

PERSIAPAN PENERAPAN PATH UNTUK RUMAH SAKIT DI INDONESIA

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DISAMPAIKAN PADA
INDONESIAN HEALTHCARE QUALITY NETWORK 2010

CHALLENGE

- PATIENTS MANAGEMENT WITH MINIMUM MEDICAL ERROR
- ENHANCEMENT OF SERVICE QUALITY
- BETTER COMMUNICATION AND COLLABORATION
- EFFECTIVE AND EFFICIENT ADMINISTRATION



HOSPITAL COMPETITIVENESS
PERFORMANCE

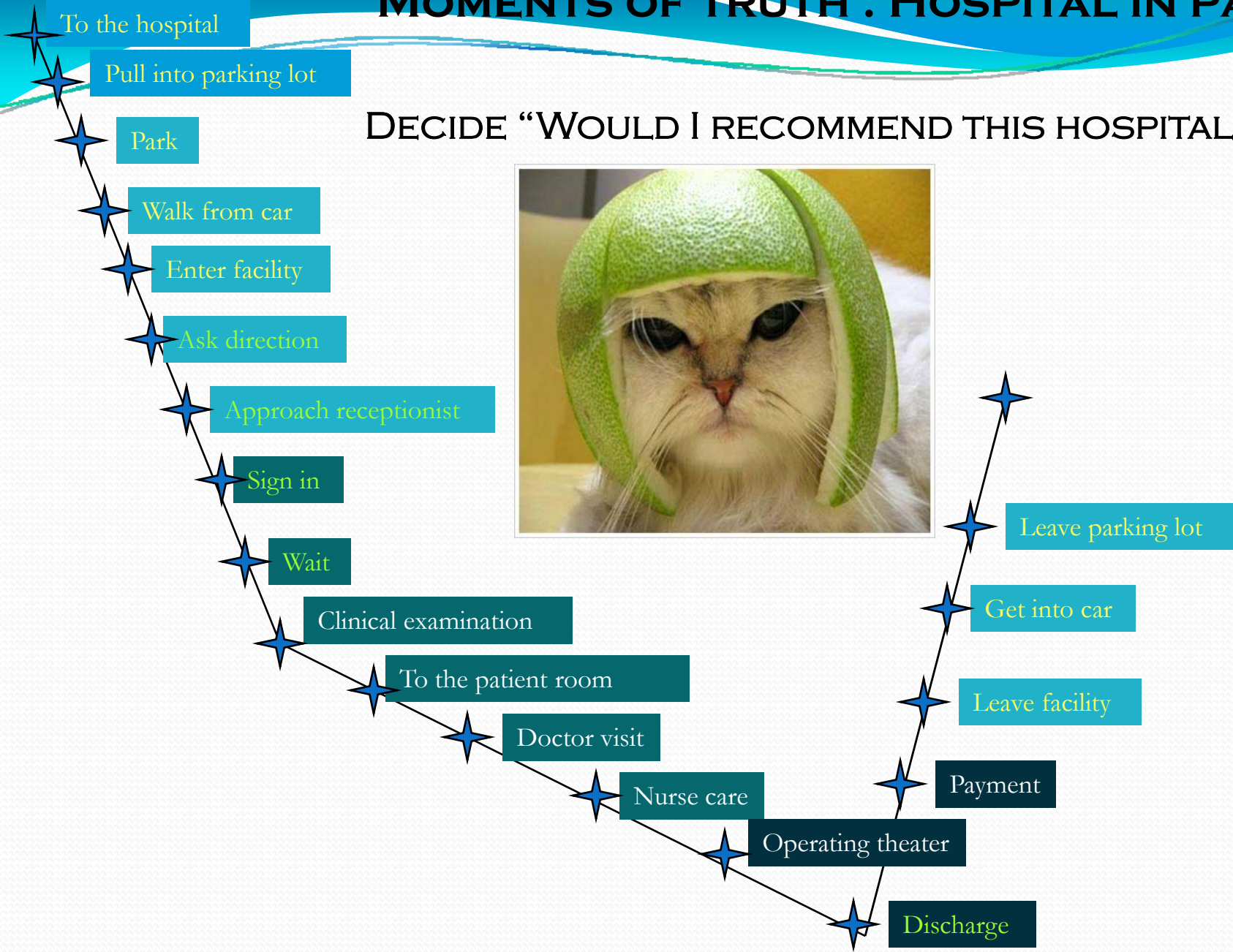
MOMENTS OF TRUTH ARE

CUSTOMER'S EXPECTATIONS OF :

- WHAT HE/SHE BELIEVES WILL HAPPEN
- WHAT HE/SHE THINKS SHOULD HAPPEN
- WHAT HE/SHE HOPES WILL HAPPEN

MOMENTS OF TRUTH : HOSPITAL IN PATIENT

DECIDE "WOULD I RECOMMEND THIS HOSPITAL ?"



DILEMMA PERUMAHSAKITAN DALAM MENCAPAI CLINICAL QUALITY DAN FINANCIAL PERFORMANCE

- CLINICAL QUALITY DAN FINANCIAL PERFORMANCE ADALAH DUA HAL TIDAK TERPISAHKAN.
- RUMAH SAKIT YANG INGIN MEMILIKI CLINICAL QUALITY YANG TINGGI HARUS MEMILIKI MODAL SDM YANG MENCUKUPI DAN BAIK, PERALATAN YANG MENCUKUPI DAN CUKUP CANGGIH , TEAM WORK YNG BAIK, GOVERNANCE YANG BAIK TERMASUK MENJALANKAN SOP DENGAN KONSISTEN, MEMILIKI PROGRAM QUALITY IMPROVEMENT, PATIENT SAFETY DLL. YANG TENTU SEMUANYA MEMERLUKAN BIAYA YANG DILAKSANAKAN MELALUI PENGANGGARAN DAN PELAKSANAAN ANGGARAN YANG EFISIEN DALAM RANGKA MEMBINA MAUPUN MEMPERTAHANKAN DENGAN BAIK CLINICAL PERFORMANCE UNTUK JANGKA WAKTU YANG LAMA
- BIAYA ITU HARUS DIPEROLEH MELALUI FINANCIAL PERFORMANCE YANG BAGUS. ARTINYA COST CONTROL DAN REVENUE GENERATING DISERTAI PROCESS EXCELLENCE DIBIDANG FINANCIAL MAUPUN BIDANG LAINNYA SEPERTI MEDICAL, NURSING, DLL HARUSLAH SELARAS, SEIMBANG DAN EFISIEN

The Dilemma



Quality without Efficiency
UNSUSTAINABLE

Efficiency without Quality
UNTHINKABLE



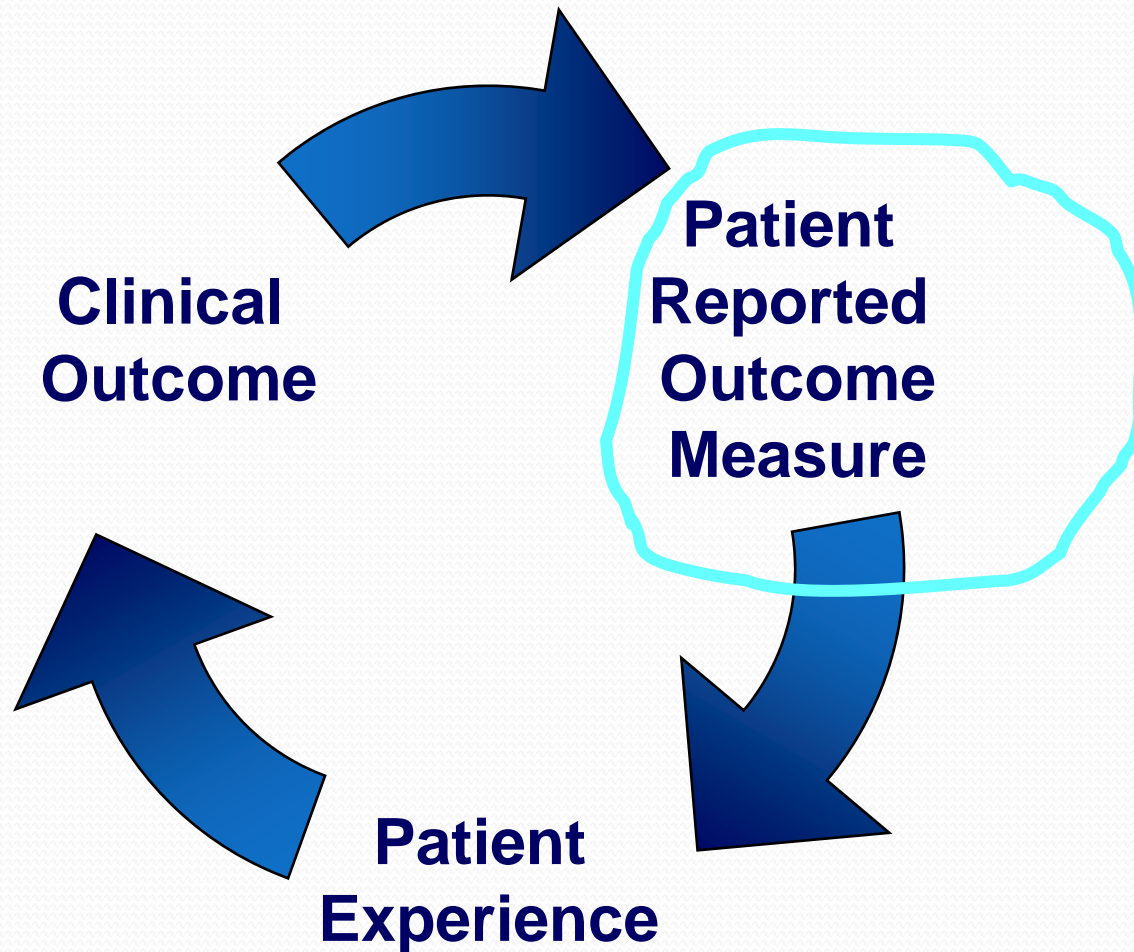
Premier
Inc U.S.

Clinical Quality and Financial Performance are Inseparable

QUALITY INDICATORS TERDIRI ATAS DAN TERKAIT DENGAN

- **CLINICAL OUTCOME (MORTALITY, LOS, READMISSION, COMPLICATIONS ETC)**
- **PATIENT REPORTED OUTCOME MEASURES (PROMs)**
- **PATIENT EXPERIENCE (PERCEPTION)**
- **COST**
- **HEALTH ECONOMICS**

The Golden Triangle



CLINICAL OUTCOME INDICATORS

	INDICATOR	NAT.HEALTH CARE GROUP	INTERNATIONAL RATE	RSPI
1	COLORECTAL SURGERY : ANASTOMOTIC LEAKAGE AFTER RESECTION OF COLON CANCER	2 – 4%	5%	
2	STOMACH CANCER SURGERY : ANASTOMOTIC LEAKAGE AFTER GASTRECTOMY (WITHIN 14 DAYS)	3,6 – 4%	8%	
3	MINIMALLY INVASIVE RECURRENCE HERNIA AFTER LAPAROSCOPIC HERNIA REPAIR	3 – 4,9%	2 – 10%	
4	ICU : VENTILATOR ASSOCIATED PNEUMONIA	1,54%	5,4% PER 1000 VENTILATOR DAYS	
	NEUROLOGY : INPATIENT STROKE MORTALITY	4%	10%	
6	OPHTHALMOLOGY : VISUAL OUTCOME AFTER CATARACT SURGERY	99,59%	95%	

BUMRUNGARD HOSPITAL, BANGKOK

LAPAROSCOPIC-CHOLECYSTECTOMY REALCOST ESTIMATES ARE BASED ON THE ACTUAL INVOICES PATIENTS PAID UPON LEAVING OUR HOSPITAL. THEY INCLUDE SURGICAL FEES, DOCTOR'S FEES, MEDICINE, LAB TESTS, ROOM FEES, THE TOTAL BILL FOR THE INCIDENT OF CARE.

