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Quality of Cardiac Care in Canada: Recommendations for Building a Sustainable Future

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ABSTRACT

Cardiovascular (CV) disease continues to present a significant disease and economic burden in Canada. To improve the quality of care and ensure sustainability of services, a national quality improvement initiative is required. The purpose of this analysis was to review the evidence for public reporting (PR) and external benchmarking (EB) to improve patient outcomes, and to recommend a strategy to improve CV care in Canada. To incorporate recent literature, the Canadian Cardiovascular Society (CCS) commissioned the Institute of Health Economics to provide a rapid update on the literature of PR and EB. The review showed that EB is more likely to promote positive effects, such as improved mortality, morbidity, and evidence-based clinical practice, and to limit negative effects, such as access restrictions or unintended provider behaviour associated with some forms of “top-down” PR. On the basis of these findings, this we recommend the following: (1) secure funding for the provincial collection of CV quality indicators and the creation of annual National CV Quality Reports; (2)

RÉSUMÉ

Les maladies cardiovasculaires (CV) constituent encore un important fardeau sanitaire et économique au Canada. Pour améliorer la qualité des soins et assurer la viabilité des services, une initiative nationale d'amélioration de la qualité est nécessaire. La présente analyse passe en revue les données probantes sur l'établissement de rapports destinés au public et l'évaluation externe. Elle a été effectuée dans l'optique d'améliorer les résultats des patients et de recommander une stratégie axée sur l'amélioration des soins CV au Canada. Afin d'y intégrer la documentation récente, la Société canadienne de cardiologie (SCC) a confié à l'Institute of Health Economics le mandat de dresser à brève échéance un bilan de la documentation touchant l'établissement de rapports destinés au public et l'évaluation externe. La revue de la documentation a montré que l'évaluation externe est plus susceptible de favoriser des effets positifs, tels que l'amélioration de la mortalité, de la morbidité et de la pratique clinique fondées sur des données probantes, et de limiter les effets négatifs, tels que les

Cardiovascular (CV) disease places a huge burden on the Canadian health care system. As a leading cause of death and cause of hospitalization for Canadians, CV disease diagnosis and treatment consumes approximately \$22.2 billion. In 2004, hospitalized patients in Canada had an adverse event rate of 7.5%–38%, many preventable ([Supplemental References S1–S4](#)). Because of the burden of CV disease and adverse events, national quality improvement initiatives are required to improve safety and quality of care. In this review we summarize the evidence for public reporting (PR) and

external benchmarking (EB) in improving patient outcomes and recommend a strategy to improve CV care in Canada.

The difference between PR and EB is that EB is intended to promote improvement using comparative assessment as part of a broader, more comprehensive improvement plan. PR presents outcome data to the public for the purpose of comparisons of health care providers and or their programs. Historically, PR has led to punitive mechanisms for change,¹ but organizations such as the National Health Service² and Institute for Healthcare Improvement have emphasized the maxim: “Measurement is for improvement, not judgement.”³ EB is the process of assessing activities and comparing their outcomes across one or more organizations.⁴ By identifying top performers and describing the methods they used, best practices are shared so that organizations can strive to improve ([Supplemental Reference S5](#)). EB informs and promotes the development of new processes of care and measurement tools, driving improvement in outcomes.

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enhance the culture of using CV quality indicator data for continuous quality improvement and opportunities for national or regional EB and sharing best practices; and (3) implement ongoing evaluation and revision of CCS clinical practice guidelines incorporating key quality indicators. This is already under way to a limited extent by the CCS with its Quality Project, but intentional, sustained support needs to be secured to enhance this ongoing effort and improve the quality of CV care for all Canadians.

Systematic Review

In 2012, the Agency for Healthcare Research and Quality published a systematic review of studies between 1980 and 2011⁵ on the outcomes of PR initiatives. The objective was to determine: (1) the effectiveness of PR as a quality improvement strategy; (2) whether PR leads to changes in health care delivery or in patients' behaviours; and (3) whether the characteristics of reports and contextual factors influence the effect of PR. There was inconsistent evidence that PR is associated with reduced mortality, but consistent evidence that PR is associated with improvement in care processes and quality indicators (QIs). Negative consequences were unintended risk aversion for high-risk, complex patients or changing coding of procedures.

