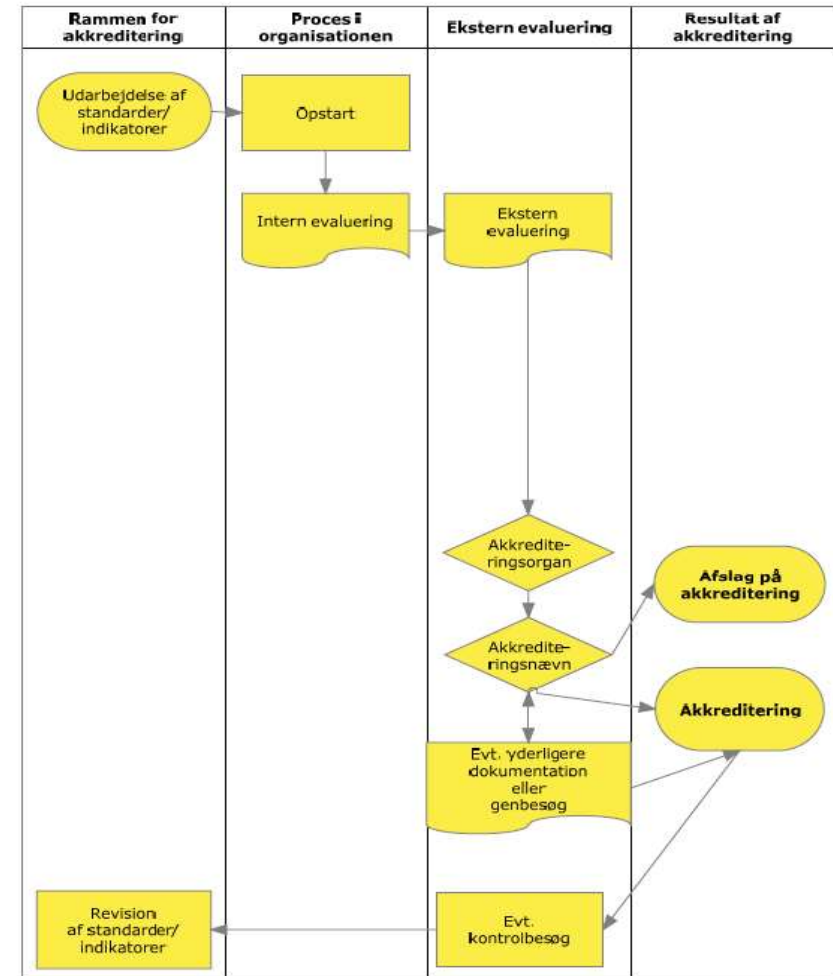
88,6%



12-01-2014

# Accreditation: The process

1. Set up standards / indicators
  1. May be done by the institution it self or by an external institution
2. Make internal evaluation according to standards
3. External evaluation
4. Accreditation granted or denied by external accreditation organization
5. Revision of standards / indicators



- **Certification of competence in a specified subject or areas of expertise, and of the integrity of an agency, firm, group, or person, awarded by a duly recognized and respected accrediting organization.**

**When accereditated – the consumer/user may assume that the hospital:**

- Has and does "what is needed"
- Is able to deliver reliable data
- Management is taking responsibility for the QoC