**SURGICAL REMOVAL OF GALL BLADDER USING LAPAROSCOPE
DATE: JAN 01, 10 BASED ON DATA: JUL 08 – JUN 09
CURRENCY: THAI BAHT**

**MEDIAN: THB 160,325
LOW: THB 142,944
ONLY ABOUT 1 IN 4 CASES
COST LESS THAN THIS.
HIGH: THB 177,009
ONLY ABOUT 1 IN 4 CASES
COST MORE THAN THIS**

WHAT PATH HAS TO OFFER:

- A MULTIDIMENSIONAL APPROACH TO HOSPITAL PERFORMANCE ASSESSMENT;
- A TOOL TO DISSEMINATE VALUES WITHIN A HOSPITAL, AND INITIATE OR SUPPORT QUALITY IMPROVEMENT STRATEGIES;
- A TOOL TO MAKE THE MOST OF THE LARGE AMOUNT OF DATA THAT IS CURRENTLY COLLECTED BUT VERY LITTLE USED;
- TECHNICAL SUPPORT IMPLEMENTATION OF PERFORMANCE MEASUREMENT WITHIN HOSPITALS;
- AN OPPORTUNITY TO QUESTION CURRENT INFORMATION SYSTEMS AND LEARN FROM EXPERIENCES IN OTHER COUNTRIES;
- EDUCATIONAL MATERIAL, INCLUDING GENERAL PRESENTATION OF QUALITY IMPROVEMENT PRINCIPLES AND DETAILED DESCRIPTION OF INDICATORS;
- TEMPLATE FOR REPORTING RESULTS TO INDIVIDUAL HOSPITALS

THE PATH FRAMEWORK INCLUDES 4 STEPS

MOTIVATE : HOSPITAL PARTICIPATION IS VOLUNTARY. PATH IS DESIGNED AROUND AND FOR HOSPITALS AS THE MAINUSERS. IT PRESUMES THEIR ACTIVE INVOLVEMENT AT ALL STEPS.

- **MEASURE** : THE PATH FRAMEWORK RELIES ON 17 INDICATORS IN A CORE SET BUT COUNTRIES CAN SELECT ADDITIONAL INDICATORS PROPOSED IN A TAILORED SET.

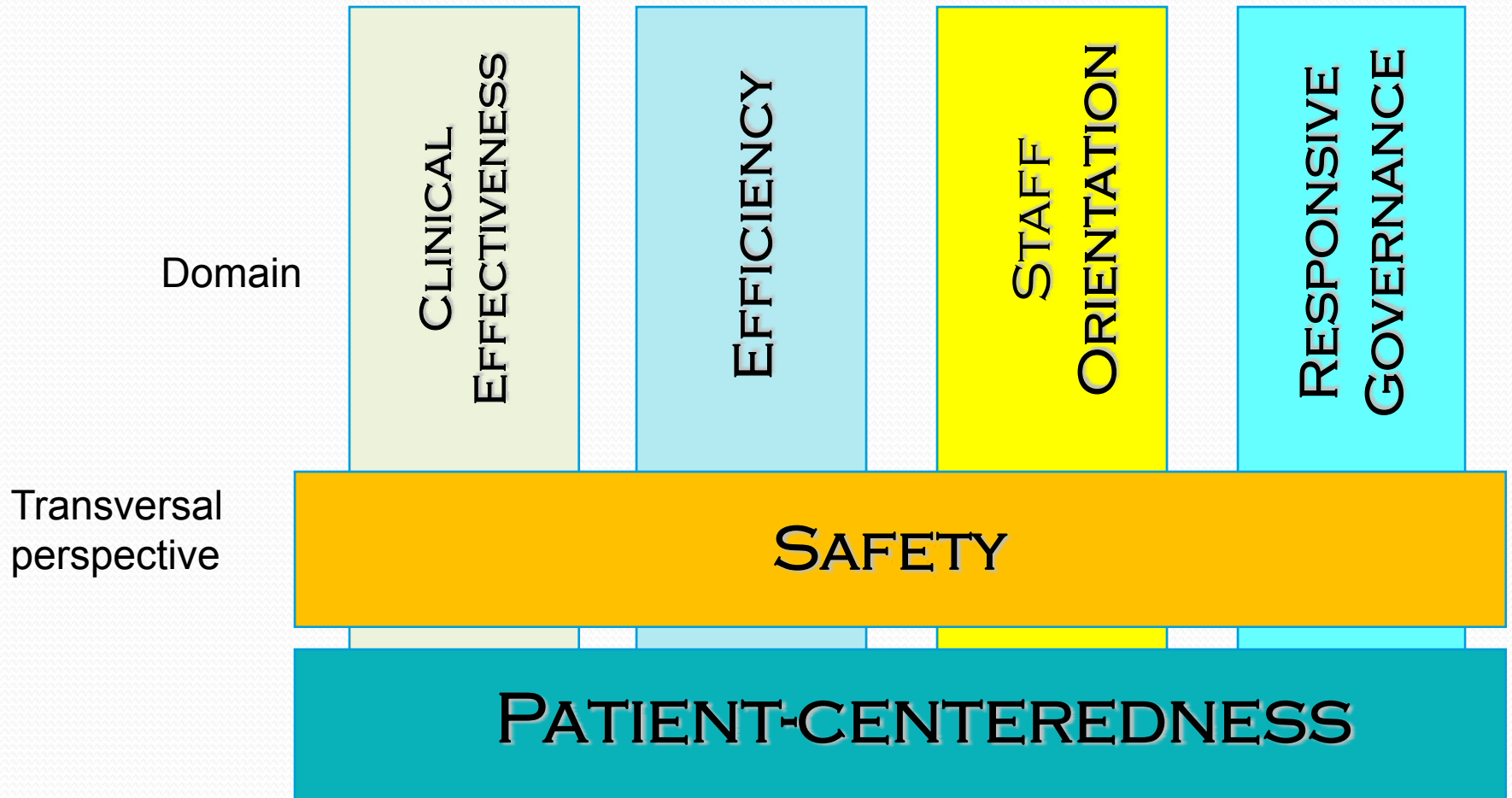
- **MAKE SENSE** : DATA ARE THE PREREQUISITE FOR IMPROVEMENT; HOWEVER, THEY ARE NOT AN END IN THEMSELVES BUT A STARTING POINT FOR ACTION. EVALUATION OF INDICATORS ALWAYS NEEDS TO BE DONE LOCALLY, COMPARING THE INSTITUTIONS' PERFORMANCE TREFERENCE POINTS AND RELATING PERFORMANCE TO LOCAL CONTEXTS

- **MOVE** : THE AIM OF PATH IS TO PROVIDE SUPPORT TO QUALITY IMPROVEMENT STRATEGIES. IT SHOULD ULTIMATELY IMPACT ON ACTIONS FOR QUALITYIMPROVEMENT.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**

6 DIMENSIONS FOR ASSESSING HOSPITAL PERFORMANCE

- CLINICAL EFFECTIVENESS
- PRODUCTION EFFICIENCY
- STAFF ORIENTATION
- RESPONSIVE GOVERNANCE
- SAFETY
- PATIENT CENTEREDNESS

THE THEORETICAL MODEL OF HOSPITAL PERFORMANCE



CLINICAL EFFECTIVENESS

CLINICAL EFFECTIVENESS IS A PERFORMANCE DIMENSION, WHEREIN A HOSPITAL, **IN LINE WITH THE CURRENT STATE OF KNOWLEDGE, APPROPRIATELY AND COMPETENTLY DELIVERS CLINICAL CARE OR SERVICE TO,** AND ACHIEVE DESIRED OUTCOMES FOR ALL PATIENTS LIKELY TO BENEFIT MOST

SUB-DIMENSIONS:
CONFORMITY OF PROCESSES OF CARE,
OUTCOMES OF PROCESSES OF CARE,
APPROPRIATENESS OF CARE

EFFICIENCY

EFFICIENCY IS A HOSPITAL'S OPTIMAL
USE OF INPUTS TO YIELD MAXIMAL
OUTPUTS, GIVEN ITS AVAILABLE
RESOURCES

SUB-DIMENSIONS:
APPROPRIATENESS OF SERVICES
INPUT RELATED TO OUTPUTS OF CARE,
USE OF AVAILABLE TECHNOLOGY FOR BEST POSSIBLE CARE

STAFF ORIENTATION

STAFF ORIENTATION IS THE DEGREE TO WHICH HOSPITAL STAFF ARE APPROPRIATELY QUALIFIED TO DELIVER REQUIRED PATIENT CARE, HAVE THE OPPORTUNITY FOR CONTINUED LEARNING AND TRAINING, WORK IN POSITIVELY ENABLING CONDITIONS, AND ARE SATISFIED WITH THEIR WORK

SUB-DIMENSIONS:

PRACTICE ENVIRONMENT

PERSPECTIVES AND RECOGNITION OF INDIVIDUALS NEEDS

HEALTH PROMOTION ACTIVITIES AND SAFETY INITIATIVES

BEHAVIORAL RESPONSES AND HEALTH STATUS

RESPONSIVE GOVERNANCE

RESPONSIVE GOVERNANCE IS THE DEGREE TO WHICH A HOSPITAL IS RESPONSIVE TO COMMUNITY NEEDS, ENSURES CARE CONTINUITY AND COORDINATION, PROMOTES HEALTH, IS INNOVATIVE, AND PROVIDES CARE TO ALL CITIZENS IRRESPECTIVE OF RACIAL, PHYSICAL, CULTURAL, SOCIAL, DEMOGRAPHIC OR ECONOMIC CHARACTERISTICS

SUB-DIMENSIONS:
SYSTEM/COMMUNITY INTEGRATION
PUBLIC HEALTH ORIENTATION

SAFETY

SAFETY IS THE DIMENSION OF PERFORMANCE, WHEREIN A HOSPITALS HAS THE APPROPRIATE STRUCTURE, AND USES CARE DELIVERY PROCESSES THAT MEASURABLY PREVENT OR REDUCE HARM OR RISK TO PATIENTS, HEALTH CARE PROVIDERS AND THE ENVIRONMENT, AND WHICH ALSO PROMOTE THE NOTION

SUB-DIMENSIONS:
PATIENT SAFETY
STAFF SAFETY
ENVIRONMENT SAFETY

PATIENT CENTEREDNESS

PATIENTS CENTEREDNESS IS A DIMENSION OF PERFORMANCE WHEREIN A HOSPITAL PLACES PATIENTS AT THE CENTER OF CARE AND SERVICE DELIVERY BY PAYING PARTICULAR ATTENTION TO PATIENTS' AND THEIR FAMILIES' NEEDS, EXPECTATIONS, AUTONOMY, ACCESS TO HOSPITALS SUPPORT NETWORKS, COMMUNICATION, CONFIDENTIALLY, DIGNITY, CHOICE OF PROVIDER, AND DESIRE FOR PROMPT, TIMELY CARE.

**SUB-DIMENSIONS:
CLIENT ORIENTATION
RESPECT FOR PATIENTS**

HOW TO DEVELOP A EUROPEAN MODEL OF HOSPITAL PERFORMANCE?