As an update to this review, the Canadian Cardiovascular Society (CCS) commissioned the Institute of Health Economics to provide a rapid update on the literature on EB as well as PR (Supplemental Appendix S1). Nearly 1000 studies were filtered down to 28 studies of interest. The report showed mixed evidence for PR but consistent evidence for EB on positive CV outcomes. EB was not associated with any negative outcomes, but was correlated with improved mortality, morbidity, and evidence-based clinical practice. Thus, although both forms of comparative assessment have potential to drive quality improvement, recent evidence indicates EB is more likely to promote positive effects and limit negative effects.

Discussion

To improve individual provider and facility outcomes, various jurisdictions have attempted to use PR to improve patient outcomes.⁵ In contrast to EB, PR is often perceived as a "top-down" approach, not associated with a deliberate plan for improving or changing the activities that generated the outcomes.¹ Previously theorized pathways for PR to result in improvements were in the American context and included: (1) the selection pathway, where patients use public reports to choose better-performing physicians or facilities, thus motivating improvement; (2) the change pathway, whereby reported quality deficits spur improvement; and (3) the reputation

restrictions d'accès ou les comportements indésirables de fournisseurs associés à certaines formes « descendantes » d'établissement de rapports destinés au public. Sur la base de ces constatations, nous recommandons de : 1) assurer le financement pour les relevés d'indicateurs de qualité en matière de soins CV à l'échelle provinciale ainsi que la rédaction de rapports annuels sur la qualité des soins CV à l'échelle nationale; 2) promouvoir le recours systémique aux indicateurs de qualité en matière de soins CV aux fins d'amélioration continue de la qualité, d'étalonnage externe à l'échelle nationale ou régionale et de mise en commun des pratiques exemplaires; 3) mettre en place un processus d'évaluation et de révision continues des lignes directrices de pratique clinique de la SCC intégrant les principaux indicateurs de qualité. La SCC a d'ores et déjà amorcé dans une certaine mesure la mise en œuvre de ces recommandations dans le cadre de son Projet de qualité, mais un appui ferme et soutenu doit être assuré pour consolider la démarche en cours et améliorer la qualité des soins CV au profit de tous les Canadiens.

pathway, where underperforming physicians suffering reputation loss, then improve (Supplemental References S6, S7). However, as shown in the reviews cited, the evidence for improvements through PR is inconsistent. Further, in the Canadian context, with its sparsely populated large land base and highly centralized health care, many individuals have only limited physicians or hospitals to choose from. Patients often have physicians and facilities selected for them, largely on the basis of their location. Therefore, improvement through the influences described is less likely to occur in Canada. Therefore, using PR to establish transparency and burning platforms for improvement, and EB to assess and compare health care outcomes might be more relevant to the Canadian context.⁴ However, large-scale change will only occur by engaging clinicians, measuring without judgement, and using EB to stimulate continuous quality improvement.

There are examples within many jurisdictions in Canada where intraprovincial benchmarking has had an effect. Cardiac Services BC has annual quality meetings, which report key QIs among their cardiac centres. Sustained improvements in outcomes, such as mortality, evidence-based medications for secondary prevention, and annual reduction in blood product transfusion have been seen (Supplemental Appendix S2). In Alberta, a 1.5- to 2-fold difference in 30-day stroke mortality was identified and through establishment of key process indicators and learning collaboratives, stroke outcomes improved throughout rural Alberta (Supplemental Appendix S3). In Quebec, repeated province-wide benchmarking of care for patients with ST-elevation myocardial infarction across individual facilities has led to the mobilization of providers and decision-makers at many levels of the health care system and led to dramatic increases in the use of prehospital electrocardiograms, improved care pathways, and reductions in treatment delays (Supplemental Appendix S4). Information from benchmarking also contributed to the deliberation process for the new quality standards for ST-elevation myocardial infarction care in Québec.

Although noteworthy improvements have been achieved within provinces, national benchmarking gives the opportunity for coast-to-coast improvement. Because of the limited choices

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