# Accreditation : what "we" expected and what "we" got

- **State, Regions Hosp. management**

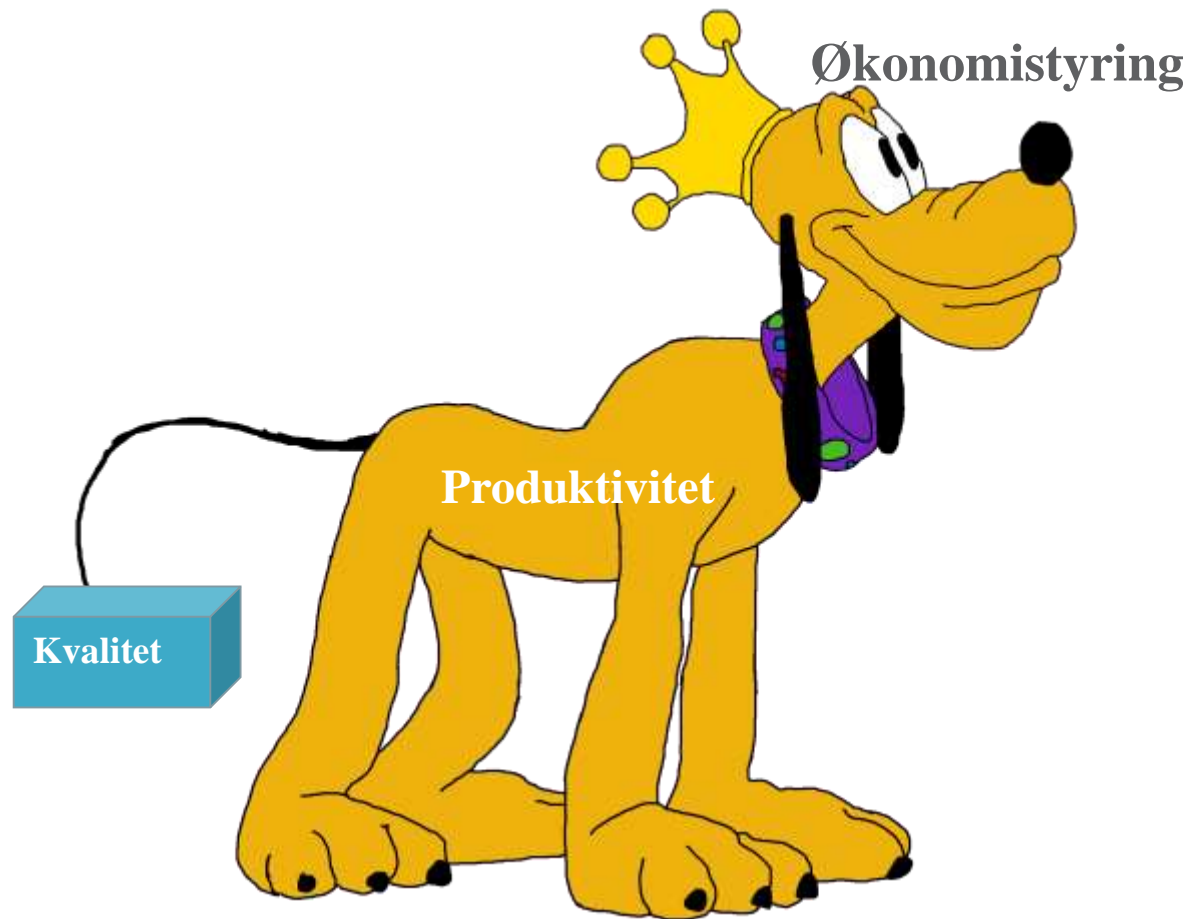
- Unified, high QoC with minimal inter-unit variability
- Independent evaluation whether targets are met
- Tool for development, planning and management
- Strong Quality-culture
- Improved QoC

- **Clinicians got**

- Focus on process – not treatment and care
- Standardization – but pt's are different and should be treated individually
- Standardization = de-professionalization
- NIP, IKAS, LUP – control methods, not expression of faith

# Fri os fra Akkreditering







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## **DATA REQUIREMENT AND DATA MANAGEMENT**