FIRST STAGE: DESIGN AND DEVELOPMENT OF A MODEL OF HOSPITAL PERFORMANCE ASSESSMENT ADAPTED TO THE EUROPEAN CONTEXT

- 1) IDENTIFY DIMENSIONS AND SUB-DIMENSIONS OF PERFORMANCE
- 2) DEVELOP A FRAMEWORK FOR INDICATOR SELECTION
- 3) REVIEW INDICATORS IN CURRENT NATIONAL/REGIONAL PERFORMANCE ASSESSMENT SYSTEMS
- 4) REVIEW LITERATURE TO FIND EVIDENCE ON RELEVANCE, RELIABILITY AND VALIDITY, AND COMPLEMENT LIST OF INDICATORS
- 5) SURVEY IN 11 EUROPEAN COUNTRIES TO ASSESS AVAILABILITY OF DATA, BURDEN OF DATA COLLECTION, POTENTIAL IMPACT ON QUALITY
- 6) SELECTION OF INDICATORS (NOMINAL GROUP TECHNIQUE)
- 7) REVIEW LITERATURE ON INTERRELATIONS BETWEEN INDICATORS
- 8) DESIGN A DASHBOARD TO REPORT THE RESULTS

A DEFINITION OF HOSPITAL PERFORMANCE

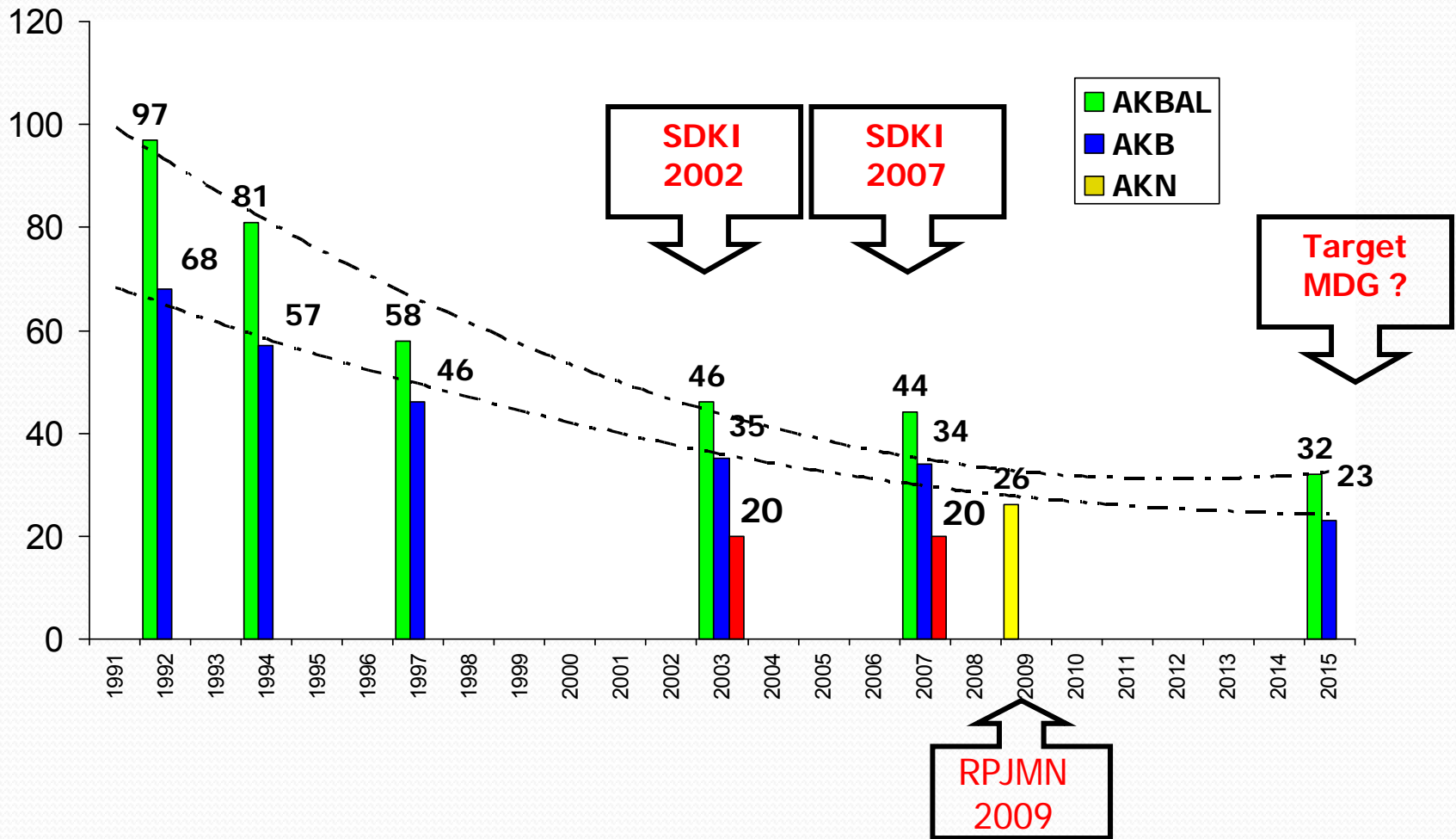
A SATISFACTORY LEVEL OF HOSPITAL PERFORMANCE IS THE MAINTENANCE OF A STATE OF FUNCTIONING THAT CORRESPONDS TO SOCIETAL, PATIENT AND PROFESSIONAL NORMS.

HIGH HOSPITAL PERFORMANCE SHOULD BE BASED ON PROFESSIONAL COMPETENCES IN APPLICATION OF PRESENT KNOWLEDGE, AVAILABLE TECHNOLOGIES AND RESOURCES; EFFICIENCY IN THE USE OF RESOURCES; MINIMAL RISK TO THE PATIENT; RESPONSIVENESS TO THE PATIENT; OPTIMAL CONTRIBUTION TO HEALTH OUTCOMES.

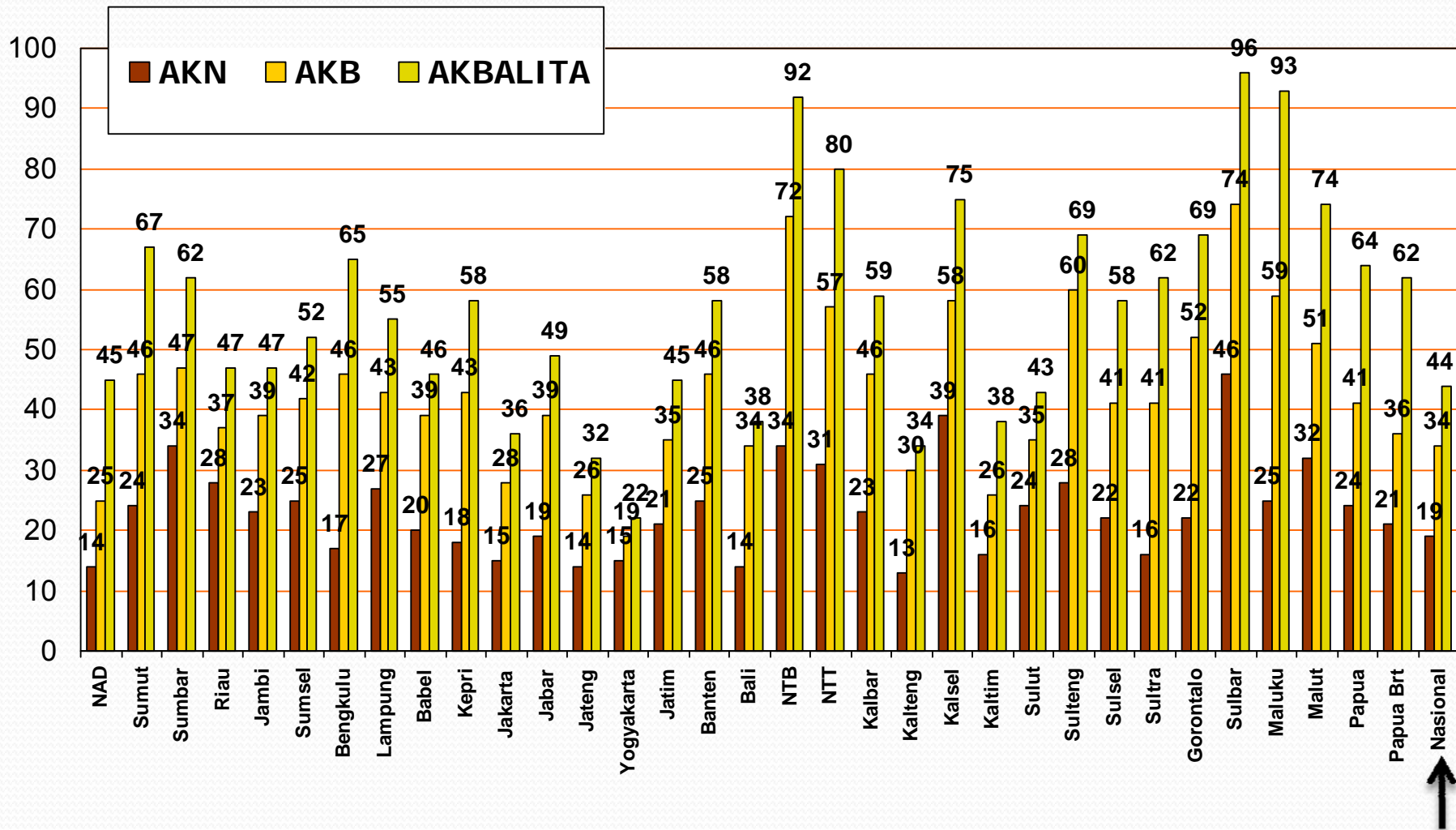
WITHIN THE HEALTH CARE ENVIRONMENT, HIGH HOSPITAL PERFORMANCE SHOULD FURTHER ADDRESS THE RESPONSIVENESS TO COMMUNITY NEEDS AND DEMANDS, THE INTEGRATION OF SERVICES IN THE OVERALL DELIVERY SYSTEM, AND COMMITMENT TO HEALTH PROMOTION.

HIGH HOSPITAL PERFORMANCE SHOULD BE ASSESSED IN RELATION TO THE AVAILABILITY OF HOSPITALS' SERVICES TO ALL PATIENTS IRRESPECTIVE OF PHYSICAL, CULTURAL, SOCIAL, DEMOGRAPHIC AND ECONOMIC BARRIERS.

