

Approach to Improving Quality: the Role of Quality Measurement and a Case Study of the Agency for Healthcare Research and Quality Pediatric Quality Indicators

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KEYWORDS

- Quality assurance • Quality indicators • Health care
- Pediatrics • Comparative reporting

A 1-year-old undergoes abdominal surgery, and her parents are relieved it is over, start to relax, and make plans for returning home. Three days later, their baby returns to the operating room for reclosure of postoperative disruption of the abdominal wall. A 7-year-old complains loudly to his mother about sharp belly pains in his lower right side; she calls the pediatrician's office and is told to come right in. Lacking transportation, she does not make it in with the boy, and no one calls to see why. That night, he is writhing and they take a cab to the emergency room from where he is rushed to the operating room to remove his rupturing appendix.

These two stories hit us in the gut, quite literally. Anecdotes of suboptimal care make us ask what could have been done to avoid the bad outcome for that child. But how do we know how well the health care system is doing on a larger scale? Data and well-constructed measures can quantify the scale of the problem and

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thereby direct efforts to make improvements. From 2000 to 2003, the rate of wound dehiscence requiring a return to the operating room during the same hospitalization remained steady at 0.76 cases per 1000 abdominopelvic surgeries, and the rate of perforated appendix was also unchanged, but much higher, at 31% of appendectomies.¹

A clarion call has sounded for children's health care² to develop interventions to improve outcomes of care, develop comparative quality reports for decision making and accountability, and create incentives that pay for performance. Each of these three goals requires data and measures. This article describes the context for measurement in pediatrics, provides a case study of the development of an indicator set using routinely collected hospital discharge data, and addresses considerations for selecting and using measures in various circumstances.

THE CURRENT MEASUREMENT LANDSCAPE AND PEDIATRICS

Many researchers, governmental agencies at the federal and state levels, provider organizations, and health care payers have instituted quality measurement aimed at performance improvement. In 2006, the Institute of Medicine published "Performance Measurement: Accelerating Improvement," a report from their Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs.³ This report highlighted the incredible proliferation of measures and consequent need for standardization to mitigate the potential burdens of excessive measurement and reporting requirements. Because the report resulted from a congressional mandate oriented toward the Medicare program, there was scant coverage of children's health, but there was a clear message that measurement is important to quality improvement.

Measure development in children's health is at an earlier stage compared with adult medicine, with a need for more measures across all settings of care.^{4,5} At some stage in the future, though, the same problem of a plethora of measures and insufficient standardization could emerge for children's health. An obstacle to rational measurement in pediatrics—development of the right number of measures, covering the right areas, available at the right moment—may be the fragmented payment terrain and, thus, a lack of a single entity or program (eg, Medicare) that can provide the necessary incentives to make health care quality measurement and underlying information infrastructures as crucial as they are becoming for adult care.^{6,7}

Nevertheless, motivation for quality measurement in pediatrics is increasing because reports show that quality gaps exist in pediatric ambulatory, emergency room, and hospital care that are similar to those demonstrated in adult settings.^{8–11} Simply applying adult indicators to younger age ranges is insufficient in many situations. Specific challenges arise from the "four Ds" that distinguish children from "little adults:" differential epidemiology, dependency, demographics, and development.^{4,12} Whether developing child health indicators from scratch or based on adult analogs, measure developers must consider the implications of each of these factors to produce robust indicators and comprehensive measure sets (**Table 1**). Although there are special challenges in pediatrics, many of the approaches to indicator development, assessment, and application are similar regardless of age of the patient population of interest.

Numerous frameworks exist for assessing indicators and measure sets, and vary somewhat with regard to the purpose of measurement (eg, comparative reporting among countries,¹³ national consensus measures for use in public reporting and quality improvement,¹⁴ and inclusion in a clearinghouse of measures¹⁵). In addition,

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