# Otte nationale mål

## NATIONALE MÅL : BEDRE KVALITET, SAMMENHÆNG OG GEOGRAFISK LIGHED I SUNDHEDSVÆSNET

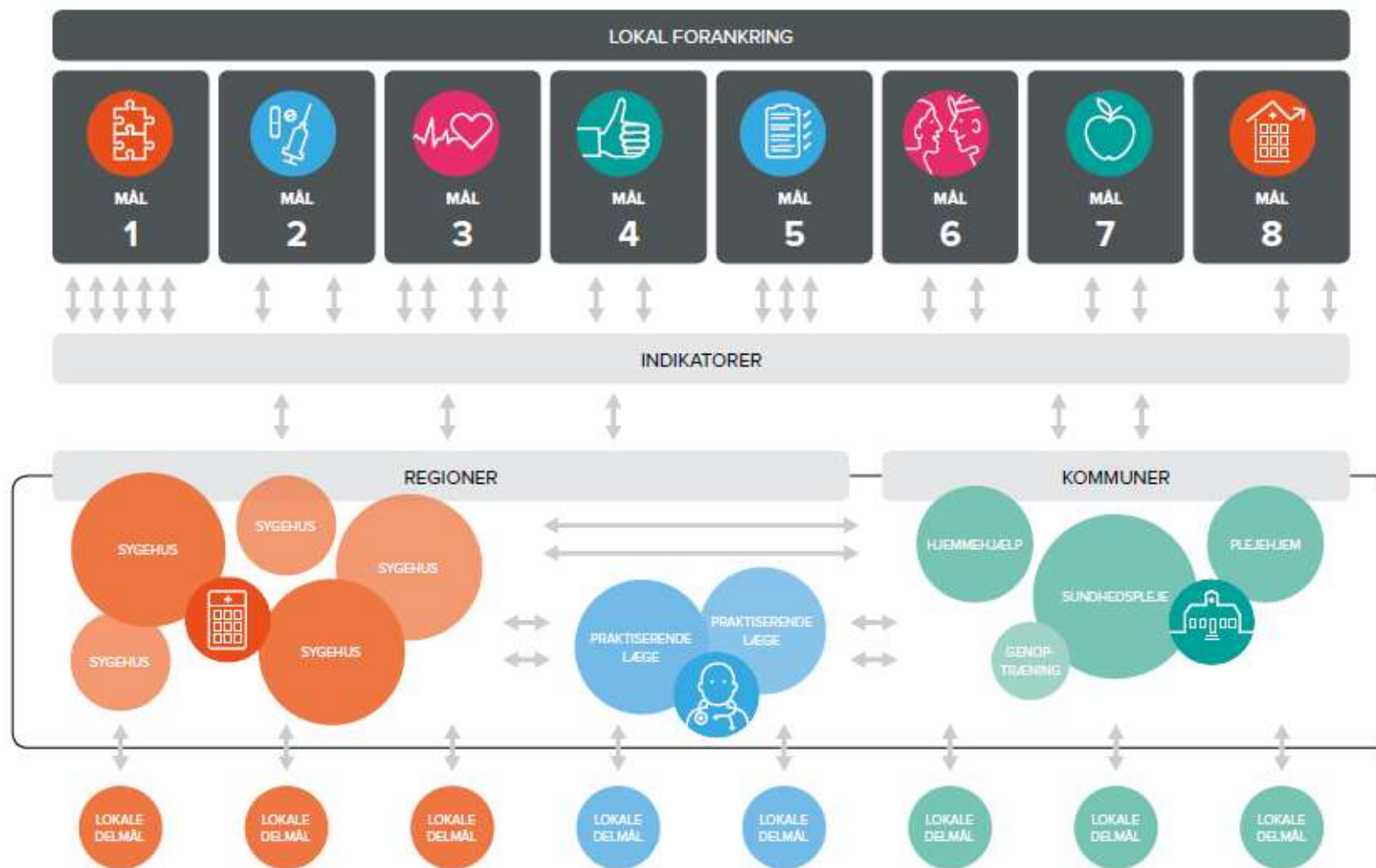


## INDIKATORER

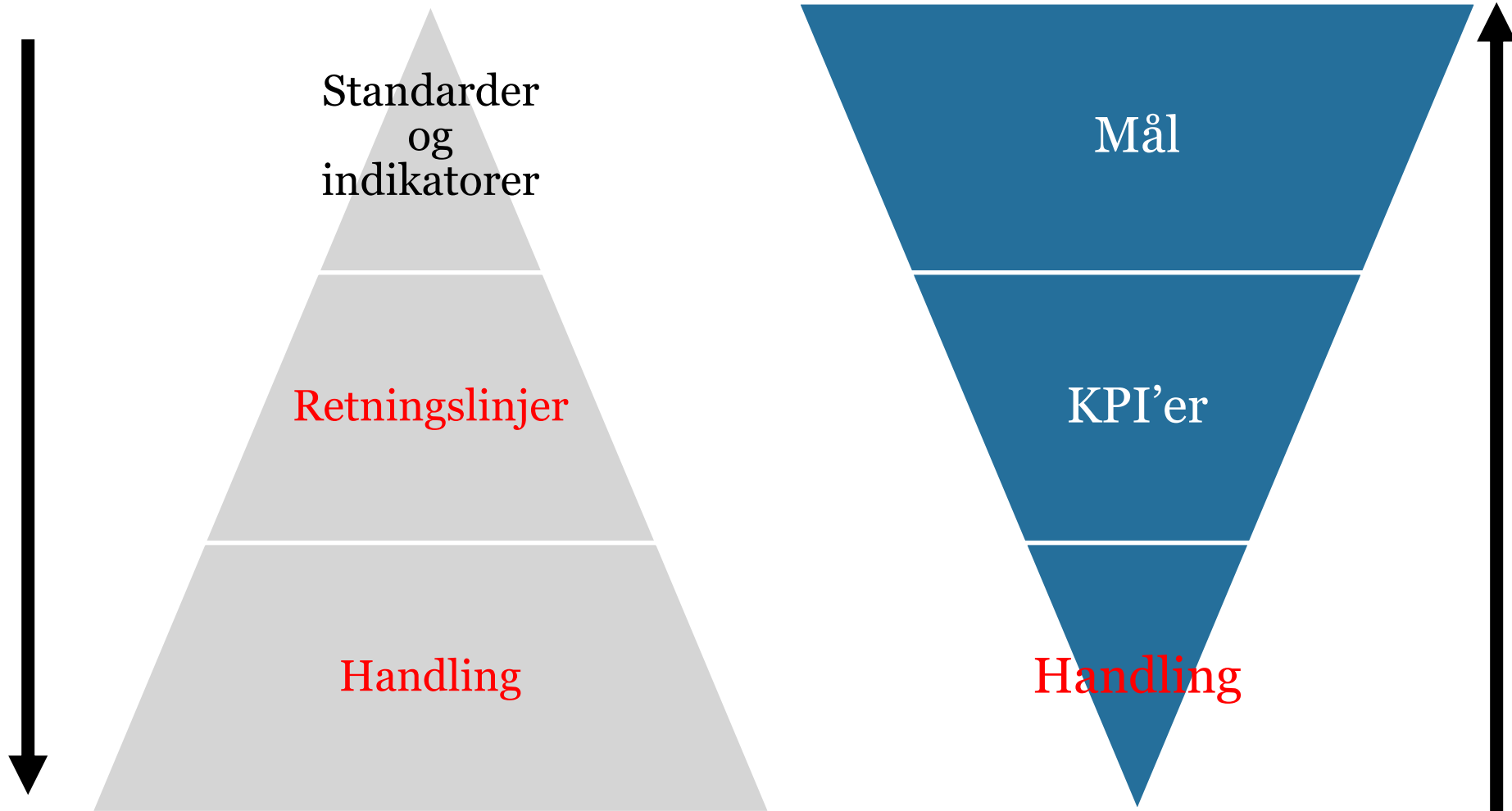


## REGIONALE / KOMMUNALE LOKALE DELMÅL

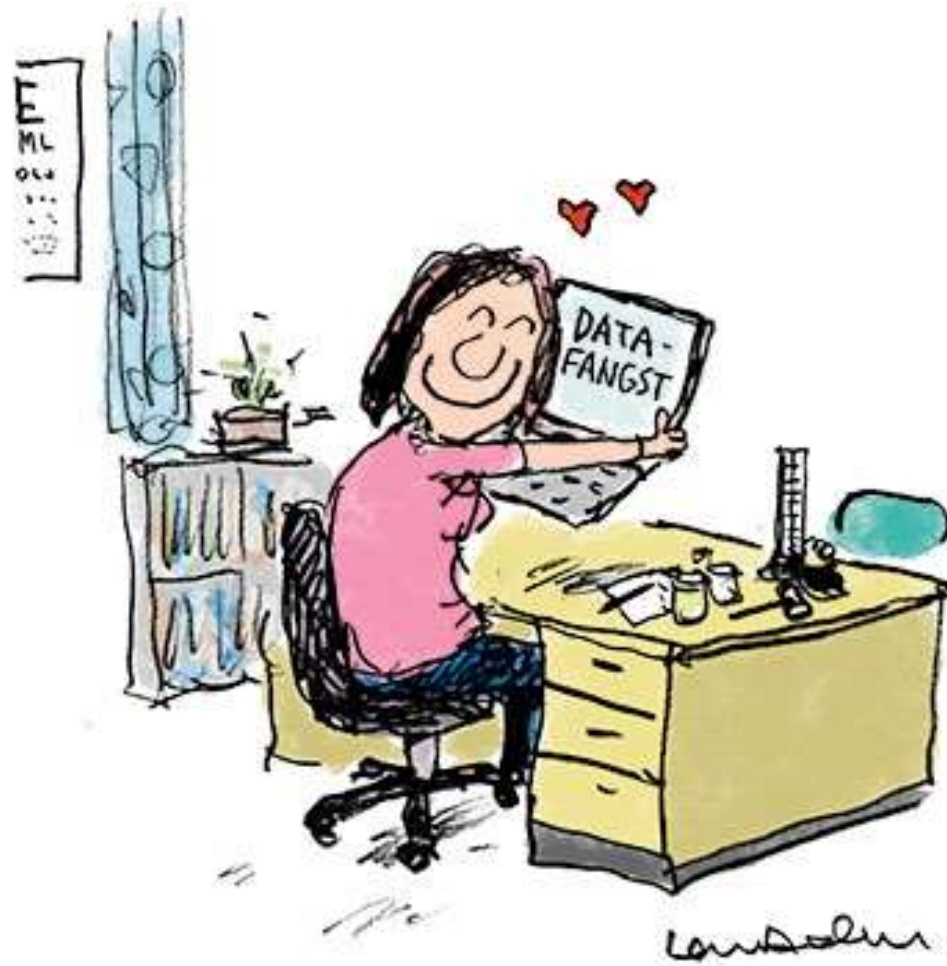
# Målhierarki



# De to modeller



# Fra Akkreditering til nationale mål



# REAL TIME DATA

# Where are we failing

## Dagens Medicin, 18. januar 2013





# Where are we failing

## Obstetric Database (2013)

4.a Angiver hvorvidt akut