PERKEMBANGAN AKB & AKBAL DAN TARGET MDG 2015



ANGKA KEMATIAN NEONATAL, BAYI DAN BALITA DI INDONESIA



INISIASI MENYUSU DINI



Gambar 1. Verniks kaseosa



Gambar 2. Diberi topi



Gambar 3. Kontak kulit ke kulit



Gambar 4. Breast crawl



Gambar 5. Bonding crawl



Gambar 6. Ibu dan Bayi lebih tenang

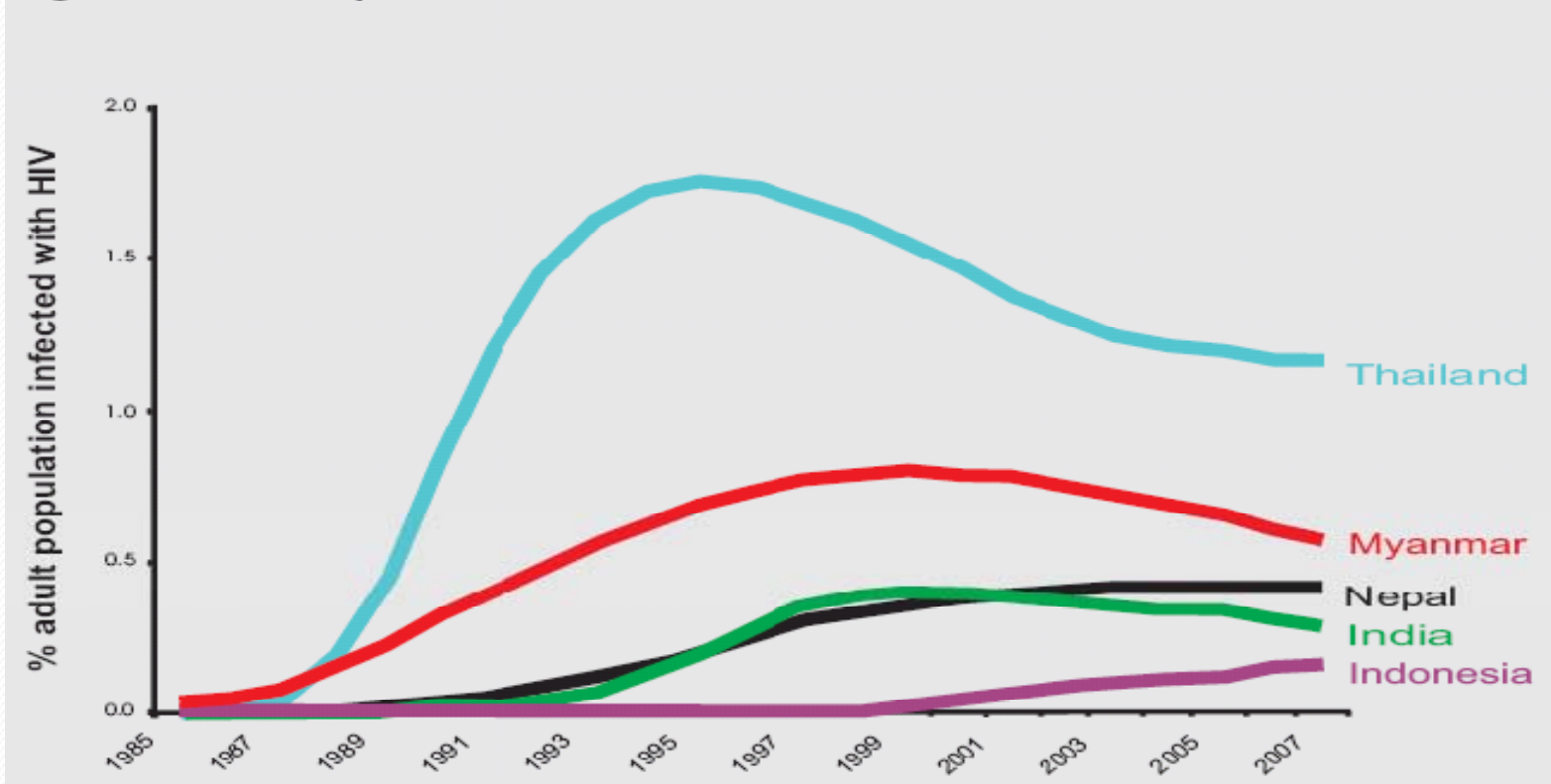
Skrining HIV di Rumah Sakit Dalam Upaya Pencegahan Penyebaran HIV



**Konvensi HTA Indonesia
2010**

Sejak tahun 2000 kurva prevalensi Indonesia cenderung terus meningkat dari tahun ke tahun sementara kurva negara lain cenderung stabil atau menurun. Kenaikan ini merisaukan.

Fig. 2: Adult HIV prevalence in selected SEAR countries, 1990-2007



(WHO. HIV Burden.South East Asia Region.2008.IIIb,C)

Prediksi tahun 2025

- *Generalised epidemic*; 1,95 juta orang dgn HIV/AIDS

- Prevalensi HIV orang dws di Indonesia > 1%; dgn 1,5 jt kematian

Papua → paling berat :

- Prevalensi HIV orang dewasa 7%

- 166.000 anak yatim piatu

Biaya pelayanan kesehatan ↑ krn 27% bed RS akan dihuni pasien HIV, di Papua 80%

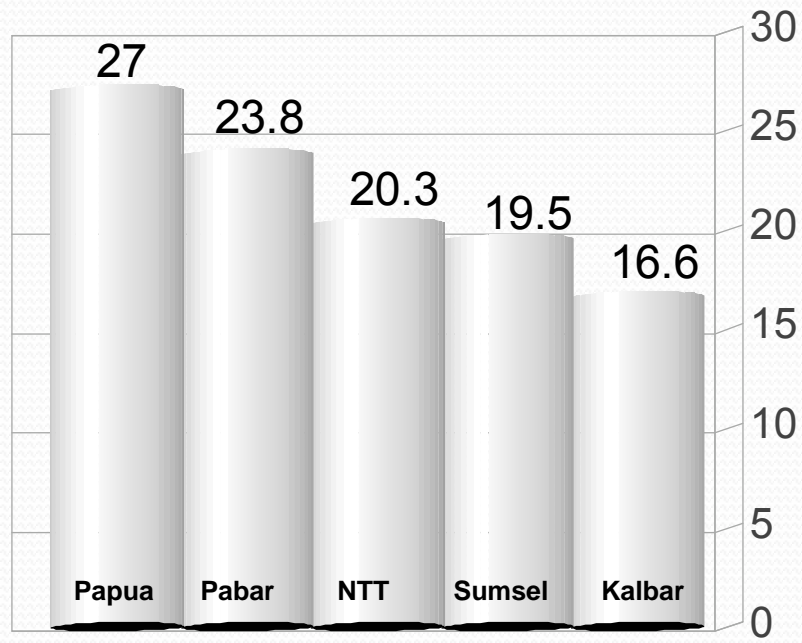


Prediksi Persalinan preterm

Santoso Soeroso, Damar Prasmusinto, Asril Aminullah, Ali Sungkar, Rukmono Siswishanto, Makmur Sitepu, Muhammad Ilhamy, Laurensia Lawintono

- Proporsi Bayi Berat Lahir Rendah (BBLR) 11,5% (Riskesdas Depkes, 2007)

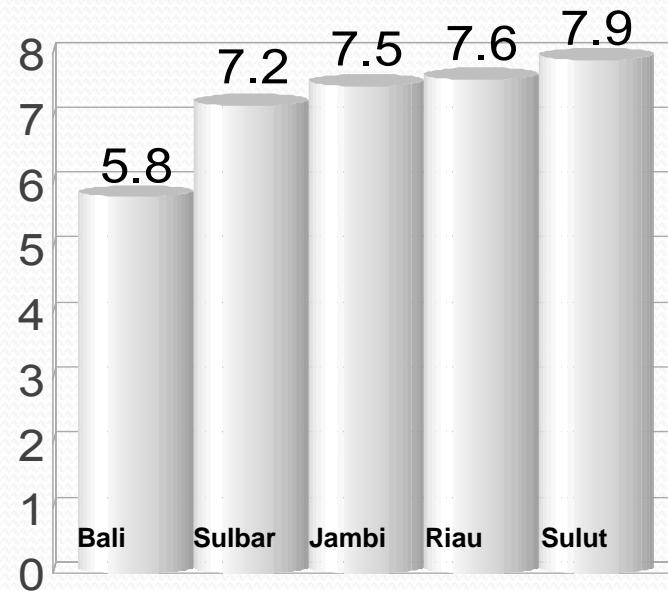
Besaran Masalah



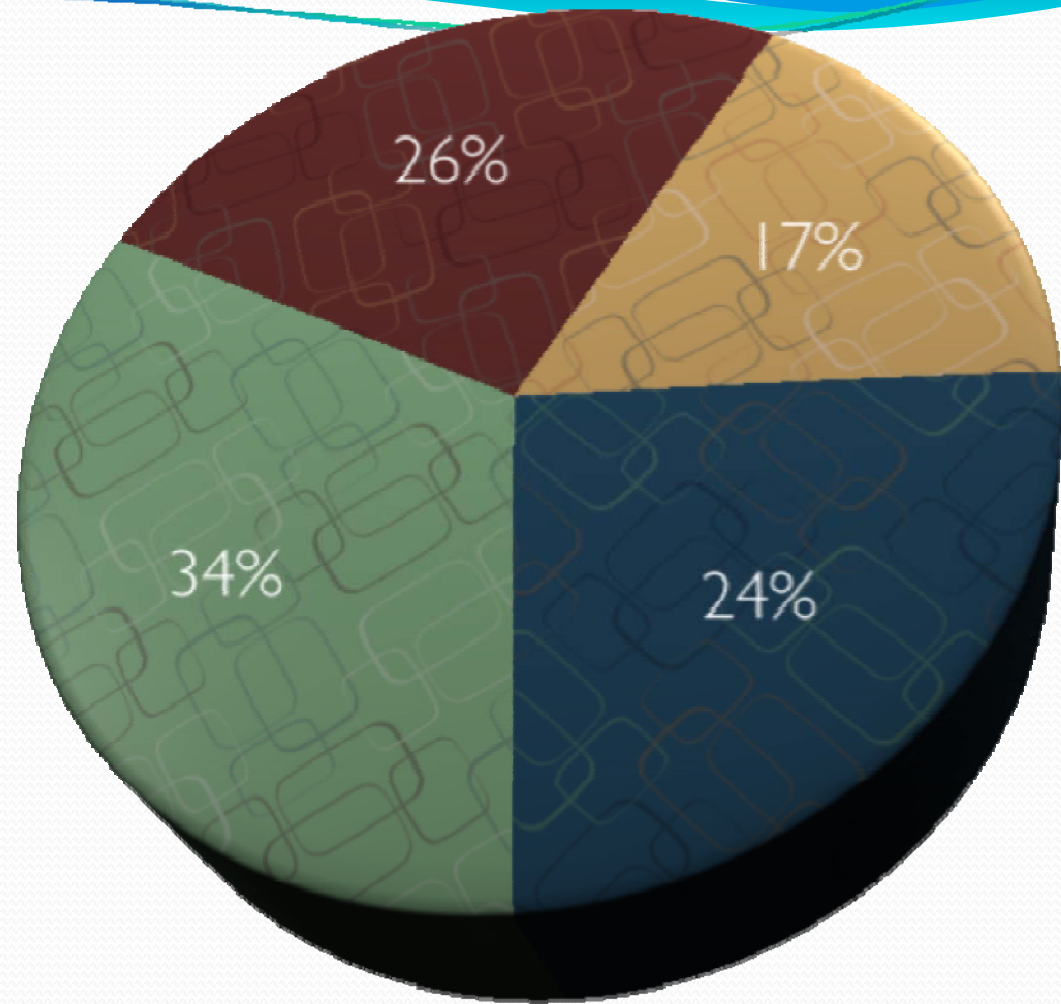
Category Title

- Proporsi Bayi Berat Lahir Rendah (BBLR) 11,5% (Risesdas Depkes, 2007)

Besaran Masalah



Category Title



- tidak diketahui sebabnya
- kehamilan ganda
- infeksi genitalia, ketuban pecah dini, perdarahan antepartum, inkompetensia serviks, dan kelainan kongenital uterus
- hipertensi dalam kehamilan, pertumbuhan janin terhambat, kelainan kongenital dan penyakit-penyakit lain

