

Quality Lines

DEVELOPING QUALITY INDICATORS FOR OLDER ADULTS: TRANSFER FROM THE USA TO THE UK IS FEASIBLE

Quality indicators are increasingly being used to assess health care, yet good indicators are expensive to develop. Can existing quality indicators be transferred from the USA to the UK? Steel and colleagues took a set of quality indicators for the health care of older adults that had been developed at RAND in the USA, and asked an expert panel in England to score them for validity. The panel judged 100% of the indicators about treatment, continuity, and follow up as valid, and 86% of the indicators overall as valid.

The 102 indicators judged as valid for use in England cover 16 clinical areas and so can be used to assess quality for several conditions simultaneously. They are designed for use in interview surveys, and so will avoid some of the problems with extracting data from clinical records. Patients are an underused source of information about quality of health care, and have the advantage that they can also provide contextual information such as health status and social and financial background.

See p 260

VARIATION IN MEDICAL DECISIONS: WHERE DOES IT COME FROM AND HOW TO REDUCE IT

Variation in medical decisions is not uncommon. Its sources are not always understood. Kostopoulou and Wildman used “paper patients” to track the decision making process of senior clinicians making intubation decisions for chronic obstructive pulmonary disease patients in acute respiratory failure. Three sources of variation were identified: clinicians attached importance to different information, gathered different information, and interpreted information differently. Assessing patients’

suitability for intubation and ventilation is a difficult and uncertain judgment. The recently published NICE guideline recommends considering seven pieces of information but psychology tells us that people cannot do this unaided. The authors argue for simple decision aids to be developed, based on prognostic models, to enable clinicians to take critical information into account, assess its relative importance, and interpret it correctly, thereby tackling all three sources of variation identified.

See p 272

IMPROVING THE QUALITY OF HEALTH CARE FOR CHRONIC CONDITIONS

Globally, chronic conditions are on the rise. This is placing new, long term demands on healthcare systems. The World Health Organization has joined with the MacColl Institute for Healthcare Innovation to create the Innovative Care for Chronic Conditions (ICCC) Framework, which provides a road map for decision makers who want to improve their health system’s capacity to manage chronic conditions. The ICCC Framework is an expansion of MacColl’s Chronic Care Model (CCM), which was developed to present a structure for organising health care for chronic conditions. The new, expanded framework comprises fundamental components within the levels of patient interactions, and organisation of health care, community, and policy. These components are described as building blocks, which can be used to help decision makers progressively create or re-design a healthcare system to expand their capacity to manage long term health problems.

A number of countries are now implementing the CCM and ICCC Framework to respond to the increasing healthcare burden. Initial results are promising and could serve as catalysts for improvement at a global level.

See p 299

EDITOR’S CHOICE

Persuading people to change practice or to work differently, even when the proposed changes are likely to benefit patient care, is incredibly difficult. We seem to accept working practices and customs that are better suited to a different age. The introduction of medical emergency teams (METs), which can be called by any member of staff who sees a patient deteriorating, resulted in a reduction in the number of people who actually suffered a cardiac arrest. Yet implementation of this life saving organisational change was hindered by “cultural barriers”. Just what did it take to persuade professionals in that hospital to move forward and embrace change, and why did it take so long? An important part of this paper (*see p251 and 255*) is the discussion: the difficulties of getting the MET established and used effectively overcoming this sort of resistance has relevance beyond the introduction of METs. Another paper in this issue (*see p281*) describes the introduction of electronic reporting. A useful innovation that increased the number of reported incidents. But again, the discussion notes the presence of “cultural factors”, this time preventing physicians reporting incidents. Unless these embedded attitudes and behaviours are recognised and challenged, progress in improving the quality and safety of care will continue but only very slowly.

Today’s health services were not designed to support the growing number of people whose lives are disturbed by chronic disease. Nor are many parts of health services tuned into the expectations of modern patients, who much more than ever want to be involved in their own care and, evidence suggests, will benefit from such active participation. In this issue Epping-Jordan and colleagues (*see p299*) describe the Innovative Care for Chronic Conditions Framework, which aims to help the redesign of local health services so they can improve their support for people with chronic disease. Improving care for people with chronic conditions will involve big changes in care delivery and patients will need to become active participants. We now have the framework for redesign, but we must make sure that we understand, too, the all the potential “cultural” and attitudinal barriers and feel able to challenge them so that they do not impede development of better systems of care.