kejsersnit gennemføres i henhold til tidsrammen for den kliniske beslutning om grad 1 kejsersnit (< 15 minutter)	Mindst 95 %	Placering i Region Sjælland	Placering DK (ex Bornholm)
Region Sjælland	55,4		nr 5 af 5
Holbæk Sygehus	16,7	4	nr 21 af 21
Næstved Sygehus	72,7	1	nr 13 af 21
Nykøbing Falster Sygehus	54,5	3	nr 20 af 21
Roskilde Sygehus	63,6	2	nr 17 af 21

4.b Angiver hvorvidt akut kejsersnit gennemføres i henhold til tidsrammen for den kliniske beslutning om grad 2 kejsersnit (< 30 minutter)	Mindst 95 %	Placering Region Sjælland	Placering DK
Region Sjælland	56,3		nr 5 af 5
Holbæk Sygehus	28,3	4	nr 22 af 22
Næstved Sygehus	51,0	3	nr 17 af 22
Nykøbing Falster Sygehus	68,4	2	nr 8 af 22
Roskilde Sygehus	74,7	1	nr 6 af 22

# Where are we failing

## What to do?

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- **Step one**
  - Establish monitoring system
    - 7-step monitoring – how much time is spent on ...
  - Review within 24h by team involved + leaders
    - What could be improved
  - All reviews are interdisciplinary (all groups involved)