Analisis Ekonomi

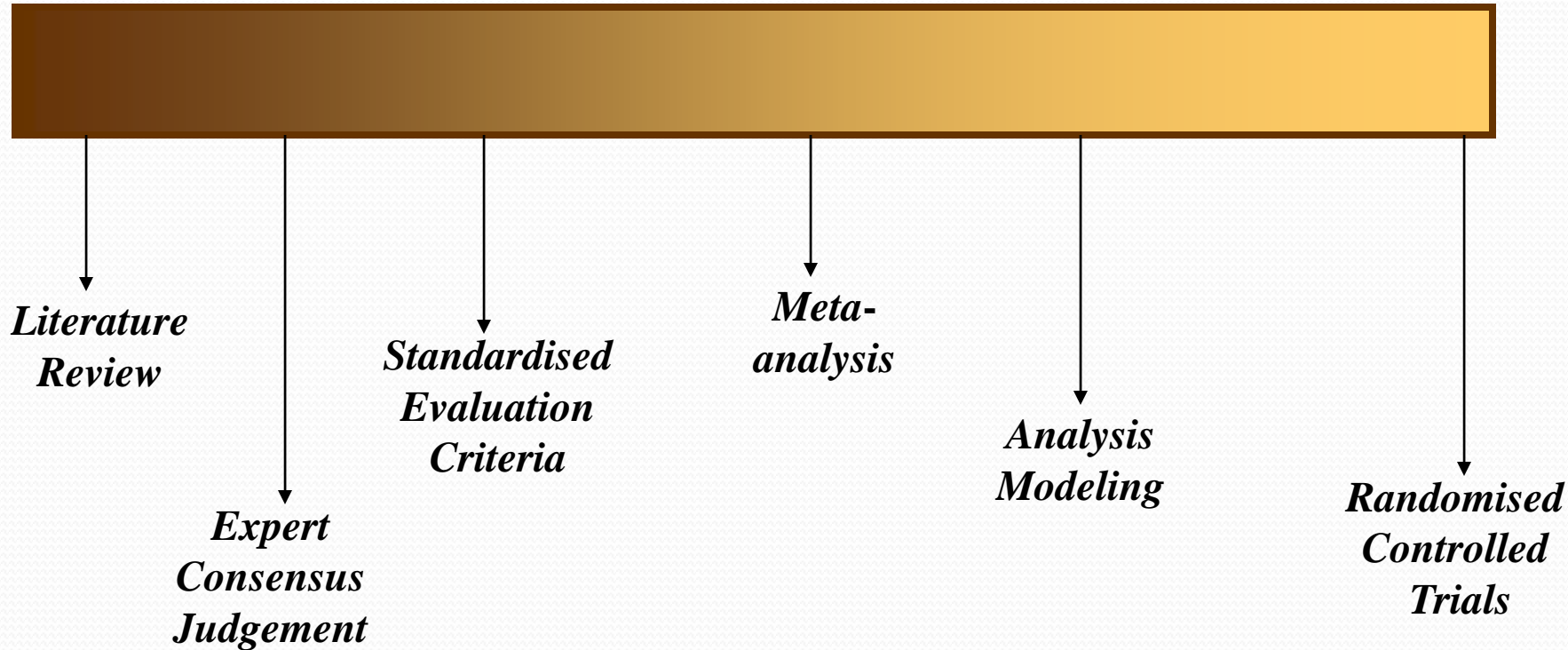
Kebutuhan biaya prediksi preterm yang direkomendasikan

No	Prediksi	Biaya (Rp)	Sensitivitas (%)	Spesifisitas (%)	Nilai Prediksi Positif (%)	Nilai Prediksi Negatif (%)
1	IGFBP-1	200.000	100	92	84	100
2	Skrining infeksi vagina (termasuk deteksi infeksi dengan pewarnaan Gram)	50	97	95		
3	USG transvaginal	60.000 – 100.000	905	98	95	96
4	Fibronektin fetal	850.000	66,7 (≤ 7 hari setelah pemeriksaan)	91,8 (≤ 7 hari setelah pemeriksaan)	9,1 (≤ 7 hari setelah pemeriksaan)	99,6 (≤ 7 hari setelah pemeriksaan)
5	Skoring faktor risiko	50	< 25-50		20-40	

SPECTRUM OF HEALTH TECHNOLOGY ASSESSMENT

**Assessment
Activities**

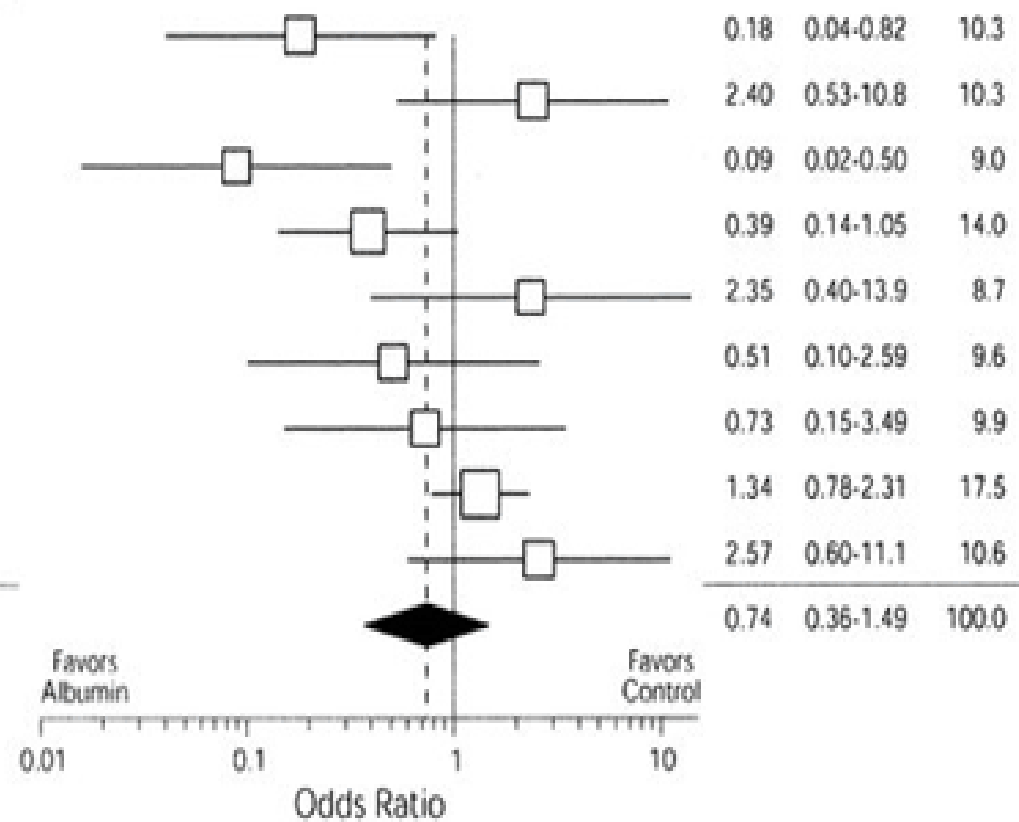
**Evaluative
Research**

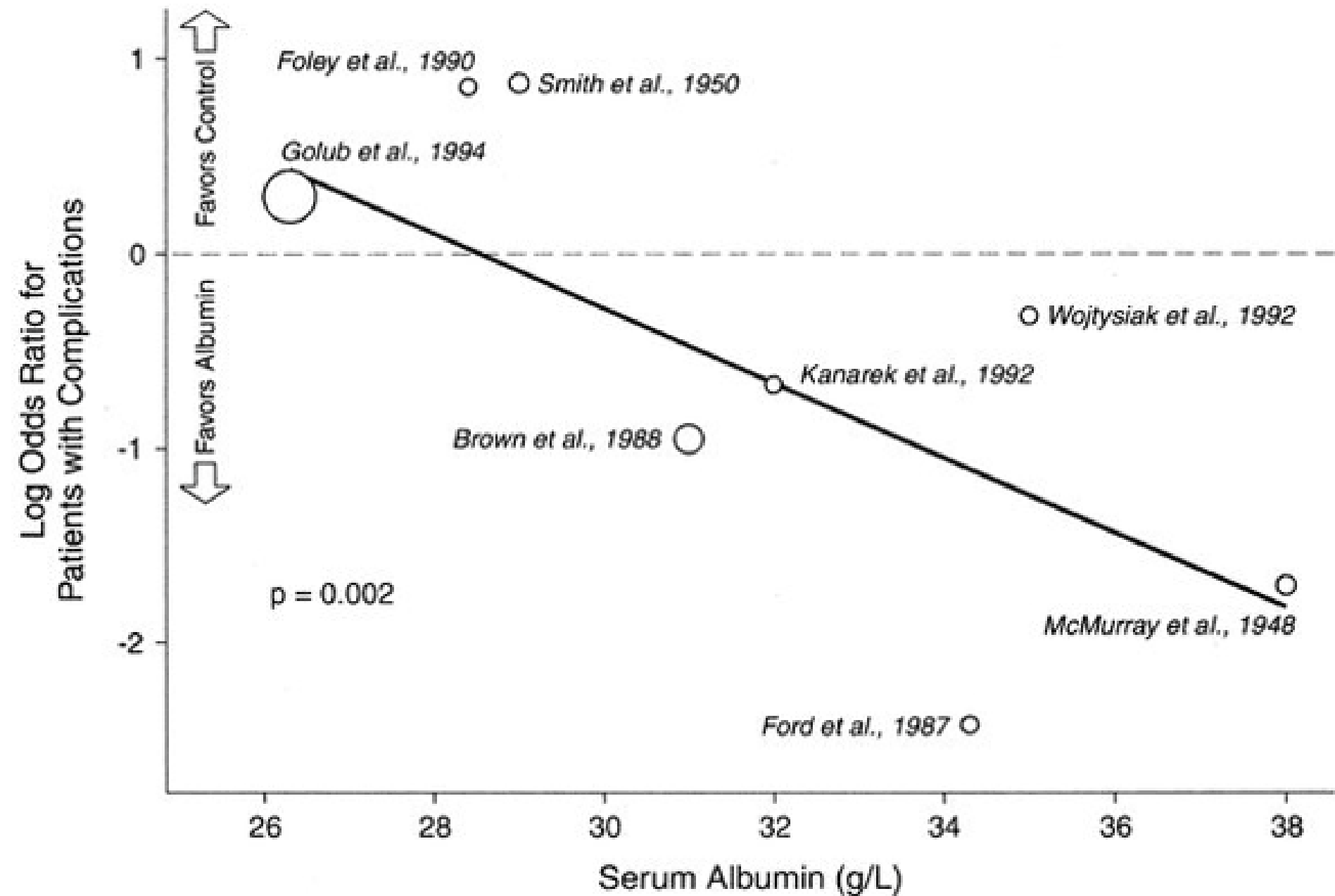


Level of Evidence dan Tingkat Rekomendasi

Level	Literatur	Rekomendasi
I a	Meta-analisis <i>Randomized Clinical Controlled Trial</i>	A
I b	Minimal satu <i>Randomized Clinical Controlled Trial</i>	
II a	Minimal satu non <i>Randomized Clinical Controlled Trial</i>	B
II b	Studi kohort dan / atau kasus-kontrol	
III a	Studi <i>cross-sectional</i>	C
III b	Seri kasus dan laporan kasus	
IV	Konsensus dan pendapat ahli	

	Albumin		Control	
	Patients with Complications	Total	Patients with Complications	Total
McMurray et al, 1948 ¹¹¹	4	16	11	17
Smith et al, 1950 ¹¹²	6	26	3	27
Ford et al, 1987 ¹¹³	2	20	10	18
Brown et al, 1988 ¹¹⁴	16	34	23	33
Foley et al, 1990 ¹¹⁵	16	18	17	22
Kanarek et al, 1992 ¹¹⁶	5	12	7	12
Wojtysiak et al, 1992 ¹¹⁷	10	15	11	15
Golub et al, 1994 ¹¹⁸	51	116	38	103
Rubin et al, 1997 ¹¹⁹	9	16	5	15
	119	273	125	262





Shouldice inguinal hernia repair in the male adult: the gold standard? A multicenter controlled trial in 1578 patients.

Hay JM, Boudet MJ, Fingerhut A, Poucher J, Hennet H, Habib E, Veyrières M, Flamant Y. Hôpital Louis Mourier, Colombes, France.

- **BACKGROUND:** Hernia repair is the second most frequently performed operation in France and in the United States, the prevalence being 36 for every 1000 males. Lowering the recurrence rate by 1% would mean 1000 fewer operations for hernia repair per year in France. **METHODS:** Between 1983 and 1989, 1578 adult males with a total of 1706 nonrecurrent inguinal hernias were prospectively and randomly allotted to undergo either a Bassini's repair, Cooper's ligament, or Shouldice repair with polypropylene or a Shouldice repair with stainless steel for determination of which technique was associated with the lowest recurrence rate. Fifty-nine hernia repairs were withdrawn after inclusion. Of the 1647 remaining hernias, 52.2% were indirect, 25.6% were direct, and 23.2% were combined. Patients were seen every 6 months for 3 years and then every year. Median follow-up was 5 years 8 months (range, 3 months-8.5 years). **RESULTS:** At 8.5 years, 5.6% of hernias were lost to follow-up. Ninety-seven hernia repairs failed, 50% during the first 2 years. The actuarial recurrence rate was 7.94% at 8.5 years. The Shouldice repair (stainless steel or polypropylene) was associated with fewer recurrences (6.1%) than either the Bassini's (8.6%) or Cooper's ligament repair (11.2%) technique ($p < 0.001$). This difference remained significant even when the maximal bias test was used. Fewer recurrences (5.9%) were observed with the stainless steel wire Shouldice repair than with polypropylene version (6.5%), but the difference was not significant. **CONCLUSIONS:** Shouldice hernia repair provides the patient with the best chances of nonrecurrence regardless of the anatomical type of hernia. The Shouldice hernia repair should be the gold standard for inguinal hernia repair in men and serves as the basis for comparison with all other techniques, be they prosthetic or laparoscopic.

RS SHOULDICE, TORONTO, CANADA

- RS Shouldice memiliki 12 ahli bedah yang hanya melakukan hernia repair
- Tiap ahli bedah melakukan 600 – 800 operasi / tahun
- Hernia repair dilakukan hanya dalam 35 – 45 menit
- Tanpa menggunakan mess / jaring untuk menutup lubang hernia
- Pertimbangannya : merupakan benda asing, menimbulkan infeksi, mahal (harga di Indonesia kl. Rp. 4 – 5 juta)
- Angka kambuh 1%
- Biaya separuh dari biaya hernia repair di AS (\$ 4000)

LINKING THE DIMENSIONS TO THEORIES OF ORGANIZATIONAL PERFORMANCE

DIMENSION	CORRESPONDING THEORETICAL MODEL
CLINICAL EFFECTIVENESS	RATIONALE OF PROFESSIONALS
PATIENT CENTEREDNESS	RATIONALE OF PATIENT EXPERIENCE AND PATIENT SATISFACTION
EFFICIENCY	INTERNAL RESOURCES MODEL + RESOURCES ACQUISITION MODEL
SAFETY	FAULT-DRIVEN MODEL
STAFF ORIENTATION	HUMAN RELATIONS MODEL
RESPONSIVE GOVERNANCE	STRATEGIC CONSTITUENCIES MODEL + SOCIAL LEGITIMACY

OUR FRAMEWORK FOR SELECTING INDICATOR PERFORMANCE S

Set

- Potential for use and abuse
- Content & Face validity

INDICATOR

LEVEL 1 : INDICATOR

IMPORTANCE & USEFULNESS

LEVEL 2 : TOOLS OF MEASUREMENT

2.1. IF AVAILABLE : RELIABILITY, VALIDITY, CAUSATION

2.2. IF NOT AVAILABLE : BURDEN OF DEVELOPMENT

LEVEL 3 : DATA COLLECTION

BURDEN OF DATA MEASUREMENT

INDIKATOR KLINIK PELAYANAN REHABILITASI MEDIK DI RUMAH SAKIT

Perhimpunan Dokter Spesialis Kedokteran Fisik dan Rehabilitasi Indonesia
(PERDOSRI)

Semarang, 26-27 Mei 2010

INDICATORS

1. A CORE INDICATOR

A NUMBER OF INDICATORS RELEVANT, RESPONSIVE AND VALID IN MOST CONTEXTS, RELYING ON SOUND SCIENTIFIC EVIDENCE, FOR WHICH DATA ARE AVAILABLE AND EASY TO COLLECT.

2. A TAILORED INDICATOR

INDICATORS SUGGESTED ONLY IN SPECIFIC CONTEXTS BECAUSE OF VARYING AVAILABILITY OF DATA, VARYING APPLICABILITY (E.G. TEACHING HOSPITALS, RURAL HOSPITALS) OR VARYING CONTEXTUAL VALIDITY (CULTURAL, FINANCIAL, ORGANIZATIONAL SETTINGS).

PROPOSED CORE SET OF PERFORMANCE INDICATORS

PATIENT CENTEREDNESS

1. CANCELLED ONE-DAY SURGICAL PROCEDURES
2. SCORE ON PATIENT PERCEPTION/SATISFACTION QUESTIONNAIRE
3. (A) OVERALL PERCEPTION SATISFACTION
3. (B) INTERPERSONAL ASPECTS
3. (C) CLIENT ORIENTATION: INFORMATION AND EMPOWERMENT; CONTINUITY

RESPONSIVE GOVERNANCE

3. (D) PERCEIVED CONTINUITY THROUGH PATIENT SURVEY
4. DISCHARGE LETTERS TO GP
5. WAITING TIME FOR SELECTED PROCEDURES AND CONDITIONS
6. WOMEN BREASTFEEDING AT DISCHARGE

STAFF ORIENTATION

7. TRAINING DAYS AND TRAINING BUDGET
8. BUDGET DEDICATED TO STAFF HEALTH PROMOTION ACTIVITIES
9. ABSENTEEISM

PROPOSED CORE SET

CLINICAL EFFECTIVENESS

12. PRIMARY C-SECTION DELIVERY
13. APPROPRIATENESS OF PROPHYLACTIC ANTIBIOTIC USE
14. READMISSION FOR SELECTED TRACER CONDITIONS / PROCEDURES WITHIN THE SAME HOSPITAL
15. ADMISSION AFTER DAY SURGERY
16. RETURN TO ICU FOR SELECTED PROCEDURES/CONDITIONS

SAFETY

17. MORTALITY RATES
18. SENTINEL EVENTS
19. WORK-RELATED INJURIES (PERCUTANEOUS INJURIES)

EFFICIENCY

20. AMBULATORY SURGERY USE
21. ADMISSION ON DAY OR SURGERY
22. LENGTH OF STAY FOR SPECIFIC PROCEDURES
23. AVERAGE INVENTORY IN STOCK
24. OPERATING ROOMS UNUSED SESSIONS

FROM INDICATORS TO INTERPRETATION TO ACTION

OPERATING MODEL:

FROM A SET OF INDICATORS TO AN **OPERATIONAL MODEL**

STRUCTURED DASHBOARD

- SYNTHETIC OVERVIEW (COMPREHENSIVE AND HIGHLIGHTS TRADE-OFFS)
- DETAILED INFORMATION ON SPECIFIC INDICATORS

INTERPRETATION: FROM MEASUREMENT TO **ASSESSMENT**

ENABLE **MEANING**: RELATE INDICATORS TO EACH OTHER

ENABLE **JUDGMENT**: RELATE INDICATORS WITH REFERENCES

ACTION: FROM ASSESSMENT TO **ACTION**

LEARNING FROM BENCHMARKS

⇒ PATH ROLE: STIMULATE CREATION OF NETWORKS

STAFF ORIENTATION INDICATORS

INDICATOR NAME C 12. EXCESSIVE WORKING HOURS

- RATIONALE (INCLUDING JUSTIFICATION, STRENGTHS AND LIMITS)
- EXCESSIVE WORKING HOURS HAVE AN IMPACT ON STAFF HEALTH AND SATISFACTION. THEY REFLECT OVERLOAD, JOB STRAIN AND POOR HUMAN RESOURCE PLANNING. BUT THEY ALSO HAVE AN IMPACT ON PATIENT SAFETY AS EVIDENCE SUGGEST THAT PROFESSIONALS THAT ARE TIRED MAKE MORE ERRORS. THE EU'S WORKING DIRECTIVE HAS DIRECT IMPLICATIONS FOR THE HEALTH SECTOR.
- STRENGTHS: STRONG FACE VALIDITY AND SOME CONSTRUCT VALIDITY
- LIMITATIONS: NOT APPLICABLE TO ALL STAFF CATEGORIES, ONLY PARTLY UNDER HOSPITAL INFLUENCE.
- DOMAIN STAFF ORIENTATION,

DEFINISI DAN CARA PENGUKURAN

DEFINITION NUMBER OF HOURS WORKED EXCEEDING NORMAL WORKING HOURS. ACCORDING TO THE EU DIRECTIVE ON WORKING TIMES, “MEMBER STATES SHALL TAKE MEASURES TO ENSURE THAT WORKERS ENJOY AN AVERAGE OF WEEKLY WORKING PERIOD OF NOT MORE THAN 48 HOURS, INCLUDING THE OVERTIME FOR EACH SEVEN-DAY PERIOD.”

TYPE OF INDICATOR : QUALITATIVE MEASUREMENT

QUALITATIVE MEASUREMENT : DO YOU MONITOR EXCESSIVE WORKING HOURS? [YES, NO]

HOW DO YOU MONITOR? [TEXT]

PLEASE PROVIDE VALUE: [FOR HOSPITALS' OWN PERFORMANCE REPORT, BY DEPARTMENT, IF AVAILABLE]

OPTIONAL

DEFINITION THE PERCENT OF WEEKS WORKED MORE THAN 48 HOURS DURING A SPECIFIED PERIOD.

NUMERATOR WEEKS WORKED MORE THAN 48 HOURS.

DENOMINATOR ALL WORK WEEKS.

INCLUSION LIMIT TO NURSES AND NURSE ASSISTANTS. INCLUDE

CRITERIA OF INDICATOR SELECTION

Level	Criteria	Issue addressed by the criterion
Set of indicator	Face validity Content validity Construct validity	Is the indicator set acceptable as such by its potential users? Are all the dimensions covered properly? How do indicators relate to each other?
Indicators	Importance and relevance Potential for use and sensitivity to implementation	Does the indicator reflect aspects of functioning that matter to users and are relevant in current health care context? Are hospitals able to act upon this indicator if it reveals a problem?
Measurement tools	Reliability Face validity Content validity Contextual validity Construct validity Burden of data collection	Is there demonstrated reliability of data? Is there a consensus among users and expert that this measure is related to the dimension (or sub-dimension) it is supposed to assess? Does the measure relate to the sub-dimension of performance it is supposed to assess? Is this indicator valid in different contexts? Is this indicator related to other indicators measuring the same sub-dimension of hospital performance? Are data available and easy to access?

indicator set

■ Clinical effectiveness & safety

- 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 melitus).
- 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 (same tracers as day surgery).
- C7 Return to ICU.