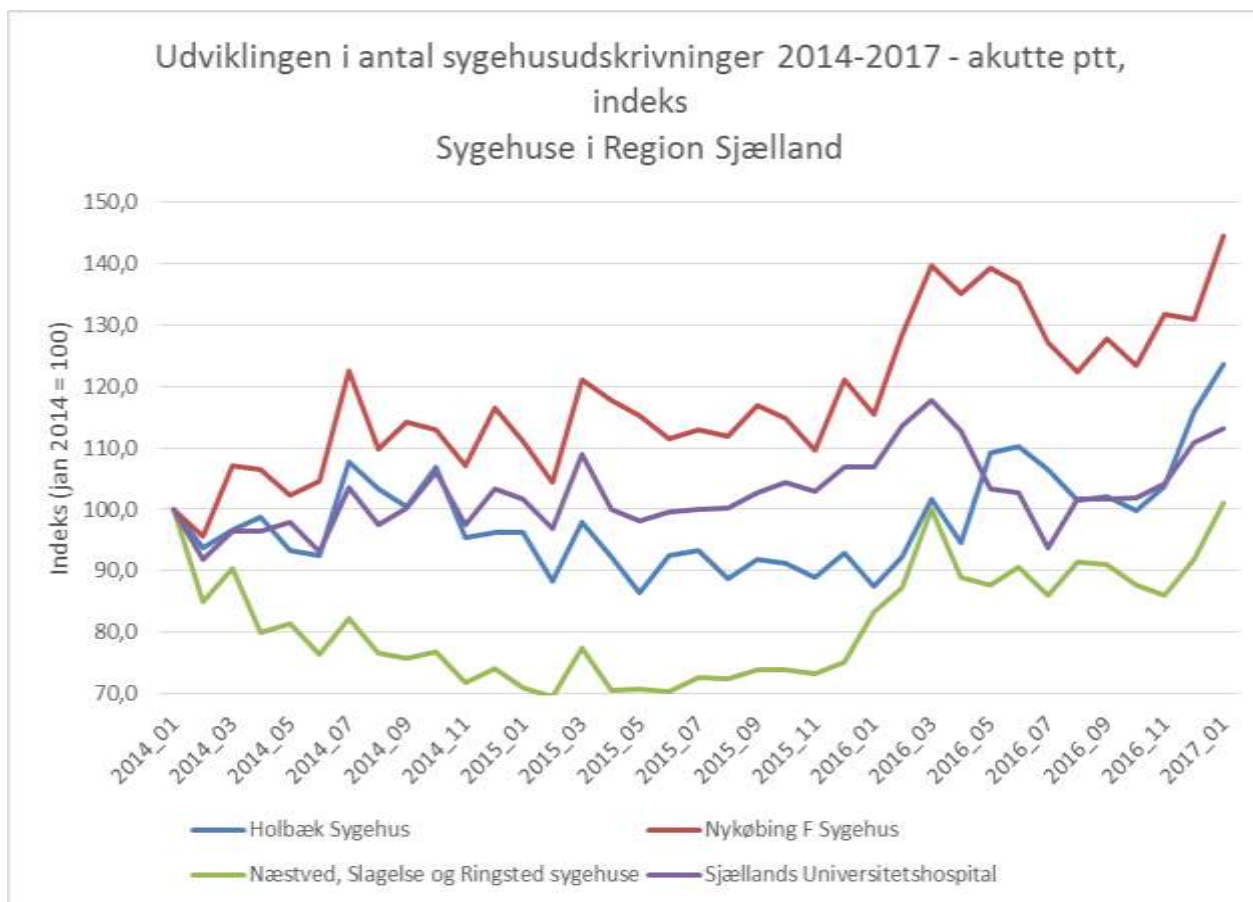
## Indikator 4A

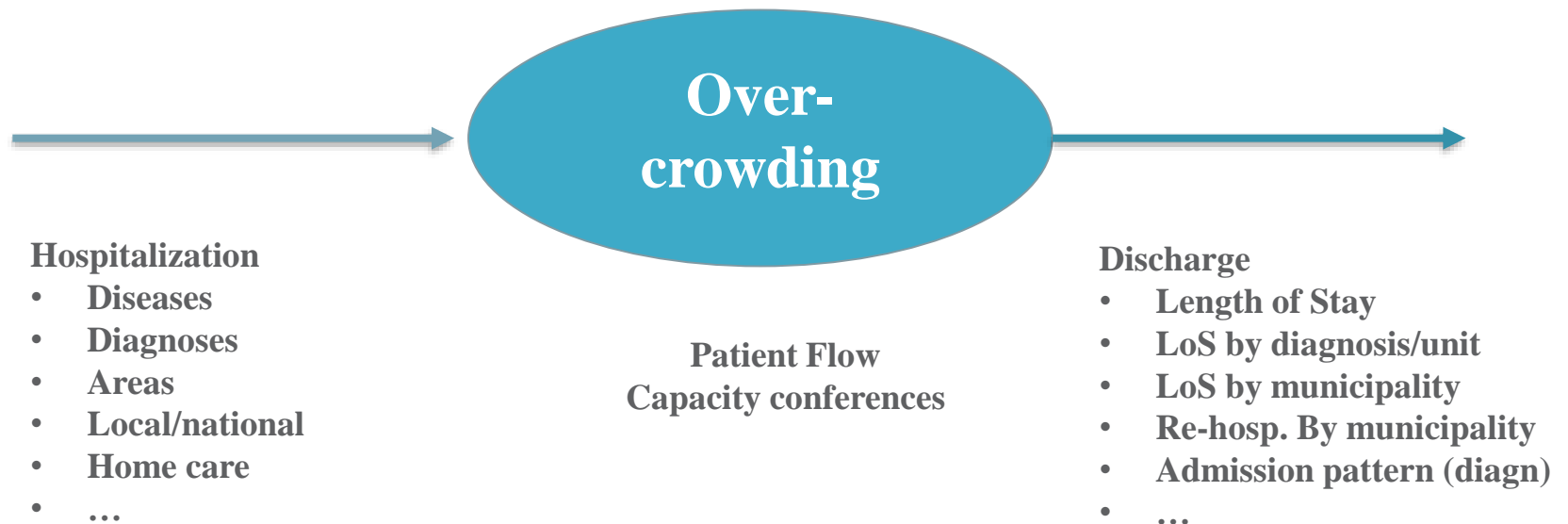
Tæller: Andelen af fødende, der føder ved akut kejsersnit i henhold til det tidsinterval kejsersnittet er meldt under (grad 1  $\leq$  15 minutter). Nævner: Alle der føder ved akut kejsersnit, grad 1.

**Tablet 3 – Resultater for indikator 4A**

Enhed	Std. opfyldt: Tæller/nævner		Uoplyst Antal (%)	Aktuelle år 2016	Tidligere år	
	Mindst 90%				2015	2014
Danmark	nej	246 / 296	18 (6)	83,1 (78,3-87,2)	81,6	75,8
Hovedstaden	nej	57 / 78	5 (6)	73,1 (61,8-82,5)	76,9	76,5
Sjælland	nej	37 / 47	0 (0)	78,7 (64,3-89,3)	71,4	59,2
Syddanmark	nej	68 / 76	4 (5)	89,5 (80,3-95,3)	83,5	67,6
Midtjylland	ja	54 / 59	2 (3)	91,5 (81,3-97,2)	89,4	90,1
Nordjylland	nej	30 / 36	7 (16)	83,3 (67,2-93,6)	80,0	78,8
Holbæk	ja	17 / 18	0 (0)	94,4 (72,7-99,9)	80,0	50,0
Nykøbing F	ja	13 / 14	0 (0)	92,9 (66,1-99,8)	77,8	44,4
Næstved	nej	5 / 11	0 (0)	45,5 (16,7-76,6)	57,1	56,3

# Over-crowding in hospitals





- **What is needed**
  - Clear strategy
  - Strategic focus areas (high risk areas, high priority areas etc.)
  - **Healthy** and **sensitive** alarm system
    - Based on real time data
    - Sensitive but realistic – signal-noise-balance
  - Reporting relevant to clinicians/staff as well as to leaders
  - LEAN-/”Målstyrings-tavler” at all levels
  - Data lifted to next level – if relevant according to
    - A: local, strategic targets
    - B: national targets

# Data-driven, strategic QoC improvement