■ Efficiency

- C8. Length of stay (acute myocardial infarction, stroke, community acquired pneumonia, hip fracture, coronary artery bypass graft).
- C9. Surgical Theatre use.

■ Clinical effectiveness & safety

- 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.

■ Efficiency

- 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.

Core indicators

■ Staff orientation & safety

- C10. Training expenditure.
- C11. Absenteeism.
- C12. Excessive working hours.
- C13. Needle injuries.
- C14. Staff smoking prevalence.

■ Responsive governance

- C15. Breastfeeding at discharge.
- C16. Health care transitions.

■ Patient centeredness

- C17. Patient expectations.

Tailored indicators

■ Staff orientation & safety

- 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.

■ Responsive governance

- 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.

■ Patient centeredness

- T23. Patient survey score on access to care.
- T24. Patient survey score on amenities of care.

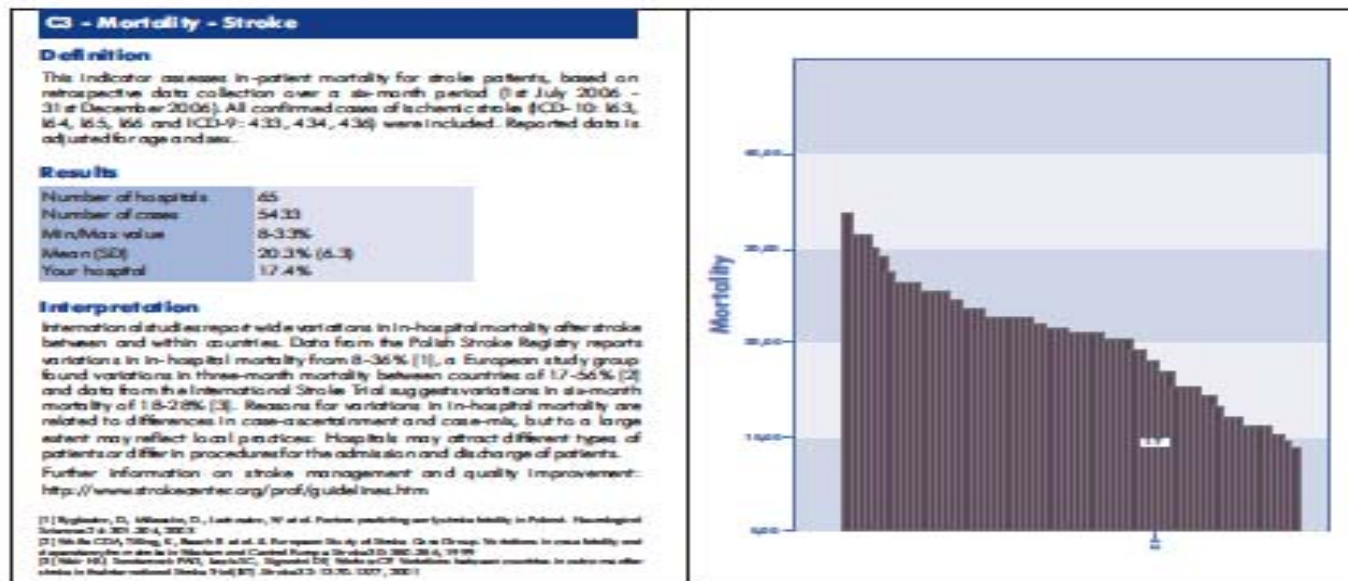
Reporting of performance

The performance reports are the core output of the PATH project. They support hospital managers in comparing the performance of their hospitals with the performance of a peer group of hospitals and also allow managers to identify where their hospitals over or underperform.

The performance reports will provide, for each of the indicators, an overview on the distribution of hospital performance. Each hospital will know how it performs relative to other hospitals; however, it will not be possible to identify those hospitals.

Statistical information will be provided on the number of hospitals contributing and the frequency of cases, measures of tendency and dispersion. Contextual information will describe the indicators and data sources, guidance on interpretation and reference values as well as links to clinical guidelines and other quality improvement tools, where applicable. Figure 3 provides an example for one indicator.

Fig. 3: Example. Presentation of Hospital performance



PRAKTIK KEDOKTERAN IDEAL DG. TATA KELOLA KLINIK YG. BAIK SEBAGAI INTI KEGIATAN RS YANG SESUAI PATH

SOP writing, compliance,
clinical audit, medical audit

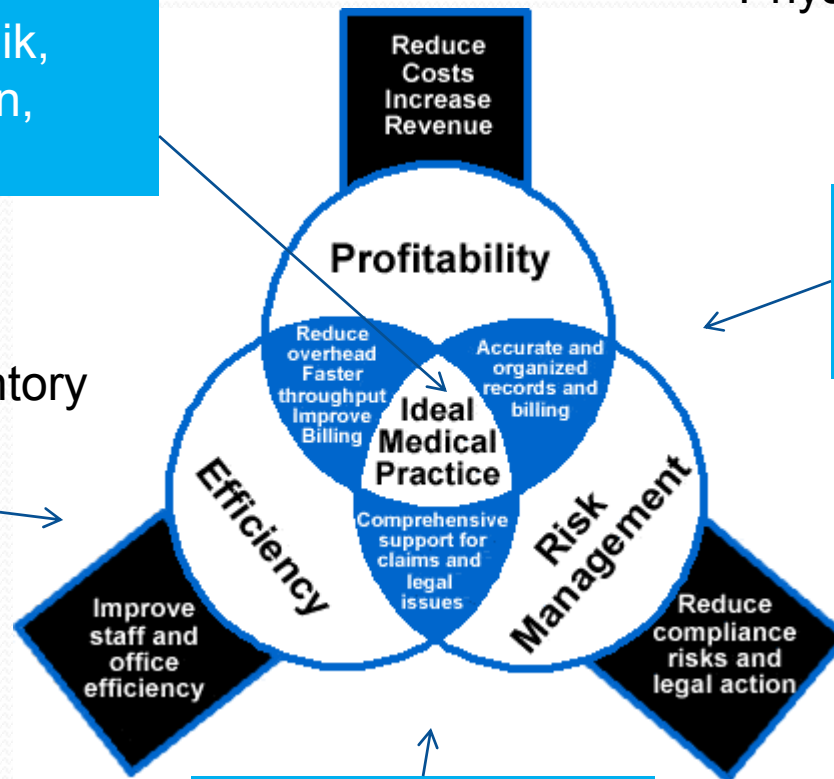
Hospital Information System
Electronic MR, Computerized
Physician order entry, etc

Clinical
Privilege
Clinical
pathway

Tata Kelola Klinik
Komite medik,
keperawatan,
farmasi dll

Farmasi,
Penunjang
medik,
penunjang
non-medik
keperawatan
Teknologi
informasi ,
manajemen
keuangan dll

Inventory
Turn
Over



Rekam medik,
teknologi informasi,
keuangan, pemasaran

Komite medik.
Keperawatan.
Manager
risiko

keuangan, hukum
dan asuransi

Patient safety
Consumer voice

CLINICAL INDICATOR MEDICAL REHABILITATION SERVICES

Dimension	Safety	Patient Centeredness	Non related
Clinical effectiveness	<ul style="list-style-type: none"> a. Diagnosis PMR/Therapist b. Fulfillment of Medical Record c. Clinical Pathway/SOP d. Intervention/therapy error e. Incident/Near miss f. Equipment maintenance 	<ul style="list-style-type: none"> a. Goal achievement b. Response time c. Informed consent d. Team /Family Meeting 	
Efficiency	<ul style="list-style-type: none"> a. Equipment maintenance 		<ul style="list-style-type: none"> a. Utilization of equipment
Staff Orientation	<ul style="list-style-type: none"> a. Working burden b. Quality improvement c. Occupational Injuries 		
Responsive Governance		<ul style="list-style-type: none"> a. Team/Family meeting b. Community Care 	

INDIKATOR KLINIK PELAYANAN REHABILITASI MEDIK

CLINICAL EFFECTIVENESS-PATIENT SAFETY

Performance Indicator	Numerator	Denominator
2. Kelengkapan Rekam Medik	Jumlah RM yang ditulis lengkap	Jumlah pasien yang dilayani
3. Adanya SPM/SOP	Jumlah SPM/SOP yang ada	10 SPM/SOP
4. Kesalahan tindakan/terapi	Jumlah pasien yang mengalami kesalahan tindakan	Jumlah pasien yang dilayani
5. Kesalahan tindakan nearmiss	Jumlah pasien dengan kesalahan tindakan nearmiss	Jumlah pasien yang dilayani
6. Pemeliharaan alat	Jumlah alat yang mempunyai checklist pemeliharaan	Jumlah semua alat yang memerlukan pemeliharaan

INDIKATOR KLINIK PELAYANAN REHABILITASI MEDIK CLINICAL EFFECTIVENESS-PATIENT CENTEREDNESS

Performance Indicator	Numerator	Denominator
1. Pencapaian Goal (RI)	Jumlah pasien rawat inap yang goalnya tercapai	Jumlah pasien rawat inap yang dilayani
2. Response Time	Jumlah pasien rawat jalan yang dilayani <2jam	Jumlah pasien rawat jalan yang dilayani
	Jumlah pasien rawat inap yang dilayani < 24 jam	Jumlah pasien rawat inap yang dilayani
3. Informed consent	Jumlah pasien yang mendapat informed consent tertulis	Jumlah pasien yang mendapat tindakan yang berisiko
4. Pertemuan Tim/Keluarga	Jumlah pertemuan tim/keluarga yang terlaksana	Jumlah pertemuan tim/keluarga yang terjadual

Indikator Klinik Pelayanan Rehabilitasi Medik

Efficiency-Patient Safety

Performance Indicator	Numerator	Denominator
1. Equipment maintenance	Jumlah alat yang mempunyai checklist pemeliharaan	Jumlah alat yang memerlukan pemeliharaan berkala
2. Utilisasi alat*	Jumlah waktu pemakaian alat tertentu	Jumlah kapasitas pemakaian alat tersebut

Indikator Klinik Pelayanan Rehabilitasi Medik Staff Orientation-Safety

Performance Indicator	Numerator	Denominator
1. Beban kerja	Jumlah total waktu pelayanan yang diberikan oleh tenaga tertentu	Jumlah kapasitas tenaga tertentu
2. Peningkatan kualitas SDM	Jumlah SDM yang mengikuti training per tahun	Jumlah SDM yang terjadwal untuk mengikuti training pertahun
3. Cedera akibat kerja	Jumlah tenaga tertentu yang cedera dalam menjalankan pekerjaan	Jumlah semua tenaga kerja tertentu

Indikator Klinik Pelayanan Rehabilitasi Medik Responsive Governance-Patient Centeredness

Performance Indicator	Numerator	Denominator
1. Pertemuan Tim/Keluarga	Jumlah pertemuan tim/keluarga yang terlaksana	Jumlah pertemuan tim/keluarga yang terjadual
2. Pelayanan Masyarakat	Jumlah klub kesehatan yang dibina oleh tim rehabilitasi medik di RS	Jumlah semua klub kesehatan yang ada di RS

PROMS AND PROMS

QUESTIONNAIRE

- PATIENT REPORTED OUTCOME MEASURES SYSTEM ELICITS INFORMATION ON THE BENEFITS OF TREATMENTS AS PERCEIVED BY THE PATIENTS THEMSELVES BY LISTENING TO PATIENTS' VIEWS OF THEIR TREATMENT, THAT CAN BE USED TO REVIEW CURRENT PRACTICE AND IMPROVE QUALITY OF CARE

PROMS QUESTIONNAIRE CONSISTS OF :

- SYMPTOMS (IMPAIRMENTS)
- FUNCTIONING (DISABILITY)
- HEALTH RELATED QUALITY OF LIFE (HRQoL)
- QUALITY OF LIFE (QoL).

VARIABEL TERKAIT HRQOL

- COGNITIVE FUNCTION
- MOTOR FUNCTION
- PSYCHOLOGICAL FUNCTION
- SENSORY FUNCTION
- SOCIAL FUNCTION
- CAREGIVER SUPPORT
- ECONOMIC
- LIFESTYLE CHANGES NECESSITATED BY ILLNESS , PAIN, PAIN VARIANTS

HOSPITAL OF THE FUTURE

HEALTH CARE AT THE CROSS-ROADS :
GUIDING PRINCIPLES FOR THE DEVELOPMENT OF THE
HOSPITAL OF THE FUTURE
THE JOINT COMMISSION
19TH NOVEMBER 2008



ECONOMIC VIABILITY

- ENCOURAGE THE ALIGNMENT OF HOSPITAL MEASUREMENT AND PAYMENT SYSTEMS TO MEET QUALITY AND EFFICIENCY-RELATED GOALS
- APPLY PROCESS IMPROVEMENT TOOLS TO IMPROVE EFFICIENCY AND REDUCE COSTS
- PURSUE COVERAGE OPTIONS TO ENSURE PATIENT ACCESS TO, AND AFFORDABILITY OF, HEALTH CARE SERVICES
- ADDRESS THE DISEQUILIBRIUM BETWEEN THE BURDENS OF GENERAL ACUTE HOSPITALS AND SPECIALTY HOSPITALS IN FULFILLING THE SOCIAL MISSION FOR HEALTH CARE DELIVERY



TECHNOLOGY ADOPTION

- ESTABLISH THE BUSINESS CASE AND SUSTAINABLE FUNDING SOURCES TO SUPPORT THE WIDESPREAD ADOPTION OF HEALTH INFORMATION TECHNOLOGY
- REDESIGN BUSINESS AND CARE PROCESSES IN TANDEM WITH HEALTH INFORMATION TECHNOLOGY TO ENSURE BENEFIT ACCRUAL
- USE DIGITAL TECHNOLOGY TO SUPPORT PATIENT CENTERED HOSPITAL CARE AND EXTEND THAT CARE BEYOND THE HOSPITAL WALLS
- ESTABLISH RELIABLE AUTHORITIES TO PROVIDE TECHNOLOGY ASSESSMENT AND INVESTMENT GUIDANCE FOR HOSPITALS
- ADOPT TECHNOLOGIES THAT ARE LABOR-SAVING AND INTEGRATIVE ACROSS THE HOSPITAL

PATIENT CENTERED CARE

- **MAKE ADOPTION OF PATIENT-CENTERED CARE VALUES A PRIORITY FOR IMPROVING PATIENT SAFETY AND PATIENT AND STAFF SATISFACTION**
- **INCORPORATE PATIENT-CENTERED CARE PRINCIPLES INTO THE ACTIVITIES OF HOSPITAL OVERSIGHT BODIES AND TRANSPARENCY INITIATIVES**
- **ADDRESS BARRIERS TO PATIENT AND FAMILY ENGAGEMENT, SUCH AS LOW HEALTH LITERACY AND PERSONAL AND CULTURAL PREFERENCES**
- **ELIMINATE DISPARITIES IN THE QUALITY OF CARE FOR MINORITIES, THE POOR, THE AGED AND THE MENTALLY ILL**
- **IMPROVE THE QUALITY OF CARE FOR THE CHRONICALLY ILL THROUGH ADOPTION OF CARE MODELS THAT ENCOURAGE COORDINATED, MULTI-DISCIPLINARY CARE**
- **USE ROBUST PROCESS IMPROVEMENT TOOLS TO IMPROVE QUALITY AND SAFETY, AND SUPPORT ACHIEVEMENT OF PATIENT-CENTERED CARE**

ADDRESS THE STAFFING CHALLENGE

- ADDRESS THE MAL DISTRIBUTION OF HEALTH CARE WORKERS ACROSS THE GLOBE BY INSTILLING FAIR MIGRATION AND COMPENSATION POLICIES FOR AFFECTED COUNTRIES
- EXPAND HEALTH PROFESSIONAL EDUCATION AND TRAINING CAPACITY TO ACCOMMODATE THE GROWING DEMAND FOR HEALTH CARE WORKERS
- CREATE WORK PLACE CULTURES THAT CAN ATTRACT AND RETAIN HEALTH CARE WORKERS
- SUPPORT THE DEVELOPMENT OF HEALTH PROFESSIONAL KNOWLEDGE AND SKILLS REQUIRED TO CARE FOR PATIENTS IN AN INCREASINGLY COMPLEX ENVIRONMENT
- EDUCATE HEALTH PROFESSIONALS TO DELIVER TEAM BASED CARE AND PROMOTE TEAMWORK IN THE HOSPITAL ENVIRONMENT
- DEVELOP THE COMPETENCE OF HEALTH PROFESSIONALS TO CARE FOR GERIATRIC PATIENTS

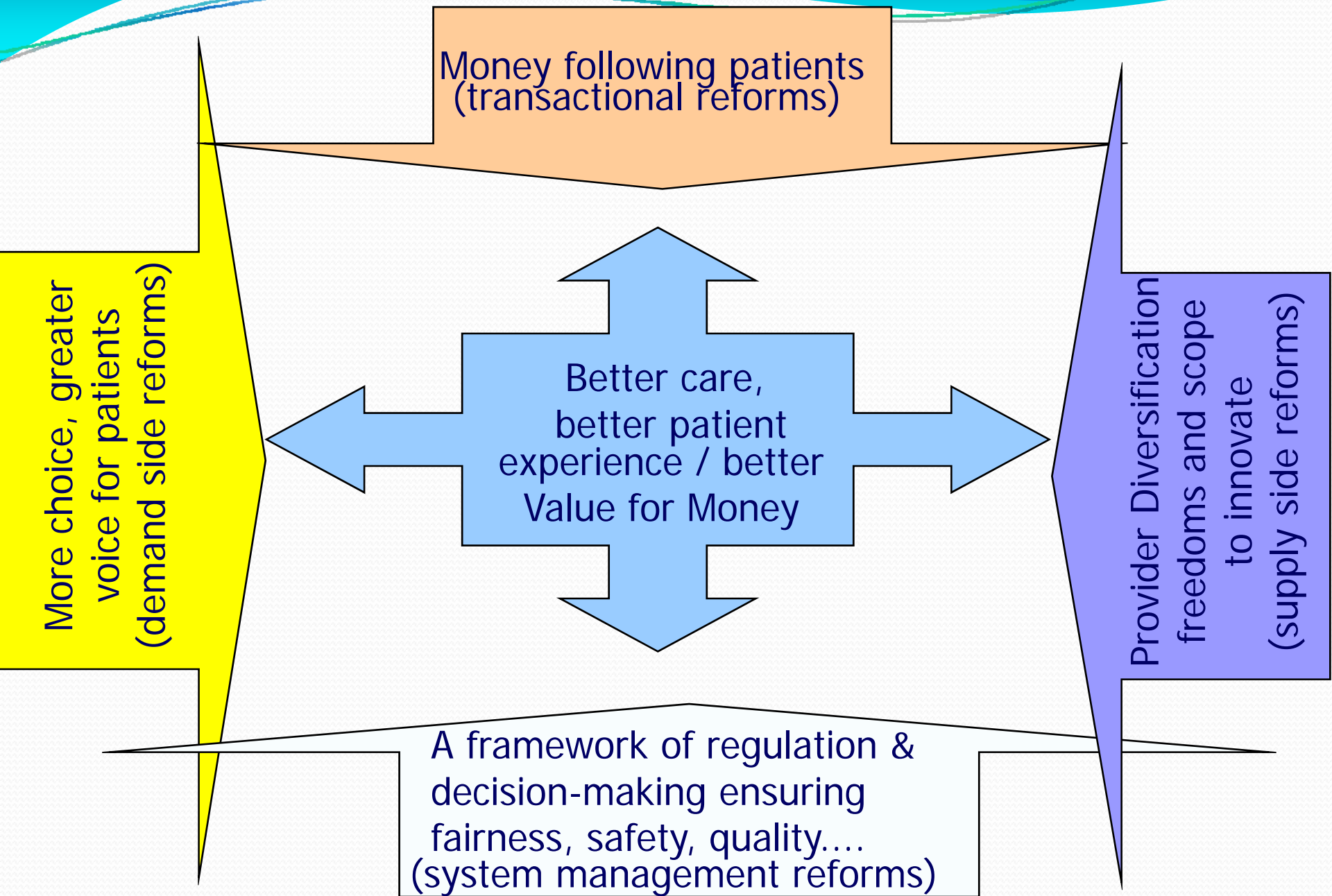


TO GUIDE DESIGN

- INCORPORATE EVIDENCE-BASED DESIGN PRINCIPLES THAT IMPROVE PATIENT SAFETY, INCLUDING SINGLE ROOMS, DECENTRALIZED NURSING STATIONS AND NOISE-REDUCING MATERIALS, IN HOSPITAL CONSTRUCTION
- ADDRESS HIGH-LEVEL PRIORITIES, SUCH AS INFECTION CONTROL AND EMERGENCY PREPAREDNESS, IN HOSPITAL DESIGN AND CONSTRUCTION
- INCLUDE CLINICIANS, OTHER STAFF, PATIENTS AND FAMILIES IN THE DESIGN PROCESS TO MAXIMIZE OPPORTUNITIES TO IMPROVE STAFF WORK FLOW AND PATIENT SAFETY, AND CREATE PATIENT-CENTERED ENVIRONMENTS
- DESIGN FLEXIBILITY INTO THE BUILDING TO ALLOW FOR BETTER ADAPTION TO THE RAPID CYCLE OF INNOVATION IN MEDICINE AND TECHNOLOGY
- INCORPORATE “GREEN” PRINCIPLES IN HOSPITAL DESIGN AND CONSTRUCTION

**A WORLD CLASS HEALTH AND
HEALTHCARE SYSTEM
(NHS)
COMMISSIONING FOR QUALITY**

NHS System Reforms



Stepping stones to transformation

Outcomes

- Reducing inequality
- Increasing quality and safety
- Value for Money
- Improved health outcomes
- Patient experience aligned

Processes

- Commissioning
- Providers - competitive behaviours
- Regulation
- System management

KEPUSTAKAAN

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- HOSPITAL OF THE FUTURE. HEALTH CARE AT THE CROSS-ROADS :GUIDING PRINCIPLES FOR THE DEVELOPMENT OF THE HOSPITAL OF THE FUTURE THE JOINT COMMISSION 19TH NOVEMBER 2008
- PERDOSRI : INDIKATOR KLINIK PELAYANAN REHABILITASI MEDIK DI RUMAH SAKIT, SEMARANG, 26 –27 MEI 2010
- NASKAH LENGKAP KONVENSI HTA INDONESIA, DEPOK 16 JUNI 2010

A photograph of a misty forest path. The path is made of dark brown earth and is flanked by lush green ferns and other vegetation. Tall, slender trees with thick trunks line the path, and a light mist hangs in the air, creating a serene atmosphere. The text "TERIMA KASIH" is overlaid in the center of the image.

TERIMA KASIH